



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

June 14, 1990

To: Donna Quinn
From: Lois Bergeisen *LB*
Re: Future Student Award in Health Promotion/Disease Prevention

In follow up to our conversation, attached is a draft for a possible award for "Excellence in Health Promotion/Disease Prevention." At this time, the award is still in the concept stage within the AAMC, AMSA, ACPM and ATPM, though we all seem to be in agreement in principal.

I'd appreciate it if you would share this with the OSR Executive Board. I would welcome any comments from them. Some of the issues which need further discussion beyond formal approval of all of our organizations are:

1. What are the types of activities that can qualify for the award?
2. What do we mean by "excellence?"
3. What should be included in the nomination packet?
4. What will the review criteria be?
5. What should the award be called?
6. How will the award be funded? Contributions from the participating organizations? Outside sponsorship by a foundation?

Thanks for your help with this.

AWARD FOR EXCELLENCE IN HEALTH PROMOTION/DISEASE PREVENTION

Purpose

This award sponsored by the Association of American Medical Colleges, American Medical Students Association, Association of Teachers of Preventive Medicine and American College of Preventive Medicine is designed to honor annually medical students for outstanding contributions to health promotion/disease prevention activities in three categories:

- efforts benefiting a community
- efforts benefiting medical students
- group community service projects

This award will carry an honorarium of \$1,000. Students will receive their award at the Association of American Medical Colleges annual meeting.¹ A description of their efforts will be published in *Academic Medicine*.²

Process

Students must be nominated by a faculty member in their institution. Each medical school may submit only one nomination in each category. The nomination package from the school must include: a description of the student's work in health promotion/disease prevention along with any materials they developed or articles written; a letter of nomination by a faculty member; a letter of support from student(s)' project (e.g, if work was done in a public school setting, then a letter from school principal or school board).

Nominations will be reviewed by an eight member panel composed of two representatives from each of the sponsoring organizations.

¹ Travel expenses to the AAMC annual meeting will also be provided.

² Other possibilities for publication include New Physician or Journal of Preventive Medicine.



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ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

August 20, 1990

Caroline Reich
1291 Mayfair Drive
Atlanta, GA 30324

Lawrence Tsen
4449 Francis
Kansas City, KS 66103

Dear Caroline and Lawrence:

The students of U.S. medical schools have a lot riding on the proposed changes in LCME accreditation standards. You will remember the "first reading" of the proposals at the June meeting of the AAMC Executive Council. The comments from that meeting were incorporated in a subsequent version of the proposed changes that will be on the agendas of the AMA Council on Medical Education in early September and the AAMC Executive Council later that month.

I urge the OSR to take a formal position (by resolution or however you do so) on the proposed changes. In the forums of academe there will be controversy over the empowerment of the curriculum committee to assure a coherent curriculum (rather than leaving it up to the department heads). There will be reluctance to abandon tests of cognitive achievement in favor of newfangled performance-based evaluations. And there already is mounting opposition to more specific policies about health and disability insurance on the grounds that is peripheral to the education program.

You might also touch base with your counterparts in the AMA's Medical School Section.

If the AMA Council on Medical Education approves the proposed changes without too much emendation, and the AAMC Executive Council could do the same, both sponsors could hold public hearings toward the end of the year and implement the new standards early next year. My intelligence leads me to believe that the AMA side will want even more explicit language on disability insurance for students, and this could be a problem with the COD and COTH.

In the past, proposed changes in accreditation standards have taken as long as three years to ratify because of disagreement among the parties who ultimately have to "sign off" on them. The united and public advocacy of students could speed the process enormously.

Caroline Reich
Lawrence Tsen
August 20, 1990
Page Two

I've enclosed copies of the latest version of the proposed changes, together with background material.

Best regards,



Donald G. Kassebaum, M.D.
Associate Vice President
Institutional Planning & Development
Director, Section for Accreditation

Enclosures

cc: Robert Beran, Ph.D.
Donna Quinn

3JUL90

PROPOSED CHANGES IN FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

ADD UNDERLINED WORDING AND (DELETE WORDING IN PARENTHESES)

1 EDUCATIONAL PROGRAMS FOR THE M.D. DEGREE/Design and Management
2
3

- 4 1. [Page 13, paragraph 1]
5

6 The program's faculty is responsible for the design, implementation, and
7 evaluation of the curriculum. To ensure integrated institutional
8 responsibility, a faculty committee, supported by the chief academic
9 officer and staff, must be given authority for the design and management
10 of a coherent curriculum. (A faculty committee should do this work,
11 with the support of the chief academic officer and staff.)
12
13

- 14 2. [Page 13, paragraph 1]
15

16 ...prepare a graduate for independent, unsupervised practice. Medical
17 schools must evaluate educational program effectiveness by documenting
18 the achievement of their students and graduates in verifiable and
19 internally consistent ways that show the extent to which institutional
20 and program purposes are met.
21
22

- 23 3. [Page 13, paragraph 2]
24

25 ...identified by the evaluations should be corrected. Medical schools
26 should use a variety of measures to evaluate program quality, such as
27 data on student performance/achievement, acceptance into residency
28 programs, postgraduate performance and licensing, and emerging measures
29 that may prove to be valid. The results of such evaluations should be
30 used to determine how well schools are fulfilling their objectives and
31 to assess the need for program improvement. Schools also should
32 evaluate the performance of their students and graduates in the
33 framework of national norms of accomplishment. Review and necessary
34 revision...
35
36
37
38
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41
42

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46

2 EDUCATIONAL PROGRAM FOR THE M.D. DEGREE/Evaluation of Student Achievement; Due
3 Process
4

- 5 4. [Page 14, paragraph 1]
6

7 (A committee of the faculty should) The medical school faculty must
8 establish principles and methods for the evaluation of student
9 achievement and make decisions regarding promotion and graduation. The
10 evaluation of student achievement should employ a variety of measures of
11 knowledge, competence, and performance, systematically and sequentially
12 applied throughout medical school. (The varied methods utilized should
13 determine whether or not students have attained the school's standards
14 of performance as well as national standards of performance, as measured
15 by licensing examinations, acceptance into residency programs, and
16 emerging measures which may prove to be valid. Each provisionally
17 accredited program must utilize methods for determining the quality of
18 its program and the level of achievement of its students compared to
19 national norms.)
20

- 21
22 5. [Page 14, paragraph 2]
23

24 ...should set the standards of achievement by students in the study of
25 that discipline. Equivalent methods and standards of evaluation must be
applied to students across all instructional sites within a given
discipline. Narrative descriptions...
28

- 29
30 6. [Page 14, paragraph 2]
31

32 ...use data in realistic problem solving. Performance-based clinical
33 assessment is encouraged to assure that students have acquired and can
34 demonstrate the core skills and behaviors needed in subsequent medical
35 training. If geographically separated...
36
37

38 MEDICAL STUDENTS/Personal Counseling; Student Health Services
39

- 40
41 7. [Page 16, paragraph 2]
42

43 There must be a system to provide preventive and therapeutic health
44 services to students and to make (hospitalization) health insurance
45 available to all students and their dependents. Schools must develop
46 policies dealing with students' exposure to infectious and environmental
47 hazards and the acquisition of disease or disability which may occur
48 during their educational program. Confidential counseling by...

PROPOSED CHANGES IN MEDICAL SCHOOL ACCREDITATION STANDARDS PUBLISHED IN THE
LCME'S FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

Background

At its meeting on June 6-7, 1990, the LCME approved changes in the accreditation standards published in Functions & Structure of a Medical School. According to LCME policy, changes must be approved by the AAMC and AMA sponsoring councils, and are subject to review and comment in public hearings held in Washington, D.C. and Chicago.

In the accompanying proposal, new material is underlined. Material to be deleted is enclosed in parentheses. Relevant pages from Functions and Structure of a Medical School are enclosed for better orientation of the emendations with the current text, and the locations of proposed changes are denoted by corresponding numbers in parentheses.

Rationale

The LCME is proposing these changes to foster the use of outcome measures in the assessment of program effectiveness; to strengthen the role of the curriculum committee and dean's office in curriculum management; to foster performance-based assessment of clinical competence in addition to tests of cognitive achievement; and to respond to new imperatives relating to students' exposure to infectious and environmental hazards imposed by their educational program.

The proposed changes will be forwarded for action by the AMA's Council on Medical Education (and a collateral public hearing) in October, 1990. They are brought to the AAMC's Executive Council at this time to avoid falling out of time with the AMA's parallel agenda later in the year. These are all of the changes proposed for Functions & Structure during the next year, although changes are likely to be considered on an annual basis as the train of events occasions more frequent revisions than in the past.

The explanation of individual changes follows (the numbers are keyed to each area of change):

1. In the current standard, "The program's faculty is responsible for the design, implementation, and evaluation of the curriculum. A faculty committee should do this work with the support of the chief academic officer and staff." The LCME believes that "should" is too permissive and that the standard ought to specify the curriculum committee's role to assure "integrated institutional responsibility for curriculum management." This is believed to better implement Conclusion V. of the GPEP report "...to formulate a coherent and comprehensive educational program...and supervise an integrated program..." It also would implement Recommendation (1) of the Macy Foundation report for "...an appropriate central unit that has authority to plan, organize, monitor, evaluate, and continuously revise the curriculum."

2. In the current standard, the curriculum committee "should monitor the content provided in each discipline in order that objectives for education of a physician are achieved....The objectives, content, and methods of pedagogy utilized for each segment should be subjected to periodic evaluation...(correcting) redundancies and deficiencies..." The LCME believes that the accomplishment of objectives must be evaluated in the assessment of educational program success. Moreover, the requirement that accredited institutions "evaluate educational program effectiveness by documenting the achievement of their students and graduates in verifiable and consistent ways that show the extent to which institutional and program purposes are met" is verbatim from the Department of Education criteria for recognition of postsecondary accrediting agencies.

3. In the current section on page 14, paragraph 1, "Evaluation of Student Achievement; Due Process", methods of program and student evaluation are commingled. This proposed change moves methods of program evaluation to page 13, paragraph 2, "Design and Management" and identifies for expository purposes typical measures that can be employed. The proposed wording preserves the language that schools should compare the performance of their students and graduates to national standards, to avoid a school's setting only parochial standards, and adds language about the use of a variety of program evaluation measures to determine success in fulfilling institutional missions and goals. This is in keeping with Department of Education criteria for recognition of postsecondary accrediting agencies.

4. The new language makes more explicit the expectation that evaluation of student achievement employ a variety of measures of knowledge, competence, and performance, systematically and sequentially applied throughout medical school. Most of the material in this paragraph proposed for deletion has been shifted to the earlier section on program evaluation.

5. With the increasing dispersal of settings for clinical education, there is greater need to assure comparability of standards and methods for evaluation across sites. In the current version of the standards, the "comparability clause" is applied only to geographically separate campuses.

6. The proposal emphasizes performance-based clinical assessment in order to help propagate its use and counter the over-emphasis on tests of cognitive achievement.

7. The proposed change aims to broaden insured services from hospitalization to health, applied to all students and their dependents, and to require schools to develop policies dealing with exposure to infectious and environmental hazards and the acquisition of disease or disability which may occur during their education program. This is congruent with AAMC guidelines about HIV/AIDS and other infections, and with resolutions adopted by the AMA's House of Delegates in the past year.

EDUCATIONAL PROGRAM FOR THE M.D. DEGREE

Duration

The program of education in the art and science of medicine leading to the M.D. degree must include at least 130 weeks of instruction, preferably scheduled over a minimum of four calendar years.

Design and Management

- (1) The program's faculty is responsible for the design, implementation, and evaluation of the curriculum. A faculty committee should do this work with the support of the chief academic officer and staff. The curriculum of the program leading to the M.D. degree must be designed to provide a general professional education, recognizing that, this alone, is insufficient to prepare a graduate for independent, unsupervised practice.
- (2)

The committee responsible for curriculum should give careful attention to the impact on students of the amount of work required. The committee should monitor the content provided in each discipline in order that objectives for education of a physician are achieved without attempting to present the complete, detailed, systematic body of knowledge in that discipline. The objectives, content, and methods of pedagogy utilized for each segment of the curriculum, as well as for the entire curriculum, should be subjected to periodic evaluation. Redundancies and deficiencies in the curriculum identified by these evaluations should be corrected. Review and necessary revision of the curriculum is an ongoing faculty responsibility.

(3)

Content

The medical faculty is responsible for devising a curriculum that permits the student to learn the fundamental principles of medicine, to acquire skills of critical judgment based on evidence and experience, and to develop an ability to use principles and skills wisely in solving problems of health and disease. In addition, the curriculum must be designed so that students acquire an understanding of the scientific concepts underlying medicine. In designing the curriculum, the faculty must introduce current advances in the basic and clinical sciences, including therapy and technology, changes in the understanding of disease, and the effect of social needs and demands on medical care.

The curriculum cannot be all-encompassing. However, it must include the sciences basic to medicine, a variety of clinical disciplines, and ethical, behavioral, and socioeconomic subjects pertinent to medicine. There should be presentation of material on medical ethics and human values. The faculty should foster in students the ability to learn through self-directed, independent study throughout their professional lives.

The curriculum must include the contemporary content of those expanded disciplines that have been tradi-

tionally titled anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine. Instruction within these basic sciences should include laboratory or other practical exercises which facilitate the ability to make accurate quantitative observations of biomedical phenomena and critical analyses of data.

The traditional required clinical subjects, which should be offered in the form of required experiences in patient care (customarily called clerkships), are internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery. Additionally, many schools require a clerkship in family medicine. Schools that do not require such a clerkship should ensure that their students develop the knowledge, skills, attitudes and behaviors necessary to enter graduate medical education programs in family medicine or the other primary care specialties. In the required disciplines or independently, students should receive basic instruction in all organ systems. Instruction and experience in patient care must be provided in both ambulatory and hospital settings and must include the important aspects of acute, chronic, continuing, preventive and rehabilitative care.

The curriculum must provide grounding in the body of knowledge represented in the disciplines that support the fundamental clinical subjects, for example, diagnostic imaging and clinical pathology. Students must have opportunities to gain knowledge in those content areas that incorporate several disciplines in providing medical care, for example, emergency medicine and the care of the elderly and disabled. In addition, students should have the opportunity to participate in research and other scholarly activities of the faculty.

Each required clinical clerkship must allow the student to undertake thorough study of a series of selected patients having the major and common types of disease problems represented in the primary and related disciplines of the clerkship. The committee responsible for curriculum must require close faculty supervision of the learning experience of each student at the appropriate level of graded clinical responsibility. Supervision must be provided throughout required clerkships by members of the school's faculty. The required clerkships should be conducted in a teaching hospital or ambulatory care facility where residents in accredited programs of graduate medical education, under faculty guidance, may participate in teaching the students. In an ambulatory care setting, if faculty supervision is present, resident participation may not be required. If required clerkships in a single discipline are conducted in several hospitals, every effort must be made to ensure that the students receive equivalent educational experiences.

The faculty committee responsible for curriculum should develop, and the chief academic officer should enforce, the same rigorous standards for the content of

each year of the program leading to the M.D. degree. The final year should complement and supplement the curriculum of the individual student so that each student will acquire appropriate competence in general medical care regardless of subsequent career specialty.

The curriculum should include elective courses designed to supplement the required courses and to provide opportunities for students to pursue individual academic interests. Faculty advisors must guide students in the choice of elective courses. If students are permitted to take electives at other institutions, there should be a system centralized in the dean's office to screen the student's proposed extramural program prior to approval and to ensure the return of a performance appraisal by the host program. Another system, devised and implemented by the dean, should verify the credentials of students from other schools wishing to take courses or clerkships at the school, approve assignments, maintain a complete roster of visiting students, and provide evaluations to the parent schools.

All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effect of social and cultural circumstances on their health. The students must be encouraged to develop and employ scrupulous ethical principles in caring for patients, in relating to patients' families, and to others involved in the care of the patients. These principles are essential if the physician is to gain and maintain the trust of patients and colleagues and the respect of the community.

In view of the increasing pace of discovery of new knowledge and technology in medicine, the LCME encourages experimentation that will increase the efficiency and effectiveness of medical education. Experiments should have carefully defined goals and plans for implementation, including methods of evaluating the results. The LCME must be notified of plans for a major modification of the curriculum so that the term of accreditation of the program can be reconsidered, if judged necessary.

Evaluation of Student Achievement; Due Process

- 4) A committee of the faculty should establish principles and methods for the evaluation of student achievement and make decisions regarding promotion and graduation. The varied measures utilized should determine whether or not students have attained the school's standards of performance, as well as national standards of performance, as measured by licensing examinations, acceptance into residency programs, and emerging measures which may prove to be valid. Each provisionally accredited program must utilize methods for determining the quality of its program and the level of achievement of its students compared to national norms.

The faculty of each discipline should set the standards of achievement by students in the study of that discipline. Narrative descriptions of student performance and of non-cognitive achievements should be recorded to supplement grade reports in all required clinical clerkships and in all courses where student-faculty interaction permits this form of assessment. The faculty committee should review the frequency of examinations and their scheduling, particularly when the students are enrolled in several subjects simultaneously. The LCME urges schools to develop a system of evaluation that fosters self-initiated learning by students, and disapproves of the use of frequent tests which condition students to memorize details for short-term retention only. Examinations should measure cognitive learning, mastery of basic clinical skills, and the ability to use data in realistic problem solving. If geographically separated campuses are operated, a single standard for promotion and graduation of students should be applied. (5)

The medical school must publicize to all faculty members and students its standards and procedures for the evaluation, advancement, and graduation of its students and for disciplinary action. There should be a fair and relatively formal process for the faculty or administration to follow when taking any action that adversely affects the status of a student. A student's records must be available for review by the student, and the student must have the right and be given the opportunity to challenge the accuracy of the record. Student records must be confidential and should be made available only to members of the faculty and administration with a need-to-know, unless released by the student, or as otherwise governed by laws concerning confidentiality. (6)

Academic Counseling and Career Guidance

The chief academic officer and the directors of all courses and clerkships must design and implement a system of evaluation of the work of each student during progression through each course or clerkship. Each student should be evaluated early enough during a unit of study to allow time for remediation. Course directors and faculty assigned to advise students should consider this duty a primary responsibility. All course directors or departmental heads, or their designates, should serve as expert consultants to the chief academic officer for facilitation of performance of both students and faculty.

The faculty and the chief academic officer must establish a system to assist students in selecting a future medical career and in developing a strategy for application to residency programs. This system should not permit disruption of a student's curriculum in general medical education by external pressures to make premature application to residency programs. Letters of reference or other credentials should not be provided until the fall of the student's senior year.

Such special students may be less well prepared to undertake the responsibilities of clinical clerkships than medical students enrolled in accredited programs. These students may require remedial work, greater supervision, and a more intense utilization of resources. In the event that an institution decides to accept such additional students into the required clinical clerkships, the LCME should be notified so that it might consider the possibility of reassessing the adequacy of that institution's teaching resources.

**Financial Aid;
Amenities for Students**

A medical school must provide students with effective counseling about financial aid. To the extent possible, a school should develop its own resources for providing financial aid to students, thereby reducing their dependence upon external sources.

A school should provide students with amenities that increase efficiency, such as study space, lounge areas and food service, if not available in the immediate vicinity of the school. Personal lockers should be available to each student. The medical school should have an appropriate security system for its personnel and all properties.

**Personal Counseling;
Student Health Services**

A school must have an effective system of personal counseling for students. The faculty and administrators should determine whether personal counsel is to be provided by an officer of administration, by assignment of faculty members or others for this purpose, or both.

There must be a system to provide preventive and therapeutic health services to students and to make hospitalization insurance available to students and their dependents. Confidential counseling by mental health professionals must be available to students.

(7)

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 Compu 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 300 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

American College of Physicians

March 12, 1990

Frank Davidoff, MD, FACP
Associate Executive Vice President
Education
215 351 2550

Caroline Reich, MD
Chairperson, Organization of Student Representatives
Association of American Medical Colleges
1 Dupont Circle, N.W.
Washington, DC 20036

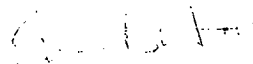
Dear Dr. Reich,

I am writing to invite OSR's formal participation in the ACP's Graduate Medical Education Subcommittee. Constituted a year and a half ago, this subcommittee has already become active in areas ranging from ambulatory education to manpower and curriculum. At its most recent meeting the subcommittee voted to expand its mission to formally include undergraduate medical education issues.

The committee and College leadership have become increasingly aware of the need for closer working relationships between the College and OSR. We would like to invite you to designate an OSR member or officer to attend the GME subcommittee meetings on a regular basis as a formal organizational liaison, **non-voting**, representative. The College is currently discussing whether it will be able to provide financial support of travel expenses for the representative.

Please call me if you have any questions or would like to discuss this further. We look forward to the opportunity of working with OSR on issues relating to medical education.

Sincerely yours,



Susan Deutsch, MD

cc. Frank Davidoff, MD, FACP
James Nolan, MD, FACP
Maxine Topping

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*Ad Bd. Please review and determine if you wish to respond or act. The
Should it be sent to consortium reps? I await your decisions.
Donna*

TO:

RECEIVED
ASSOCIATION OF
AMERICAN MEDICAL COLLEGE APPLICATION SERVICE
Division of Student Services
1776 Massachusetts Avenue, Northwest, Suite 301, Washington, D.C.
20036-1990

We, the Institute of Medicine of Timisoara, country Romania, recently liberated from the hardship of the abusive socialist regime whose leader was Ceausescu, are more than happy today when finally there is the freedom of reaching out to the most admired nations of all United States of America.

In our Institute, there are several American students, who were more than happy to give us our address with the warm recommendation and assurance that you, especially students, are willing to reach out to us, thus to form together an International Student Union.

We, are like the today born eagle, whose wings are weak, thus we are looking to you to help us in any possible way, so together to be able to become under your care and assistance an true eagle ready to fly with you to the peak of the humanity and science, freed from any reticence or doubt.

Useless to tell you in which way we survived the past so abusive and so dark, because we very well know that Romania was an European Ethiopia, we are very sorry and ashamed of the darkness which poured on our minds, hearts and souls, that is way we are writting you today, making a plea to you, as well to every American Medical Association if it is possible for you to help our Institute of Medicine in any possible way, so in that way we will be enrolled among you in the mondial medical arena, as did our Romanian predecessor dr. prof. Ana Aslan, whose product Gerovital is so well known in States.

Our mailing address is: INSTITUTE OF MEDICINE TIMISOARA
Division of STUDENT SERVICES -S S M T
Str. Piata 23 August nr. 2-4 Room 17
City TIMISOARA, zip 1900 ROMANIA
Tel. 14402 or 34096 (961)

conventional aspect, but perhaps you may have seen thru the television and thru the press, the bloody massacres and damages that the socialist past dictatorial regime had done. At this moment we are in great need of every thing, you name it, beginning with books and magazines of medical science ending with the microscopical slide, copy-machine, etc..

AND, an organisatorial brevhar, since we are 100% all agreed to try with your help and assistance to have an indentic medical profile.

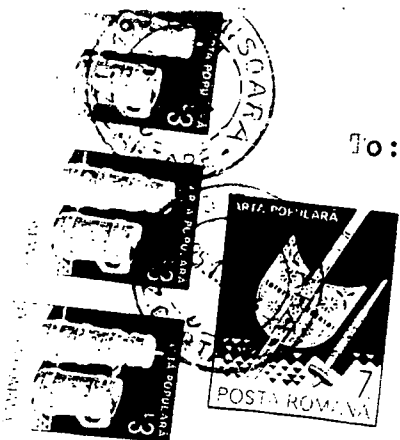
If, by any mean would be possible to sent somebody in person to contact us, we would be more than happy to be at your service.

In conclusion, we are looking forward to see you, and to receive an ever lasting help and correspondence.

May long live the Union between the American and Romanian
Students

God Bless You All !

Medical Student Union of Timisoara



To: ASSOCIATION OF AMERICAN MEDICAL COLLEGE /
APPLICATION SERVICES
Division of Student Services
1776 Massachusetts Ave, Northwest
Suite 301 Washinton, D.C. 20036-1990
U. S. A.

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Division of Student Services S.S.M.T
(Sindicatul Studentilor de Medicina
- Inst. Timisoara)
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Timisoara, Romania, 1900



6/6/90 Enclosed OSR materials with a packet of info being sent from AMCA

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

September 26, 1990
1776 Massachusetts Avenue
Washington, DC 20036

MINUTES

Present:

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

Representatives-At-Large

Cindy Knudson
Krishna Komanduri
Lee Rosen
Andrea Hayes
Anita Jackson

Absent:

Amy Davis

Regional Chairs

Phillip Noel
Tom Lee
Ashleigh Keyser

AAMC Staff

Donna Quinn
Robert G. Petersdorf
Brownie Anderson
Leslie Goode
Robert Beran
Donald Kassebaum
Lois Bergeisen
Elizabeth Martin
Herbert Nickens
Douglas Kelly

I. Call to Order

Caroline Reich called the meeting to order at 8:15 a.m.

II. Consideration of Minutes

The Minutes of the June 27, 1990 Administrative Board Meeting were approved without change.

III. Regional Reports

Oral regional reports were deferred. Amy Davis's written Central Region report was enclosed in the agenda booklet. Ashleigh Keyser submitted a written report at the meeting (both are attached).

IV. Information Items

A. Cases for the Annual Meeting Joint Plenary

Caroline described, and sought feedback on, the cases to be used for the joint plenary on student mistreatment. The board members offered suggestions and pinpointed the

key focus/discussion issues for each of the four cases.

B. Consortium Report

Lawrence reported the Military Medical Association was accepted for Consortium membership, but the Latino Midwest Association was not. The Consortium meeting to be held at the AAMC Annual Meeting is scheduled for Sunday, October 21 from 9:00 a.m. - 12:00 noon.

C. Housing Exchange Network

Students like this year's booklet. The next time it is mailed, the "disclaimer" memo needs to be attached to each booklet. No addendum is scheduled at this time.

D. President's Report

Dr. Petersdorf opened with highlights of the upcoming Annual Meeting. He updated on AAMC activities, including issues generated by the summer colloquia on biomedical research, reaching consensus/seeking Executive Council approval on the Physician Supply Task Force Report, and By-law changes. Regarding National Boards pass/fail, Dr. Petersdorf and the Executive Staff support the approach the students are taking, but warned that it would not be easy; while supporting the arguments regarding residency selection, he reiterated the arguments in support of scores. Dr. Petersdorf was in support of an OSR representative on the NBME and in favor of a student liaison to the American College of Physicians (ACP).

V. Discussion Items

A. Annual Meeting

Caroline reviewed the sessions one at a time to confirm the logistics and content. Some time was spent fine-tuning the OSR Plenary on Saturday, including securing the keynote speaker and clarifying the goal and end-product of the session. It was agreed that a "booklet" should be created immediately following the plenary by pulling together the recorders' notes generated by small group discussions. Ideally, this booklet would be distributed to the participants before they left the Annual Meeting.

It was decided that an addendum to the OSR Program would be valuable; board members were to submit any remaining information to Donna ASAP. The October "OSR Newsletter" would include the latest information about the meeting and the announcement about Administrative Board openings, with instructions to students interested in running/expecting to be nominated.

B. GEA - Breakfast Meeting, Pass/Fail Issue, Rewarding Teaching

Brownie Anderson joined the meeting to cover several topics. The board shared with her their ideas for a joint OSR/GEA project to be discussed with the GEA Steering Committee at a breakfast meeting during the Annual Meeting. The theme - Rewarding Teaching - lends itself to numerous possibilities, including an OSR Teaching Award, the development of an innovative evaluation system to assess quality teaching, and a teacher training program. Lee, Krishna and Phillip agreed to prepare a proposal for the breakfast meeting.

The GEA has addressed the issue of the National Boards pass/fail. Brownie

confirmed that, although not unanimous, the GEA supported the students' position. Caroline summarized the OSR's recent activities and plans to talk to the Councils and Groups at the Annual Meeting in an attempt to build additional grass roots support. The effort also includes letters asking constituents to lobby, addressing and educating constituents the Annual Meeting, and placing the issue on the February Executive Council Agenda, presumably for a vote.

The Administrative Board sought Brownie's opinion on the concept of a Video Tape Library of presentations on innovative curricula. Brownie stressed the need for a "dynamic" presenter and the inclusion of a simulation of the experience, and asked that such a resource be distributed through the GEA in order not to undermine the impact of the GEA Workshop Series.

C. Legislative Update

Leslie Goode reported on the status of and projections about the funding levels of the Budget. The Minority Health Bill -- approved by the subcommittee on Health, and preferential to the Senate's proposal, expanding funding to more institutions -- is likely to pass. The National Health Service Corps (NHSC) has passed in the House and the Senate; the House language is preferable. There was no progress on the Student Loan Deferment issue and the Student Loan Interest Deductibility, in spite of three hundred cosponsors, will not make it this year (due to the expense). It was suggested the Consortium is a good group to address key legislative issues and to get people stimulated.

D. Health Services/Insurance/Indebtedness

Bob Beran provided background on the GSA's Health Services Survey, results and subsequent guidelines. A Framework Document is in progress. There is a preliminary proposal pending in regard to insurance for HIV-positives students. It is too early to discuss the details, but the goal is to get students covered first, followed by institutions and residents/hospital employees.

Bob also raised the serious problem of indebtedness and its implications for students and institutions. The issue needs to be elevated to a high priority. It will be the topic of the President's Address at the Annual Meeting. The Council of Deans will address it at its 1991 Spring Meeting. Groups need to seek creative solutions for the deferment issue that, while not solving the high debt problem, will enable students to manage their debt more effectively. He mentioned the GSA-COSFA Default Prevention Subcommittee's Third Year Resident Survey, highlighting some results. It raised the question of how to encourage students to pursue Academic Medicine and provide real support for that pursuit.

E. Future Student Award in Health Promotion/Disease Prevention

Lois Bergeisen met with the Board to get ideas for a co-sponsored (AAMC, AMSA, ATPM, ACPM) award to recognize student contributions/projects beyond the DHHS Secretary's Award. The group discussed the purpose of the award, eligibility criteria (a project versus numerous personal contributions), sources of financial support, and other factors. Andrea and Lawrence will work with Lois to define the categories and criteria. The new award(s) may be initiated at the 1991 Annual Meeting.

Lois also discussed and sought input on prevention and other issues -- "Healthy

People 2000", a possible student survey on preventive medicine (or lack of it) in the curriculum, and the "Prevention '91" Program.

F. Proposed Changes to Accreditation Standards

Donald Kassebaum prefaced the discussion with a synopsis of the rationale and process of revising the standards. Providing background on all seven points, with attention to tricky words or phrases, Dr. Kassebaum answered questions and listened to student feedback. Caroline pointed out that students should be included in the curriculum development process and was pleased to see that student reports were beginning to get into Accreditation Self-Studies.

G. Proposed Educational Video on Issues of Discrimination

Liz Martin, Herb Nickens and Doug Kelly joined the Ad Board in an exploratory discussion on Joia Mukherjee's video proposal. Herb raised quality issues, the need to get a real sense of the product, the question of video as the best medium, distribution, and the AAMC addressing the issue on a larger scale. Krishna explained the genesis of the idea from a regional meeting presentation designed for use in the curriculum to generate discussion of discrimination issues; a set of vignettes allows the presenter to stop where appropriate, according to the format of the session in which it would be utilized. Liz wanted to clarify the audience(s), how it will be used, and the need and worth of such a project. In light of the changing applicant pool, there does seem to be a need to understand the new minorities; faculty need to know how to present information. A video like this should go to faculty and minority affairs officers. Herb reminded the group that this can be an explosive topic; the moderator of a video viewing would have to be comfortable with controversial discussion of the issues raised. The proposal needs to be strengthened and refined. If a survey of various constituents revealed a need and interest in this project, it could be a joint OSR/MAS/GSA/CAS effort.

H. NBME Pass/Fail

Caroline outlined the activity needed between the September Ad Board Meeting and the Annual Meeting to gather grass roots support for Pass/Fail. OSR Representatives would be asked to survey fellow students and to bring signed petitions to the Annual Meeting. Students and members of the GEA, GSA and COD would be asked to contact the CAS Administrative Board and members of the NBME Comprehensive Test Committees to express their viewpoint on the issue.

It was agreed that students need to learn about all the changes to the NBME exams. Tom would submit the information he obtained to Donna for inclusion in the October newsletter.

I. OSR Newsletter

October: NBME Informational Pack; Career Idea for October; Societal Responsibility Article; Notice about Ad Board Openings and Bringing CV's to the Meeting; New OSR Action Pack; and Call for Petitions in regard to the Pass/Fail Issue.

November: Post-Annual Meeting Information; Career Idea for November; Societal Responsibility Article; and Action Item seeking ideas for OSR projects and issues.

December: NO NEWSLETTER

January: Post-Retreat Information...

- J. ORR Proposal
After some initial discussion, it was decided that the Administrative Board Members who were residents would draft a proposal with ideas for representation, issues and process for the upcoming Organization of Resident Representatives (ORR).
- K. Romanian Medical Students
The group, wanting to help the Romanian students, agreed to try to send old journals and books, information about the OSR and other student organizations, and to ask AMSA, AMA and other groups to contact them as well.
- L. Responsibilities
The drafts of "Responsibilities of OSR Committee Representatives" and "OSR Representative Responsibilities" were approved with minor changes.
- M. Executive Council Items
The Board discussed the relevant Executive Council Items in order to provide Caroline and Lawrence the basis for voting at the Council Meeting.
- N. New Business
Caroline requested the generation and distribution of the updated "Designated Liaison" List for November.

Caroline ended her last Administrative Board meeting as Chair with a request for suggestions regarding the upcoming year.

Phone Tree -- mixed feelings: may not be cost-effective; consider doing it "rarely"; representatives appreciated it; call fewer at a time/split the list.

Monthly Newsletter: keep it going; it's effective.

Improve Accountability: remind representatives and Student Affairs Deans; recognize representatives' frustrations.

Submit articles to Weekly Report; work more with other medical student organizations.

Limit the number of projects; differentiate between OSR projects and Administrative Board projects. Make topics more specific.

VI. Adjournment

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

**REGIONAL REPORT
FOR THE SEPTEMBER ADMINISTRATIVE BOARD MEETING**

CENTRAL REGION

Submitted by: Amy Davis, Central Regional Chair
 University of Missouri-Columbia School of Medicine

1991 Regional Meeting

Kevin Baskin, Central Regional Chair-Elect is coordinating the 1991 Central OSR Regional Meeting to be held April 11-14 in Indianapolis, IN. Plans are well under way. The focus is "evaluation" from all perspectives (i.e., of teaching, of students, of curriculum, of standardized tests, etc.).

Annual Meeting

The Central Region will be hosting a social at the Annual Meeting in San Francisco; it is open to all groups (details to follow).

The Career Counseling/Mentor Lunch: a buffet lunch with "mentor" physicians from the San Francisco area and a speaker that will address career counseling. The speaker, William Pancoe, Ph.D., is Assistant Dean for Student Affairs at Creighton University. Suggestions for mentors would be appreciated. The number of students is limited to 100. Without assurance that the event is being funded by an external group, there would be charge for the students (amount not determined...), per Caroline's instructions.

Legislative Update: a small-group discussion format. Due to lack of funds, Capitol Hill folks will not be going out to San Francisco. Leslie Goode, and the new legislative analyst Jessica Sutin, will be present and Sarah Carr plans to attend as well.

ORGANIZATION OF STUDENT REPRESENTATIVES
WESTERN REGION REPORT
FROM THE SEPTEMBER ADMINISTRATIVE BOARD MEETING

Submitted by: Ashleigh Keyser, Western Region Chair
 University of Washington

The Western OSR Regional Meeting in April went well, with OSR focusing on training for practice in underserved areas -- rural and urban -- with emphasis on differences in conditions, resources, patient populations, and lifestyles. The take-homes were formulae for expanding training opportunities at home. The Fireside Chat, "Defining the Product" (of medical education) -- not as well-attended this year as fewer deans were at the meeting -- was too nebulous to achieve any consensus. It was, however, a wonderful joint discussion with OSR/GEA/GSA that has fostered an even better working relationship than we had before. The Business Meetings focused on "action items" follow-up. Some schools' representatives shared their efforts on the deferment issue using Krishna's OSR Action Pack, and other reps described innovations in medical education as they were affecting the students (e.g., OSKE's and PBL).

Since the meeting, the region has been busy further pursuing action items, gathering and submitting project forum ideas, and trying to produce the western region's newsletter.

One last project I am working on is a Chair's Handbook - supplement to the resource guide - with yearly planning schedules, rough regional and meeting schedules, successful (and unsuccessful) programs from the past, and local resource persons....all in an effort to prevent "reinventing the wheel" from year to year. If useful, we will be encouraging all representatives to devise similar supplements. A copy of the western region Chair's Handbook will be sent to Donna in case the original gets lost.

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AAMC PAPERS

*Two Reports of the AAMC Committee on AIDS and
the Academic Medical Center*

POLICY GUIDELINES FOR ADDRESSING HIV INFECTION
IN THE ACADEMIC MEDICAL COMMUNITY

THE HIV EPIDEMIC AND MEDICAL EDUCATION

JUNE 1989

Committee on AIDS and the Academic Medical Center

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Uniformed Services University of the Health Sciences

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Policy Guidelines for Addressing HIV Infection in the Academic Medical Community

October 1988

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Preface

IN SEPTEMBER 1987, the Association of American Medical Colleges (AAMC) appointed a Committee on AIDS and the Academic Medical Center, chaired by Jay Sanford, M.D., president and dean, Uniformed Services University of the Health Sciences. The Committee was charged to identify and discuss issues raised by the human immunodeficiency virus (HIV) epidemic that have specific relevance for academic medicine and to recommend policy positions and program initiatives for the AAMC and its member institutions.

Under the able leadership of Dr. Sanford, the Committee has developed this first full report which provides guidelines for institutions in addressing cases of HIV infection among medical students, residents, or faculty/staff. The report was drafted by the subcommittee on institutional policies, chaired by Festus Adebajo, M.D., chairman, department of pediatrics, Meharry Medical College. On September 8, 1988, the Executive Council of

the AAMC accepted the Committee report and approved distribution of it to AAMC members and other interested publics.

We are appreciative of the Committee's work and commend this report to you as a thoughtful reflection on the issues raised by the possibility of HIV infection within our academic medical community. Those who are charged with developing institutional policies in this area as well as those who administer them will benefit from it. We hope that the report will stimulate academic medical institutions to write policies that are responsive to the gravity of the epidemic and sensitive to the rights of those who are victims of it.

ROBERT G. PETERSDORF, M.D.
President
Association of American Medical Colleges

THE COMMISSIONING OF THIS REPORT

The acquired immunodeficiency disease syndrome (AIDS) and related diseases caused by human immunodeficiency viruses (HIV) pose unanticipated challenges to medical schools and to hospitals engaged in medical student and graduate education, biomedical research, and patient care. Institutional responsibilities in the face of these challenges merit thoughtful reflection and discussion by member institutions of the Association of American Medical Colleges (AAMC).

Toward this end, the Executive Council of the AAMC formed the Committee on AIDS and the Academic Medical Center. The Committee was charged to deliberate on issues raised by the HIV epidemic that were especially relevant for medical schools and teaching hospitals and to suggest policy positions and program initiatives for the AAMC and its member institutions.

This is the first full report of that Committee. The Committee has drafted a statement on the professional responsibility of medical students, residents, and faculty to provide care to HIV-infected persons. That statement has been endorsed by the AAMC Executive Council and distributed to AAMC members and the general public.* A further report is planned to offer guidance on the implications of the epidemic for medical student and resident educational programs.

This paper addresses the development of institutional policies and procedures directed at actual or possible cases of HIV infection among medical students, resident physicians, and faculty/staff. Particular attention is paid to the infected individual as a health care worker and the issues that arise in the context of

ensuring safe patient care and protecting individual rights. The report also contains specific recommendations with regard to providing information about and access to testing to all members of the academic community, and administrative actions in response to those known to be HIV-infected. Finally, the report offers a conceptual framework for dealing with the issue of admission to medical training of HIV-infected applicants.

This report does not discuss institutional responsibilities in the special case of HIV infection acquired occupationally in the clinical or laboratory setting. The Committee recognizes the intense concern of medical students, residents, and faculty/staff regarding personal health care and disability compensation consequent to acquiring HIV infection in the course of medical training or employment. The resolution of these issues will require a prospective collaborative effort by teaching institutions, union, insurers, and health care providers.†

Although the recommendations contained in this report are discussed specifically in regard to medical education, the Committee believes they may be useful to other health professions whose educational programs involve interactions with patients in hospital or clinic settings.

THE NEED FOR POLICIES

Recommendation 1. Institutions should develop specific policies in anticipation of cases of HIV infection among medical students, residents, and faculty/staff.

†The Committee has asked the AAMC Executive Council to establish a process to confer with academic medical institutions, groups representing affected students and employees, and the insurance industry to address these issues.

*Text of the statement appears in Appendix A.

Rationale. The issue of HIV infection in health care personnel evokes both appropriate concerns and irrational fears. These concerns are a legitimate warrant for policy development. Irrational fears of transmission of HIV have magnified the injury of the epidemic to its victims and to the community by stigmatizing infected individuals, justifying discrimination against them, and depriving the community of their contributions. These irrational fears have complicated efforts to develop effective public policies to address this epidemic.

Given these concerns and fears, a carefully considered, institutional policy offers several advantages over ad hoc administrative responses. The prospective consideration of institutional procedures and policies to address HIV-infected persons can facilitate the resolution of appropriate concerns and help to minimize the adverse consequences of irrational fears. By establishing clear lines of authority and responsibility and procedures for communication within the institution, policies can help to preserve the safety of patients and staff while protecting the personal rights of infected individuals.

The Committee's recommendations are addressed to academic medical center institutions, medical schools, and teaching hospitals. These are diverse and complex organizations. The appropriate locus of policy development may vary from institution to institution. All relevant clinical and administrative authorities and constituencies within institutions should be invited to contribute to the developing policy and be fully informed of its requirements. Coordinated and uniform policies throughout multi-institutional teaching programs are advisable.

Recommendation 2. Institutions should periodically review and, when appropriate, update policies in light of evolving medical and scientific understanding of HIV.

Rationale. Current medical and scientific understanding of HIV infection is the basis for responsible policy development. Evolving insights into the pathophysiology of HIV infection, the development of improved diagnostic, prognostic, staging tools, and treatment modalities, as well as new epidemiological perspectives on the disease and evolving social policy and legal thought — all require that policy responses be updated regularly. At the same time, the promise of new information does not lessen the responsibility of medical educators to address these issues using available information. Current policies must be designed in light of present knowledge and needs.‡

THE OBJECTIVES OF POLICIES

Recommendation 3. Institutional policies should be grounded in an explicit understanding of the multiple objectives they are intended to promote.

Rationale. There are a number of potential objectives for policies addressing HIV-infected health care workers. To some degree, these objectives are in tension with each other and merit policies that strike a balance between competing goals. Policies designed

by academic medical institutions should be mindful of the diverse interests and objectives that will be served or that may be affected by policies. The single-minded pursuit of one objective may result in policies or procedures that compromise or injure other important interests. Medical educators, by virtue of their scientific expertise, will be important leaders in the rational resolution of these issues.

The Committee suggests that the objectives of policies addressing HIV infection include the following:

- to provide expert and safe patient care;
- to protect the personal rights of HIV-infected individuals, including the right to freedom from unwarranted disparate treatment and improper handling of private information;
- to provide information, education, and counseling that promotes the personal and professional well-being of students, residents, and faculty/staff;
- to provide a safe work environment for all students, residents, and faculty/staff; and
- to provide for the implementation of laws and regulations pertaining to public health and welfare.

Several of these objectives merit special discussion. The concern for safe patient care and the issues pertaining to protection of personal rights will be discussed in this section. The relevant policy implications of the other objectives will be elaborated in later sections addressing particular policy concerns.

Safe Patient Care and the HIV-Infected Health Care Worker

Recommendation 4. Any modification of the clinical training or privileges of HIV-infected medical students, residents, or faculty/staff should be determined case-by-case, taking into account the nature of the clinical activity, the technical expertise of the infected person, and the risks posed by HIV carriage, attendant functional disabilities, and the transmissibility of simultaneously carried infectious agents.

Rationale. Although no case of transmission of HIV from health care worker to patient has been documented, concern for patient welfare is a proper foundation for the construction of policy. In contrast to other viral agents, for example hepatitis B, HIV has been shown to be relatively difficult to transmit, requiring minimally the transfer of body fluids, blood, or blood products. Health care worker-to-patient transmission of HIV is a theoretical risk in a limited scope of clinical activities, primarily invasive procedures, where it is conceivable that an infected health care worker could expose the patient to infected body fluids. Additionally, HIV-infected persons with advanced immunosuppression may be infectious with mycobacteria, herpes viruses, enteric pathogens, or other agents that pose a potential nosocomial hazard to patients. Finally, some HIV-infected health care workers may have neurologic conditions that impair their judgment.

Institutions may legitimately monitor or modify the clinical activities of students, residents, and faculty/staff who are believed to pose an unwarranted risk to patients. The Committee supports following the most current guidelines issued by the

‡A brief summary of the scientific and medical understanding of HIV infection available to the Committee at the time of its deliberations appears in Appendix B.

Centers for Disease Control addressing this issue with regard to HIV infection as well as those addressing nosocomial transmission of other agents. § Given that HIV is not believed to be transmissible in many types of clinical encounters and that the attendant presence of other infectious agents or functional disabilities will vary from person to person, the decision to restrict or monitor clinical activities cannot be based simply on all HIV-infected status. Rather, actions should be based on an individualized evaluation of each person's activities, his or her technical expertise, the risk posed by HIV carriage, attendant functional disabilities, and the transmissibility of simultaneously carried infectious agents. Institutions should affirm and support the participation of HIV-infected persons in clinical activities that do not pose a risk to patients.

Policies or administrative actions to restrict or monitor the clinical training or privileges of HIV-infected persons should be consistent with those directed at other infectious hazards and functional impairments. The development of policies addressing HIV infection affords an opportune occasion for institutions to review and update previously established policies addressing related issues.

Protection from Discrimination

Recommendation 5. Institutions should take positive actions to prevent discrimination against HIV-infected persons in employment, education, or use of public facilities.

Rationale. Ethical imperatives establish and legal statutes protect the rights of handicapped individuals. Section 504 of the 1973 Vocational Rehabilitation Act, as amended, specifies that "no otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program of activity receiving Federal financial assistance." The AAMC has supported the intent of this legislation to make more widely available vocational opportunities for handicapped individuals as it has also affirmed the responsibility of medical schools to examine the implications of each handicapping condition in terms of the observational, communicative, and motor skills, conceptual, integrative, and quantitative abilities, and behavioral and social attributes required for successful completion of the medical education program and competence in medical practice.

HIV-infected students, residents, and faculty/staff are vulnerable to unwarranted disparate treatment in housing, employment, and access to educational resources. Institutions should be mindful of this potential in the design of policies for HIV-infected persons. This problem might be addressed in several ways. Policies can affirmatively state the rights of infected persons. They can provide explicit, rational, proportionate, and equitable criteria for addressing the special concerns raised by their infected status. Infected individuals should be advised of and have access to intrainstitutional channels to appeal and obtain re-

dress of allegedly discriminatory policies, procedures, or administrative actions.

Proper Handling of Information

Recommendation 6. Institutions should establish policies and procedures to ensure the proper handling of information related to a person's HIV status.

Rationale. The need to handle personal and medical information in a manner sensitive to the rights of individuals is especially significant to HIV-infected persons. The way in which such information is treated is intimately related to the right not to be subjected to discrimination.

The nature of academic medical institutions poses especially complex problems for the maintenance of appropriate levels of confidentiality for their own students, residents, and faculty/staff. The issues posed by the unusual access of colleagues or coworkers to medical information should be explicitly addressed by institutions that test, counsel, treat, monitor, or intervene in the cases of HIV-infected students, residents, or faculty/staff. Clearly defined, confidential means of communication and information storage should be established. The "need to know" basis for reporting information outside of the therapeutic relationships between infected persons and persons treating them should be explicitly and individually justified. Information should be shared only to the degree necessary for the effective implementation of policies. The designation of one official to coordinate policy implementation may help to maintain confidentiality of such information.

AREAS OF SPECIAL CONCERN

The Committee recognizes several areas of special attention. The first is policies and procedures to provide information about HIV and access to HIV testing. The second concerns administrative actions in response to known cases of HIV infection. The last to do with the admission of HIV-infected persons to medical school and residency programs.

Information and Testing for Medical Students, Residents, and Faculty/Staff

AVAILABILITY OF INFORMATION

Recommendation 7. Institutions should inform medical students, residents, and faculty/staff of the relevance of HIV infection to their personal health, medical practice, the public health, and their professional careers, and of the institution's policies and procedures that pertain to possible cases of HIV infection among medical students, residents, or faculty/staff.

Rationale. The institution is responsible for providing information to medical students, residents, and faculty/staff so that they can protect their own health, treat and counsel patients, perform legitimate public health responsibilities, make informed career decisions, and, if HIV-infected, avoid transmitting the virus. The institution bears a special responsibility for informing st-

§At the time of the Committee's deliberations, these were the following: MMWR 1988; 37:377-382, MMWR 1987; 36:3S-18S.

ents, residents, and faculty/staff of the scope, requirements, and rationale for its own policies to address HIV infection in health care workers.

ACCESS TO TESTING

Recommendation 8. Institutions should encourage medical students, residents, and faculty/staff who believe they are at risk of HIV infection to seek testing and counseling. Institutions should provide access to both confidential and anonymous HIV-antibody testing programs that are methodologically sound and that properly counsel tested persons about the implications of positive or negative results.

Rationale. Early diagnosis is a fundamental principle of good medical care. It allows patients to benefit from care based on an accurate medical understanding of their condition. Although HIV infection is not curable, recent advances in therapeutic interventions enable physicians to prevent the occurrence of *Pneumocystis carinii* pneumonia, the leading cause of death, and to prolong life with specific antiviral therapy. Early diagnosis coupled with counseling is also important in preventing further spread of infection.

In order to attract into testing programs all persons who may be infected, institutions should provide access to various testing options, including both confidential and anonymous testing programs. All programs should employ approved testing methods and procedures for quality control. Information about testing programs should include a clear explanation of policies and procedures for reporting and storing test results.

Testing programs that are separate from the institution may be preferable to achieve policy objectives. Such programs may encourage more persons to take advantage of testing opportunities, because the promise of confidential handling of information may be more credible. Institutions that choose to provide access to HIV testing for medical students, residents, and faculty/staff through their own existing programs are encouraged to consult with legal counsel in order to understand fully and to alleviate to the maximum extent possible the legal risks that may attend such a choice. Advice of counsel should be sought on the question of whether knowledge of a person's HIV status obtained by the institution through such a testing program could be imputed to the institution in a later legal proceeding in which the failure to act consistent with such knowledge (e.g., in an appropriate case, by curtailing or limiting an infected person's role in an invasive procedure) arguably resulted in a patient's or other person's infection.

MANDATORY HIV SCREENING

Recommendation 9. Institutions should not initiate mandatory HIV screening of medical students, residents, or faculty/staff unless justified by evidence of a significant risk to patients.

Rationale. A requirement that the institution be aware or informed of the HIV status of all students, residents, or faculty/staff would have to be based on its responsibilities to safeguard patients and to protect the public health. The decision to screen must be anchored in medically and scientifically sound theory

and data concerning the risk of transmission and gravity of outcome. To justify mandatory screening, infection control authorities would have to agree first that a significant risk was present and could be reduced by additional monitoring or modification of clinical practices. Less intrusive alternatives to controlling the risk would have to be considered and demonstrated as ineffective or infeasible. The objectives to be achieved by mandatory screening would have to be balanced against the infringement of personal liberties that might be involved. The rationale and intervention to control the nosocomial transmission of HIV should be proportionate to those for other nosocomial risks.

Medical Students, Residents, and Faculty/Staff Known to be HIV-Infected

REPORTING

Recommendation 10. Institutions should encourage HIV-infected medical students, residents, and faculty/staff to discuss their situation with a designated institutional official.

Rationale. Medical students, residents, or faculty/staff who are aware that they are HIV-infected should be encouraged to inform the institution. Such reporting will enable a designated official to assist the individual in obtaining medical care and counseling, to work with the individual in managing occupational risks, to provide education and career counseling, and in the case of individuals performing selected invasive procedures, to manage nosocomial risks (as discussed above). To a considerable degree, encouragement for such reporting will be accomplished by the institution's demonstration of its commitment to confidentiality, protection against discrimination, and proportionate, equitable, individualized, and rational responses to such situations.

MEDICAL CARE AND COUNSELING

Recommendation 11. HIV-infected medical students, residents, and faculty/staff should have access to expert medical care and counseling and also be counseled on how to prevent further spread of infection.

Rationale. The immediate needs of the infected medical student, resident, or faculty/staff member are the same as those of any HIV-infected person: expert medical care and counseling. Medical care, even for someone not exhibiting symptoms of disease, is necessary to monitor the infected person's condition, to advise on the natural history of the viral infection and course of disease progression, and to consider treatment options. Counseling is required to help individuals cope with the psychological impact of HIV infection and to ensure that they know to prevent further spread of the virus. Medical care and counseling are best provided by a physician who is knowledgeable about HIV infection and disease, including the immunological consequences of infection, psychosocial aspects, and both proven and investigative therapeutic regimens. Institutions should ensure that infected individuals can avail themselves of such care and should provide access to expert care givers when necessary.

MANAGING OCCUPATIONAL RISKS

Recommendation 12. *Institutions should identify clinical settings with infectious hazards that might pose an additional risk to the personal health and well-being of HIV-infected persons, inform infected persons of these risks, and encourage them to consult their personal physicians to assess the significance of these risks for the personal health and safety.*

Rationale. Risk to a health care worker from exposure to infectious hazards in the clinical setting is inherent in the choice of a medical career. This risk is made manageable by access to, and use of, various safeguards and precautionary measures.

Medical training may pose a greater-than-normal risk to those whose immune systems are compromised. These possible risks may suggest the need for extra precautions or may cause immunocompromised individuals to reconsider their career intentions. In this context, the additional potential risks to HIV-infected health care workers should be addressed in institutional policies.

Consideration should be given to whether these risks call for modifications or restrictions in the clinical activities of students, residents, or faculty/staff. The personal health status of the individuals in question, their status in the educational program, and the clinical specialties of residents and faculty at the time they are identified as HIV-positive bear heavily on the nature and degree of modifications or restrictions on clinical activities that may be considered. Institutions should cooperate with the HIV-infected person, his or her personal physician, and other medical experts as appropriate in identifying and implementing special precautions and program modifications to safeguard the personal health and safety of such persons. Institutions must judge whether the curricular modifications required to reduce risk to a level acceptable to the infected medical student or resident are compatible with essential requirements of the medical education program.

EDUCATIONAL AND CAREER COUNSELING

Recommendation 13. *Institutions should provide HIV-infected medical students, residents, and faculty/staff with supportive and individualized educational and career counseling.*

Rationale. HIV-infected students, residents, and faculty/staff should have access to educational/career counseling. They will need to review their educational or career objectives in light of the realities of HIV infection, scientific progress, and professional responsibilities. Institutions may be able to adapt their clinical education programs in order for the HIV-infected medical student or resident to complete the training requirements. Institutions should make every effort to assist students, residents, or faculty/staff who wish to continue to pursue their current educational or career objectives. Assistance should be given to those contemplating a change in career within medicine as well as those electing to leave medical careers or training.

HIV Status and Admission to Medical Training

HIV INFECTION AND CAREER DECISION MAKING

Recommendation 14. *Institutions should inform medical school and residency program applicants of the relevance of acquiring HIV infection to their career goals.*

Rationale. Institutions have a responsibility to assist applicants to medical school and residency programs in making informed career choices. Knowledge that one has been infected with HIV is particularly relevant to the decision to apply to medical school or to elect specialty training. HIV-infected applicants may wish to reconsider their career goals. First, they may wish to reconsider the election of a prolonged period of medical education, in light of the significant possibility that they will become disabled during training or early in their career. Second, they may wish to reconsider career choices in light of the infectious hazards of certain portions of medical education and practice. Third, they may wish to reconsider career choices in recognition of possible barriers to certain invasive clinical activities and field of specialization within medicine that may be imposed because of possible nosocomial hazards to patients. Fourth, given the personal health and career uncertainties that confront them, they may wish to reconsider assuming the financial costs of medical education. Institutions should make special informational material about these issues generally available to all applicants.

HIV TESTING OF AT-RISK APPLICANTS

Recommendation 15. *Institutions should encourage medical school and residency program applicants who believe they are at risk of HIV infection to seek HIV testing and counseling prior to admission.*

Rationale. As discussed above, the benefits of early diagnosis and the importance of preventing virus transmission support the value of HIV testing and counseling for those who may be at risk. Also, such information may be particularly relevant to the applicant's choice of a medical career.

ADMISSIONS DECISIONS AND HIV-INFECTED APPLICANTS

Recommendation 16. *In considering the admission of a medical school or residency program applicant known to be HIV-infected, institutions should determine whether they are qualified in terms of the technical standards established by the institution in compliance with Section 504 of the 1973 Vocational Rehabilitation Act.*

Rationale. Determining whether the condition of being infected with HIV provides a basis for denying admission to medical school or residency training presents a complex problem for admissions committees. Although symptomatic HIV-infected persons currently have a poor prognosis, a number of uncertainties remain concerning the natural history of infection and disease progression and the development of therapeutic options, especially for asymptomatic persons. Admission of an asymptomatic HIV-infected applicant could be denied only if the institution concluded, on the basis of sound medical and scientific evidence, that the applicant's infected status would prevent him or her from completing essential degree requirements and that no reasonable accommodation could be made that would enable the applicant to do so.

It is unlikely that a person with the debilitating symptoms that ensue from HIV infection would seek admission to medical school or residency training. In the event that such an individual were to apply, the applicant's limitations or impairments could be considered, as is the case with other medical and handicapping conditions. Evaluation for admission should focus on whether the individual in his or her current health state, with

reasonable accommodations by the institution, possessed the functional abilities necessary for the successful completion of the medical education program. Admission might be denied on the basis of physical limitations that are consequent to progression of infection. The AAMC has issued guidelines for the development of technical standards by institutions to ensure that their admissions processes are in compliance with Section 504.

PRE-ADMISSION INQUIRIES

Recommendation 17. Institutions should not inquire about the HIV status of medical school or residency program applicants,

unless they have determined that the condition of being infected is grounds for denial of admission.

Rationale. An institution's need to know the HIV status of its applicants can be based only on the relevance of the information to the admissions process. Therefore, questions of the legitimacy of preadmission inquiries or screening related to HIV status arise only subsequent to a determination by the institution that an infected status as such is grounds for denial of admission, as discussed previously.

Appendices

APPENDIX A: AAMC STATEMENT ON PROFESSIONAL RESPONSIBILITY IN TREATING AIDS PATIENTS

The following statement was adopted by the Executive Council of the AAMC February 25, 1988. The statement was drafted by the AAMC Committee on AIDS and the Academic Medical Center.

THE acquired immunodeficiency syndrome (AIDS) has had an impact on the medical profession far beyond its pathophysiology. All fields of clinical practice have been dramatically altered by this disease. It has posed a significant challenge to the nation's health care system in providing for both the financing and delivery of care to those afflicted. Moreover, this epidemic, which is unparalleled in the latter half of the twentieth century, has confronted the medical profession with numerous moral and ethical issues. A central concern, to which this statement is directed, is the physician's responsibility to provide care to all patients.

The Association of American Medical Colleges (AAMC) has taken special note of the fears and concerns of medical professionals and those in training regarding the care of patients infected with the human immunodeficiency virus (HIV). Data indicate that a physician's occupational risk of acquiring HIV infection is small. However, because of the lethal nature of the disease, many physicians are concerned about transmission of infection, especially in settings where invasive procedure are performed such as the operating room or the cardiac catheterization laboratory.

Personal risk to the physician in the practice of medicine is not a new phenomenon even within this century, as the history of tuberculosis, poliomyelitis, influenza, and syphilis demonstrates. But

scientific advances, especially the development of vaccines and antibiotics, have tended to lower consciousness of these continuing risks for an entire generation of younger physicians, medical students, and residents. AIDS has brought this consciousness once again to the fore.

The AAMC's special concern is with those medical students and residents, now and in the future, whose preparation for entry into the profession is the responsibility of medical school faculties. Medical education cannot be narrowly conceived as simply the imparting of knowledge and skills. It has as its objective the development of professional men and women who are prepared to adhere to the highest standards of conduct and behavior asked of few members of our society. Entry into the medical profession is a privilege offered to those who are prepared for a lifetime of service to the ill.

The HIV epidemic must serve to remind us of these basic principles and the fundamental responsibilities of those who aspire to the practice of medicine and those charged with preparing them for it:

Medical students, residents, and faculty have a fundamental responsibility to provide care to all patients assigned to them, regardless of diagnosis. A failure to accept this responsibility violates a basic tenet of the medical profession—to place the patient's interest and welfare first.

Faculty members have a special re-

sponsibility to model the professional behavior and attitudes expected of physicians in training in their own willingness to provide competent, sensitive, and compassionate care to all patients.

Each medical school and teaching hospital must accept the responsibility to help medical students, residents, and faculty address and cope with their fears and prejudices in treating HIV-infected patients. This responsibility includes providing the following:

- *an accurate portrayal to medical school applicants of the personal risks involved in medical practice;*
- *training in protective measures to be employed in the clinical setting, monitoring compliance with them, and defining procedures to be followed in the event of potential exposure;*
- *appropriate facilities, equipment, and personnel to avoid unnecessary risk;*
- *counseling to those who continue to express reluctance to participate in education and patient care programs with HIV-infected individuals.*

Further, each medical school and teaching hospital should articulate a clear policy emphasizing the physician's responsibility to provide care to patients without regard to the nature of their illness.

APPENDIX B: SCIENTIFIC AND MEDICAL SUMMARY OF HIV INFECTION

*Prepared for the AAMC Committee on AIDS and the Academic Medical Center
by Gary Simon M.D., Ph. D., Associate Professor and Associate Chairman, Department of Medicine,
George Washington University Medical Center*

THE acquired immunodeficiency syndrome was first described in 1981, when it was recognized that young homosexual males appeared to be at risk for the development of unusual opportunistic infections and a particularly malignant form of Kaposi's sarcoma.^{1,2} The common theme that united these seemingly diverse clinical entities was a characteristic immunologic defect in which there is a profound deficit in cell-mediated immune function.³ In 1983 the cause of the immunologic deficit was identified—a T-lymphocytotropic virus that is now called HIV or human immunodeficiency virus.^{4,5}

EPIDEMIOLOGY

Since the onset of the epidemic more than 60,000 cases of AIDS have been identified in the United States.⁶ These cases represent the very tip of the iceberg of HIV infection. Estimates of total number of infected individuals in the United States range from 1.4 to more than 2.0 million persons.⁷ In east and central Africa the seroprevalence may be as high as 10%.⁸

In the United States the disease has been identified predominantly in homosexuals, intravenous drug abusers, and sexual partners of these two risk groups.⁹ There are several risk factors that appear to predispose to infection.¹⁰ Foremost among these is the number of sexual partners. Seropositive individuals have a significantly greater number of sexual partners than do their seronegative counterparts. Other risk factors include receptive anal intercourse, presence of other sexually transmitted disease, and, possibly, genetic factors.¹⁰

Heterosexual transmission of HIV occurs most commonly male-to-female.¹⁰ Female-to-male transmission has also been reported, although much less frequently. It has been estimated that by 1991 10% of all AIDS cases will be heterosexually transmitted.¹¹

Children of infected mothers, and recipients of blood or blood products, have also been identified as groups at risk for acquiring HIV.¹⁰ The recent development

of enzyme-linked immunosorbent assay (ELISA) tests for detecting HIV antibody in blood has reduced, but not totally eliminated, the risk of acquiring HIV through blood or blood products.¹²

The prevalence of HIV in various populations depends upon a number of factors which include age, race, locale, and socioeconomic group.^{11,13-15} In the self-selected population of volunteer blood donors the prevalence of HIV seropositivity is 0.04%.¹⁶ Substantially higher prevalence rates have been noted in other populations. Among gay individuals in the Midwest the prevalence rate is 5%; in San Francisco 70% of gay men are seropositive. Similarly, there is a geographic distribution among intravenous drug abusers. In Newark 75% are infected, as opposed to 5% in the Midwest.

Among military recruits a prevalence rate of 0.15% was found.¹³ This prevalence rate increased linearly between the ages of 18 and 27. Blacks had the highest antibody prevalence (0.39%). The prevalence rate among those applicants who lived in rural counties was lower, 0.079%, than that among applicants from high-density counties, 0.57%. As might be expected, a statistically significant correlation existed between HIV seropositivity and the state-specific incidence of AIDS.

A survey from an inner-city hospital emergency room revealed a prevalence rate of 5.2% among 2,302 consecutive adult patients.¹⁴ The seropositivity rate was 13% among the 276 individuals with recognized risk factors, whereas 3.1% of those patients with unknown risk factors were positive. None of 102 patients who reported no risk factors was positive.

An identical prevalence rate (5.2%) was noted at a sexually transmitted disease clinic in the same city.¹⁵ The most commonly identified risk factor in both men and women was parenteral drug use. No risk factor was acknowledged by 34% of men and 49% of women who were seropositive.

The results of these epidemiologic sur-

veys indicate that among individuals without acknowledged risk factors the group at highest risk for HIV infection is black inner-city males in their late 20s-30s who live in recognized AIDS-endemic areas of the United States.

There is considerable concern regarding the risk of nosocomial acquisition of HIV infection by health care workers. As of April 22, 1988, there had been 2,586 health care workers with AIDS reported to the Centers for Disease Control (CDC).¹⁷ This represents 5.4% of all AIDS cases. The proportion of health care workers in the U.S. labor force is 5.7%. The vast majority of health care workers with AIDS belong to recognized risk groups. More than 87% were homosexual, bisexual, and/or intravenous drug abusers. There has been one case of AIDS following needlestick exposure. As noted in the next section, there have been several additional cases of HIV infection among health care workers following needlestick or other work-related exposures.

Among the group of health care workers with AIDS there were 135 individuals with undetermined risk factors. Following epidemiologic investigation 41 of these could not be assigned to any risk group. Of these individuals 68% were male; 23% of all persons employed in health services are male. Seventeen reported needlestick or mucous membrane exposures.

TRANSMISSION

HIV can be spread by three routes: sexual contact, parenteral inoculation, and perinatal transmission.¹⁰ There is substantial evidence to suggest that casual transmission does not occur. Routine nonsexual exposure to persons with AIDS does not constitute a risk factor for development of HIV infection.¹⁸

There is a remote, but real, risk of acquiring HIV infection by transfusion of blood that has been screened as seronegative.¹² There are several possible explanations that could account for HIV-infected blood's testing seronegative. Obviously, a

false-negative ELISA test can result from laboratory error, but there are other conditions in which infected blood could be seronegative. A recently infected patient may not have had time to develop HIV antibodies that can be detected by the screening test.¹⁹ In addition, several patients who have had prolonged or persistently negative tests due to viral latency have been described.^{20,21} The infectious potential of the latter group is not defined.

Although the ELISA test is very sensitive ($\geq 99\%$), a small proportion of samples will test falsely negative.²² This may have a substantial impact when multiplied by the 18,000,000 units of blood components transfused annually. Based on the sensitivity of the ELISA tests and the prevalence of HIV, it is estimated that 72-90 individuals will be infected with HIV annually despite screening of all transfused bloods. Considering the effect of new infections, one worst-case scenario suggested as many as 460 recipients of transfused blood will become infected with HIV.

Since the onset of the epidemic, volunteer blood donors have been asked to refrain from donating blood if they perceive that they may be in any high-risk group. Such a program reduces the transfusion risk, but it is not likely to be totally effective. The development of newer, more sensitive assays for detecting HIV antigens, or assays that detect antibodies earlier in the course of infection, may help to reduce the risk associated with transfusion.

An issue of concern to the medical community is the potential risk associated with exposure to body fluids. HIV has been isolated from a variety of body fluids, including blood, semen, cervical secretions, saliva, and tears.²³ The single most important source of HIV remains blood, and a major focus of the recommendations regarding prevention of transmission of HIV in the health care setting has been on the exposure of the individual to contaminated blood products.

The current recommendations for prevention of occupational transmission of HIV incorporate the use of universal precautions which are extended to all patient contacts, since it is impossible to determine the HIV status of each and every individual at the time of first presentation to the health care delivery system.²⁴ The

Centers for Disease Control have recommended that universal precautions apply to exposure to semen, vaginal secretions, and cerebrospinal, synovial, pleural, peritoneal, and pericardial fluids, as well as blood and serum.

Universal precautions include the use of gloves, gowns, masks, and protective eyewear in situations where exposure to blood or other possibly infectious secretions is a consideration. While the use of these protective barriers will reduce exposure to secretions and spilled blood, they will not prevent penetrating injuries caused by needles and other sharp instruments. This fact, coupled with anecdotal reports of occupational and transmission of HIV, has caused considerable concern among health care workers and dictates the need for rational approaches to infection control issues regarding HIV.

The risk of occupational transmission of HIV appears to be statistically low. In an ongoing study by the CDC, four of 870 health care workers have seroconverted following needlestick exposures.¹⁷ Seroconversion within six months of the needlestick episodes occurred in three of 489 individuals (0.6%). No nonoccupational risk factors were identified in these individuals.

There have been no seroconversions among 103 individuals who have had needlestick exposures and 691 with skin or mucous membrane exposures followed at the National Institutes of Health.¹⁷ One seroconversion has been reported from 235 health care workers with 644 needlestick exposures in San Francisco.¹⁷

A recent report from the CDC documents 15 individuals with seroconversion associated with exposure to HIV-infected patients.¹⁷ The majority, but not all, of these exposures were related to needlestick injuries. There were a few cases of infection following exposure to blood without documented parenteral inoculation. The risk of transmission under these conditions is unknown, but it is likely to be substantially less than that for needlestick injuries. Transmission has not been reported to occur as a result of routine contact with HIV-infected patients or with clinical laboratory specimens.

Laboratory workers in research laboratories who are exposed to high concentrations of virus may be at increased risk for acquisition of HIV. In one case the nosocomial nature of acquisition was evi-

denced by Southern blot analysis in which the patient's virus was shown to be identical to the laboratory isolate.²⁵

Despite these relatively reassuring statistics, the fact remains that HIV infection is believed to be virtually 100% fatal. The impact of this singular piece of data cannot be minimized, and every effort must be made to reinforce the need for exercising extreme care when health care workers are at potential risk for exposure. On the other hand, these data need to be placed in perspective with other nosocomial risks. The currently reported highest risk of HIV infection associated with needlestick exposure is 0.6%.¹⁷ Current estimates are that 50% of HIV-infected patients will develop AIDS within eight years of infection, and nearly half of those individuals will die within the following year.^{26,27} This needs to be compared with the risks associated with another blood-borne pathogen, hepatitis B virus. The risk of developing lethal fulminating liver failure or chronic active hepatitis and dying within eight years as a result of a needlestick exposure to hepatitis B virus is 0.6% (private communication, Dr. Hyman Zimmerman). This should not be interpreted as an excuse for complacency in addressing the risk of nosocomial acquisition of HIV, or HBV. There is a real need for constant reinforcement in utilizing proper technique when obtaining blood and performing invasive procedures on all patients. This is most evident when one recognizes that the single most common circumstance associated with needlestick exposure is recapping a used needle, a procedure that is proscribed.²²

VIROLOGY

The HIV virus is a retrovirus.^{23,28,29} It consists of a single-stranded RNA genome wrapped in a core of viral protein. The viral genome is actually diploid and the virion contains two identical chains of RNA. This core structure is surrounded by an envelope which is derived from the membrane of the host cell and contains viral glycoproteins. Like all other retroviruses, it contains reverse transcriptase. In addition, a number of genetic elements have been identified which appear to play a major role in regulating viral replication and post-transcriptional events.

Since the identification of HIV as the etiologic agent of AIDS, a second related retrovirus, HIV-2, has also been identified

in some patients with AIDS.³⁰ This virus has biologic properties similar to those of HIV-1, but differs in nucleic acid composition and antigenic properties. The predominant geographic location of this is West Africa, and a recent study of randomly selected U.S. blood donors did not reveal any evidence of infection with HIV-2.^{8,31} Nevertheless, spread of this virus in the future is likely, and vigilance will need to be maintained.

The virus is tropic to cells that contain the CD4 antigen on the cell surface.^{32,33} An envelope glycoprotein of the HIV virus, gp120, binds to the CD4 antigen, and, by a yet-undefined mechanism, the virus enters the cell.^{28,34} Once inside the cell, the virus is uncoated and the genomic RNS is converted to proviral DNA by reverse transcriptase. The DNA is then integrated into the host cell genome, where it acts as a template for viral replication. Following integration, the proviral DNA is dependent upon host cell mechanisms, for transcription, replication, and translation. The consequence of this process is that the genetic material of the HIV virus is irreversibly incorporated into the genetic material of the host.

Proviral DNA may reside within the host cell in a state of latency, integrated into the host genome, but with no evidence of viral replication. With activation of the infected cell, transcription, viral protein synthesis, and viral replication occur. Activation of the cell can occur through a variety of stimuli, which may include other infectious agents such as cytomegalovirus or Epstein-Barr virus, or exposure to antigens or other immune activators.^{28,29,35} The process of replication proceeds as viral proteins and viral genomic RNA are assembled at the cell surface and virions are released by budding. Envelope (gp120 and gp160) and core (p17 and p24) proteins may be expressed on the cell surface.

The hallmark of infection with HIV is a progressive depletion of the CD4 lymphocyte cell line.^{3,36-38} Infection of the CD4 lymphocyte with HIV leads to cell death. Although the mechanism of cell death has not been fully elucidated, it appears that an indirect mechanism must be operative, since the actual number of infected cells is quite small.³⁹ One possibility is that cell death is mediated through syncytial formation with cell-to-cell transfer of information.⁴⁰ Another possibility is that circulating viral antigen (gp120) is bound to

CD4 lymphocytes, which are then cleared by immune mechanisms such as antibody-dependent cellular cytotoxicity or T-cell-mediated cytolysis.^{29,41} HIV-induced production of an antibody directed against a component of the CD4 cell membrane has also been suggested.²³

The presence of the CD4 antigen on the surface of the cell is not limited to a select population of lymphocytes. Certain monocytes and macrophages, as well as Langerhans cells in the dermis and glial cells, also contain CD4 antigens and may be infected with HIV.^{23,33} These cells are less susceptible to HIV-induced cell death and may constitute an important reservoir for the virus in the host.

The characteristic immunologic defect of HIV infection is a loss of CD4 lymphocyte-mediated immune function.^{3,29,36-38,41} The CD4 lymphocyte is the central figure in orchestrating the host's immune response. Depletion of the CD4 lymphocyte cell line results in a wide variety of immunologic defects. The development of immune deficiency in HIV-infected patients is progressive, and in patients with early disease there may be almost no discernible immunologic defect. In patients with more advanced disease there is considerable evidence of immune impairment, including skin test anergy, reduced proliferative responses to T-cell mitogens and antigens, reduced mixed-lymphocyte response activity, depressed natural killer cell activity, and an impaired antibody response to new antigens.

NATURAL HISTORY

The identification of HIV as the causative agent of AIDS has provided a framework for uncovering the natural history of HIV infection, at least two classification schemes have been based on the various manifestations of HIV disease that were subsequently recognized.

The Centers for Disease Control adopted a classification scheme based on distinguishing the clinical features of different stages of HIV infection.⁴² The initial exposure and subsequent infection (CDC class I) with the virus may be totally asymptomatic. In some individuals a flu-like syndrome occurs, and aseptic meningitis has also been reported.⁴³ These symptoms resolve and the individual becomes asymptomatic at which time the only manifestation of the HIV infection is a positive serologic test (CDC class II). Following seroconversion there is

prolonged period during which the virus may exist in a state of latency.⁴² Ultimately however, there is progressive deterioration of the immune system; during this period the individual may develop progressive generalized lymphadenopathy (CDC class III). As the immune system deteriorates, systemic manifestations of HIV infection develop, including opportunistic infections and neoplasms (CDC class IV). Other manifestations of CDC class IV disease include oral thrush, multidermatomal herpes zoster, oral leukoplakia, and constitutional symptoms such as unexplained fever, weight loss, diarrhea, or fatigue. Neurologic problems such as peripheral neuropathy or decreased cognitive function may also develop. The latter may progress to dementia. CDC class IV disease is divided into subgroups based on the different clinical features of the illness.

The Walter Reed staging system utilizes both the clinical features of the illness and an immunologic assessment which is useful in predicting disease progression and stratifying patients for subsequent analyses.⁴⁴ Patients with chronic lymphadenopathy are subdivided into several groups based on the total number of CD4 lymphocytes and the presence or absence of delayed skin test hypersensitivity.

The incubation period between exposure to the virus and the development of AIDS (opportunistic infection or tumor) may be quite long. A mathematical model has suggested that the mean incubation period for children less than 5 years old is two years. For individuals between the ages of 5 and 59 the mean incubation period is 8.23 years.²⁶ Virtually 100% of HIV-infected patients will progress to the development of AIDS.

The prolonged incubation period may provide some comfort to individuals with HIV infection, but most such persons cannot date their time of exposure. Furthermore, individual predictions cannot be based on mean data. If we regard HIV infection as a slide down an immunologic hill, we need to be able to estimate where the patient sits on that slope.

A number of factors have been identified as predictors of disease progression. HIV-seropositive individuals at high risk for the development of AIDS include those with constitutional symptoms (fever, diarrhea, weight loss, or excessive fatigue), a low CD4 lymphocyte count, a

low level of circulating anti-P24 antibody, detectable circulating P24 antigen, or detectable viremia.⁴⁶⁻⁴⁷ A high CD8 lymphocyte cell count and an elevated antibody titer to CMV have also been recognized as independent variables predicting disease progression.⁴⁶

The probability of surviving one year after a diagnosis of AIDS was estimated to be 48.8% among 5,833 patients followed in New York City.²⁷ This is quite variable among individuals with different manifestations of disease. Patients in whom the sole manifestation of AIDS is Kaposi's sarcoma have a longer mean survival than do those who have opportunistic infections. The one year survival for men aged 30-34 with Kaposi's sarcoma was 80.5%, whereas patients with *Pneumocystis carinii* pneumonia had a one-year survival of 45.4%. Women tend to have a shorter survival period than men. Other risk factors that indicate increased mortality include nonwhite race, older age, intravenous drug abuse, and multiple manifestations of disease.

DIAGNOSIS

The usual method for establishing a diagnosis of HIV infection is dependent on demonstration of serum antibody to viral proteins.⁴⁸ The most frequently utilized test is the ELISA, which detects circulating antibody to envelope proteins. The major issues with any testing program are its specificity and sensitivity. The sensitivity of the currently available ELISA tests is believed to be at least 99% when they are done properly with sera obtained from patients infected for more than 12 weeks.²² Although these tests are quite sensitive, false-negative results will occur as a result of improper techniques, changes in viral characteristics (HIV-2 will not react as well, if at all, in ELISAs based on HIV-1), or testing before the immune response has generated sufficient concentrations of circulating antibody. Some individuals may not seroconvert for many months after exposure. Recently, the importance of latency as a cause of false-negative tests was also recognized.²¹ Several seropositive individuals who became seronegative had only developed latency.

The specificity of the ELISA tests is estimated to be greater than 99% when repeatedly positive tests are considered. This indicates that when the tests are done properly, false-positive results are

uncommon.

Despite the apparent reliability of the screening tests, in large populations the predictive value of these tests is limited.²² Assuming a prevalence rate of 2.0% and ELISA sensitivity of 99% and specificity of 99.5%, the predictive value of a positive result is only 80.16%.

The standard approach has been to couple a positive ELISA screening with the more specific Western blot assay.⁴⁸ This test has extremely high specificity, but it is subject to errors of interpretation. The best results appear to be obtained when multiple protein bands are required for positivity. A single p24 band should not be regarded as diagnostic.

Other approaches to establishing the presence of HIV infection involve demonstrating directly the presence of the virus. This may include identifying circulating viral antigens such as the p24 antigen or direct viral isolation by magnification techniques such as the polymerase chain reaction.⁴⁹

The quality of the tests currently available for diagnosing HIV infection is quite good; advances in technology continue to improve the accuracy of these diagnostic techniques. Employing monoclonal antibodies in newer ELISAs and carefully done Western blot assays will improve both sensitivity and specificity. Nevertheless, it must be recognized that testing is imperfect and both false positives and false negatives will occur.

TREATMENT

Various treatment issues need to be considered in a discussion of HIV infection. They include the treatment of the viral infection itself, both whom to treat and when to treat. Treatment of the immunologic defect is another, equally important, issue. Other considerations include advances in the treatment of opportunistic infections, neoplasms, and other AIDS-related disorders, such as thrombocytopenia, myocarditis, and renal failure.

The treatment of established HIV infection has been an area of intense research interest since the recognition of the epidemic. Initially, the observed defect in the immune system led to therapeutic trials with agents such as thymosin, alpha-interferon, and interleukin-2 that were designed to reconstitute the immune system.^{50,51} This approach, which failed to deal with the replicating virus, was not successful. Furthermore, such an

approach has a theoretical risk, since stimulation of the immune system is known to promote viral replication.^{35,41}

Currently, the major therapeutic focus is on the development of safe, effective antiretroviral agents. It needs to be recognized that classic cure of HIV infection, that is, eradication of the virus from the host, is not a realistic possibility once the virus has integrated itself into the host genome. The goal of antiretroviral therapy is to prevent replication of the virus and establish a state of functional or true latency in order to prevent further deterioration of the immune system. Once such latency is achieved, it may be possible to restore or improve immune function, either as a result of normal host restorative processes or by pharmacologic intervention.

There are a number of potential sites of activity for antiretroviral agents.²⁹ Anti-gp120 antibody could prevent the initial step in virus proliferation by blocking binding of the virus to the surface of the cell. In a similar manner, soluble CD4 molecules could bind to virus and competitively inhibit binding of the virus to the CD4 lymphocyte.⁵² The utility of this approach is unknown, although one might speculate that administration of this antibody would protect individuals during acute exposures to the virus such as needlestick injuries.

Inhibition of reverse transcriptase activity is the major focus of antiretroviral drug development. Zidovudine, the only drug approved for the treatment of HIV infection, acts to inhibit reverse transcriptase and, when incorporated into DNA, acts a terminator of chain synthesis.⁵³⁻⁵⁵ Other dideoxynucleoside analogs such as dideoxyinosine and dideoxycytidine inhibit HIV replication in vitro.⁵⁰ Dideoxycytidine has undergone clinical trials and, as a single agent, appears to be excessively toxic.⁵⁶ However, the drug may be efficacious and not too toxic if it is given in an alternating regimen with zidovudine.⁵⁶ Additional clinical trials are in progress to address these issues. Phosphonoformate is another reverse transcriptase inhibitor that is being studied in preliminary clinical trials.

Other potential areas for antiretroviral activity include inhibition of integrase activity, which would block incorporation of proviral DNA into the host genome; prevention of viral protein synthesis; and blocking release of virions at the cell sur-

face level.⁵⁷ Ampligen, a mismatched double-stranded RNA, induces 2,5-oligoadenylate synthetase activity and thus inhibits replication of the virus once it has entered the host cell.⁵⁸ A number of regulatory proteins are synthesized in response to HIV. Agents that inhibit such proteins, such as an anti-TAT drug, would be a potential therapeutic avenue to explore.

The use of zidovudine in HIV-infected patients has prolonged survival.⁵⁴ Zidovudine is currently approved for patients with AIDS or symptomatic HIV infection with CD4 lymphocyte counts less than 200. Therapeutic trials evaluating zidovudine in infected individuals with higher CD4 counts are under way. Unfortunately, the hematologic toxicity of zidovudine frequently necessitates a dosage reduction, which may reduce antiviral efficacy.⁵⁵

Combination studies are being initiated at various centers in the United States and abroad. Acyclovir is synergistic in vitro with zidovudine, and therapeutic trials are examining the efficacy of this combination.⁵⁷ Both alpha- and beta-interferon are also synergistic with zidovudine, and these combinations are under study. Another combination approach employs drugs designed to limit the toxicity of zidovudine. Therapy with zidovudine and erythropoietin is designed to reduce the incidence of drug-induced anemia. Granulocyte macrophage colony-stimulating factor has been given to improve AIDS-related neutropenia, and a study of it with zidovudine is in progress.⁵⁹

The long-term effects of these various agents are unknown, but a review of the current zidovudine data suggests that this drug continues to prolong life more than a year after initial administration. Continued advances in therapy will, it is hoped further improve survival with HIV infection.

VACCINE DEVELOPMENT

The development of an effective vaccine to prevent transmission of the HIV virus is an area of paramount importance. With the recognition that the causative agent of AIDS is a virus, there was considerable optimism that the sophistication of our scientific tools and the recent advances in molecular virology would allow us to develop an effective vaccine rapidly. We

foresaw difficulties, but these were in the area of implementation, such as "in what population could such a vaccine be tested to demonstrate clinical efficacy?" Unfortunately, our optimism has faded as we have learned more about the peculiarities of this virus; we are a long way from needing to worry about appropriate populations for a clinical efficacy trial.

To develop a vaccine that is protective, we need to understand the nature of the immune response that is generated on exposure to HIV. We need to determine how we can manipulate this immune response. We need to determine what immune response, if any, will protect a person who is exposed to the virus so that the proviral nucleic acid will not be incorporated into the host cell genome.

This is an extremely complex problem. Infection with HIV may result in the development of neutralizing antibodies that inactivate the virus in vitro.^{23,60,61} Individuals who develop such neutralizing antibodies have a better prognosis than do those who lack neutralizing antibodies, but the presence of these antibodies in an infected individual does not halt progression of the disease.²³ Whether the presence of such antibodies could prevent primary infection in humans is unknown. Other HIV-specific immune responses have also been described.^{23,62-65} HIV-specific cytotoxic T-lymphocytes, as well as antibody-dependent cellular cytotoxicity directed against components of the gp120 protein, have been identified in infected individuals. It is possible that such cytotoxic responses may be more important than the production of neutralizing antibodies in the development of a vaccine. One postulated mechanism of disease transmission involves direct transfer of infected cells. Neutralizing antibodies would not be effective in preventing acquisition of infection under those conditions. The appropriate manipulation of these immune responses may be important in preventing acquisition of HIV following exposure as well as in preventing disease progression.

The genomic diversity of HIV isolates is a major obstacle to the development of a vaccine.^{66,67} Neutralizing antibody effective against one strain of the virus may be ineffective against other isolates. The need for understanding the molecular virology of HIV is evident. An effective vaccine should be directed against regions of

the virus that are conserved and do not readily mutate.⁶⁸

Several candidate vaccines are in various stages of study. Most of these vaccines are directed against portions of the surface gp120 (or parent gp160) molecule. The rationale is that such a vaccine could prevent binding of the virus to the cell and thus block infection. In one study the complete envelope glycoprotein (gp160) was coupled to a vaccinia virus vector and injected into healthy volunteers.⁶⁹ A weak immune response was generated; both neutralizing antibodies and T-cell proliferative responses to HIV antigens were elicited. Additional immunizations resulted in strong anamnestic humoral and cellular responses.⁷⁰ The antibody produced could neutralize the parent HIV strain from which the envelope glycoprotein was obtained as well as other strains. This is a critical issue inasmuch as many of the mutations of different HIV isolates are expressed by antigenic variations in the envelope glycoprotein.

Other potential vaccines based on the envelope glycoprotein employ recombinant subunits or couple the HIV envelope product to immunostimulants.⁷¹⁻⁷³ Another candidate vaccine is based on the relatively constant P17 core protein, which may also be present on the surface of the virus as well as being buried in the viral core.⁷⁴ The latter agent is in clinical trials in California, Britain, and Japan.

Vaccine studies have been hampered by the lack of satisfactory animal models. Chimpanzees can be infected with HIV,⁷¹ but they are endangered species and thus are difficult to obtain, as well as being extremely expensive. Furthermore, results with chimpanzees have not been encouraging.⁷² Although the animals may develop neutralizing antibodies that are effective in vitro they are not protected from development of infection following viral challenge. This may be due to direct cell transfer of virus such that neutralizing antibody will not be an effective means of preventing infection.

CONCLUSION

The HIV epidemic represents a unique challenge to modern medicine. Great strides have been made in both the clinical and the basic science arenas. Our knowledge of immunology, molecular biology, virology, and clinical medicine has advanced in concert with our understand-

ing of the biology of HIV. Despite these advances, the fact remains that we are deeply involved in a race between the ability of the HIV virus to spread and cause disease and our ability to prevent dissemination and disease progression. We have made considerable progress, but we are still a long way from effective therapies and disease prevention strategies.

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Preface

IN SEPTEMBER 1987, the Association of American Medical Colleges (AAMC) appointed a Committee on AIDS and the Academic Medical Center, chaired by Jay Sanford, M.D., president and dean, Uniformed Services University of the Health Sciences. The Committee was charged with identifying and discussing issues raised by the human immunodeficiency virus (HIV) epidemic that have specific relevance for academic medicine and to recommend policy positions and program initiatives for the AAMC and its member institutions.

Under the able leadership of Dr. Sanford, the Committee has written this second full report, which examines the implications of the HIV epidemic for general professional education in medicine. The report was drafted by the Committee's subcommittee on medical education, chaired by Richard E. Behrman, M.D., vice-president and dean, Case Western Reserve University School of Medicine, and subsequently approved by the full Committee. On February 23, 1989, the Executive Council of the AAMC accepted the Committee report and approved its distribution to AAMC members and other interested publics.

The current report follows a previous one by the Committee, *Policy Guidelines for Addressing HIV Infection in the Academic Medical Community*, which was published by the AAMC in October 1988. That report provides 17 recommendations for institutions in their development of policies for medical students, residents, and faculty/staff. Policy areas covered include the

provision of information about HIV and access to testing facilities, administrative actions in response to those known to be HIV-infected, and considerations in the admission of HIV-infected applicants to medical school or residency programs. The Committee has also developed a statement, reprinted here, on the professional responsibility of medical students, residents, and faculty to provide care to HIV-infected persons. That statement was endorsed by the AAMC Executive Council.

We appreciate the Committee's work and commend this report to you as a thoughtful reflection on the educational challenges posed by the HIV epidemic. All who are involved in medical education, especially those who are responsible for medical school curricula and for residency training programs, will find the educational objectives outlined by the Committee in this report useful to their program planning. We hope that the publication of this report will encourage medical educators to review their programs in light of the HIV epidemic and to reaffirm their commitment to educating physicians with the values, attitudes, knowledge, and skills needed to assist in preventing the further spread of HIV infection and to provide care to the growing number of those infected.

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INTRODUCTION

The gravity of the human immunodeficiency virus (HIV) epidemic and its impact on the nation's medical and social institutions is difficult to overstate. The discovery of HIV and the acquired immunodeficiency syndrome (AIDS) has provided one of the major challenges to biomedical research in this century, while the consequences of HIV infection pose a problem of significant proportion to the nation's system of health care delivery and financing. The research and patient care missions of academic medical centers position them at the center of the nation's response to the epidemic. However, the educational mission of these institutions prescribes a further challenge: to educate physicians who are prepared to assist in preventing further spread of infection and to provide care to those already infected.

The Association of American Medical Colleges (AAMC) Committee on AIDS and the Academic Medical Center has accepted as part of its responsibility an examination of the implications of the HIV epidemic for medical education. The Committee was charged to deliberate on issues raised by the HIV epidemic that were especially relevant for medical schools and teaching hospitals and to recommend policy positions and program initiatives

for the AAMC and its member institutions. The Committee has issued a previous report which provides institutional policy guidelines for dealing with cases of HIV infection among medical students, residents, and faculty/staff.* It has also issued a statement, endorsed by the AAMC Executive Council, on the professional responsibility of medical students, residents, and faculty to provide care to HIV-infected persons.†

This report addresses the educational challenges posed by HIV/AIDS. Its focus is general professional education in medicine, the period of medical student education and the early years of residency training. The report is based on the Committee's examination of the likely impact of the epidemic on future medical practice, its review of medical school efforts to introduce HIV/AIDS education into the medical school curriculum, its judgement regarding the knowledge, skills, and attitudes physicians need to care for HIV-infected persons and to help in pre-

*Association of American Medical Colleges, *Policy Guidelines for Addressing HIV Infection in the Academic Medical Community*. October 1988.

†Association of American Medical Colleges, *Statement on Professional Responsibility in Treating AIDS Patients*, adopted by the AAMC Executive Council February 25, 1989.

venting further spread of infection, its conclusions as to the resources needed to achieve desired objectives, and its analysis of special issues for academic medicine. The Committee concludes its deliberations with specific recommendations on the role of the AAMC in assisting its member institutions to meet their responsibilities in these areas.

IMPACT OF THE HIV EPIDEMIC ON MEDICAL PRACTICE

While the long-term impact of the HIV epidemic on medical practice is difficult to project, an understanding of the demands it places on medical educators must start with some shared understanding of the epidemiology of disease and future scientific and medical progress. The following are conclusions of the Committee with regard to HIV/AIDS that form the basis of judgements reached and recommendations made in this report.

1. *The spread of HIV infection has already reached epidemic proportion. The need for health care services even by those already infected will place extraordinary demands on physicians and other health care providers.*

Since the first cases of HIV infection were identified in 1981, over 87,000 Americans have been diagnosed as having AIDS.[†] The Public Health Service projects a cumulative total of 365,000 diagnosed cases of AIDS, including 263,000 cumulative deaths, by the end of 1992. In 1992 alone, 80,000 cases of AIDS will be diagnosed, only slightly less than the cumulative total achieved during the 1981-1988 period.[§] The number of AIDS cases, however, reflects only in small part the magnitude of the HIV problem. It is estimated that between 1.0 and 1.5 million Americans are currently infected with HIV.[§] The incubation period from infection to clinical symptoms varies. However, experts generally agree that, given the current state of therapies, the majority of those who are infected, if not virtually all, will eventually progress to the clinical syndrome of AIDS. Even a massive, successful public education effort cannot reverse the demands that will be placed on health care providers and institutions in the short term.

2. *While initially concentrated in distinct geographic areas, HIV infection will become more dispersed and involve physicians in virtually all communities.*

By the end of 1988, 20 metropolitan areas accounted for over two-thirds of the diagnosed cases of AIDS reported to the Centers for Disease Control (CDC). The New York City area alone reported 22% of the cases, followed by San Francisco and Los Angeles with 8 and 7%, respectively. However, evidence of a gradual diffusion of AIDS cases away from the historic epicenters of the epidemic is clear. The 20 metropolitan areas in which the infection is concentrated accounted for 75% of AIDS cases reported before 1986 but only 62% of those cases reported

in 1988.[¶] New cases of AIDS are now being reported in every state. While certain metropolitan areas may remain with a disproportionate number of cases, the mobility among members of society precludes a geographic containment of HIV infection.

3. *A vaccine for HIV is not likely to be available in the near term. The prevention of additional infections will depend upon people's learning how to avoid exposure and modifying behaviors and lifestyles to bring them in concert with such knowledge.*

Optimism that a vaccine could be quickly developed once HIV was identified as the etiologic agent of AIDS has faded. Much more needs to be learned about the nature of the immune response that is generated on exposure to HIV and how it can be manipulated. The genomic diversity of HIV isolates is an additional major obstacle. Most experts do not expect an effective vaccine to be developed within the next decade.

However, since the main routes of HIV transmission are known, additional infections can be prevented. This knowledge needs to be used in the development of effective education and counseling programs targeted particularly to those most at risk.

4. *State-of-the-art care of individuals with HIV infection or HIV-related disease will require close collaboration with and the involvement of specialists who devote a considerable amount of their professional time to this particular disease syndrome. However, it is unlikely that the medical care needs of the large number of infected persons in this country can be provided for solely by a small number of HIV specialists. Primary care physicians will need to assume greater responsibility for the ongoing care of HIV infected patients, in consultation with specialists as appropriate. Primary care physicians must also assume a major role in the prevention of the spread of infection.*

The HIV epidemic imposes a new set of demands on the medical manpower system. The growing caseload of patients with tumors and opportunistic infections will strain the current supply of oncologists and infectious disease specialists. Moreover, the protean manifestations of HIV/AIDS and the heavy requirements for patient support, education, and ambulatory and long-term management will significantly extend the dimensions of care. Tumor and infectious disease specialists may have to take on these elements of primary care or, at least, organize their work in networks of primary care physicians and other health professionals.

The pervasiveness of HIV infection in many parts of the country will make it necessary for primary care physicians—general internists and family practitioners, in particular, but also obstetricians/gynecologists and child and adolescent care specialists—to assume greater responsibility for the care of HIV-infected patients, in consultation with specialists, as appropriate. Primary care physicians will be increasingly involved in the diagnosis, treatment, and management of HIV infection, in addition to education and prevention. Primary care physicians are in an ideal position to provide information, education, counseling about prevention, and early diagnosis of HIV infection and

[†]U.S. Centers for Disease Control, *AIDS Weekly Surveillance Report*, February 20, 1989.

[§]U.S. Centers for Disease Control, *Report to the White House Domestic Policy Council*, July 26, 1988.

[¶]U.S. Centers for Disease Control, *AIDS Weekly Surveillance Report*, February 20, 1989.

should be adept at recruiting and organizing the home health care resources and support needed by HIV-infected patients.

ISSUES FOR GENERAL PROFESSIONAL EDUCATION IN MEDICINE

The preceding suggests that the HIV epidemic will have a major impact on the professional careers of today's medical students and residents. For some, HIV/AIDS may define their professional lives. The dimensions of the challenge posed to medical educators, who are currently coping with increasing demands on curriculum time from various quarters, are apparent. The needs for multidisciplinary education related to HIV/AIDS cannot be addressed simply by adding another course but require an institutional strategy to integrate HIV/AIDS-specific subject matter and skill development opportunities into existing courses, clerkships, and other training experiences.

The implications of the HIV epidemic for curriculum are not limited, however, to the introduction of HIV/AIDS-specific content and skills. The epidemic focuses attention on certain values, attitudes, knowledge, and skills that are fundamental to medical practice. To the extent that these areas currently receive inadequate curriculum time and resources, the focus provided by HIV/AIDS may have a salutary effect on general professional education in medicine. A renewed emphasis on these basic areas, in particular those which prepare physicians for their responsibilities in health promotion and disease prevention, is likely to have the most direct impact on the epidemic.

Basic Values and Attitudes

The development of professional responsibility for the care of HIV-infected persons by medical students and residents is a basic educational objective that must be at the cornerstone of any plan to address HIV/AIDS within the medical education program. The provision of care in the context of HIV/AIDS has several facets, each of which relates more generally to the ideals of physician practice. First is the understanding and acceptance of personal risk in the practice of medicine; second is the need to overcome prejudicial attitudes that impede high-quality care; and third is the development of skills for coping with the psychological demands of certain types of care.

ACCEPTING PERSONAL RISK

The gravity of becoming infected with HIV, which leads to AIDS, a disease with no known cure that is believed to lead inevitably to death, has raised a consciousness of personal risk in medicine that had been largely dormant. Survey studies and reports have documented the anxieties and fears of medical students and residents in caring for HIV-infected persons, anxieties about their personal safety and by extension, the safety of their spouses and families.¹¹ Reports of physicians who have refused to care for HIV-infected patients have heightened the controversy surrounding this issue.

Institutions should state unambiguously their expectations that medical students and residents have a professional responsibility to provide care to HIV-infected patients to whom they

are assigned. Simply stating the facts of the low risk of occupational acquisition of HIV infection is not sufficient to deal with the perceived risk and associated fears. The acculturation of medical students and residents to the norms and obligations of the profession pertaining to the acceptance of personal risk is a process that occurs over the continuum of their medical education. The example set by faculty is critical to this process. Medical educators must also recognize the importance of providing information, education, and counseling to assist medical students and residents to accept this responsibility and of providing training to minimize personal risk.**

OVERCOMING BIASES AND PREJUDICES

At this stage in the evolution of the epidemic in this country, many of those with HIV infection have acquired the virus as a result of specific behaviors and lifestyles that tend to be viewed with less than complete acceptance by society, such as homosexuality, or with outright disapproval, such as intravenous drug use. In addition, a disproportionate number of those infected are among racial minorities that remain the victims of discrimination. Medical students and residents are not exempt from the biases and prejudices that pervade society. Their attitudes towards various social groups are a concern to medical educators when such attitudes are incompatible with the values and ideals of the medical profession. Medical educators should help medical students and residents to examine and to overcome attitudinal barriers that prevent them from establishing caring and supportive relationships with their patients and providing medical care of the highest quality.

COPING WITH THE EMOTIONAL DEMANDS OF PATIENT CARE

HIV/AIDS provides a reminder of the psychological demands associated with many areas of physician practice. The care of patients with AIDS may be for many medical students and residents a first encounter with death and dying in their professional career. The experience is intensified by the fact that many of those who are infected are young adults, quite often of the same generation as the students and residents, or are infants and children. Medical educators should recognize the emotional intensity associated with certain patient care experiences and provide counseling and support for medical students and residents.

¹¹For example:

1. Link RN, Feingold AR, Charap MH, et al. Concerns of medical and pediatric house officers about acquiring AIDS from their patients. *Am J Public Health.* 1988;78:455-459.
2. Cooke M. Housestaff attitudes toward the acquired immunodeficiency syndrome. *AIDS Pub Policy J.* 1988;3:59-60.
3. Imperato PJ, Feldman JG, Nayeri K, DeHovitz JA. Medical students' attitudes towards caring for patients with AIDS in a high incidence area. *NY State J Med.* 1988;88:223-227.
4. Whalen JP. Participation of medical students in the care of patients with AIDS. *J Med Educ.* 1987;62:53-54.

**An expanded statement on professional responsibility in this context, issued by the Committee early in its deliberations, is included as an appendix to the preceding report.

Basic Knowledge and Skills

TRAINING IN INFECTION CONTROL

HIV/AIDS prompts a renewed emphasis on the training of all health care workers in infection control procedure and in monitoring compliance with them. The behavior of faculty and practicing physicians is a critical reinforcer of good infection control practices and is essential to ingrain what is learned into practice behavior. Studies have documented a low but finite risk to a health care worker exposed to the blood of an HIV-infected patient. Of critical significance, however, is the finding that many of the cases of exposure could have been prevented by strict adherence to recommended procedures, especially those that reduce the number of needlestick injuries.^{††}

Training in infection control procedures, which include universal precautions with blood and body fluids, should be an essential element of the medical education program. Medical educators should ensure the orientation to the clinical setting includes express written procedures and demonstrations in infection control practices. Knowledge of these procedures should be a prerequisite for entry to the clinical setting.

PHYSICIAN-PATIENT COMMUNICATION SKILLS

The sensitivities surrounding the ways in which HIV is transmitted and the current role of education and counseling in reducing risk of infection emphasize the importance of physician-patient communication skills. Developing skills in patient interviewing, history-taking, and counseling is an established part of the medical education program. HIV/AIDS prompts particular attention by medical educators to specific aspects of these skills, including:

- taking a comprehensive and thorough sexual history;
- eliciting a history of substance abuse;
- counseling about the meaning of medical information and test results;
- eliciting patient preferences regarding different levels of life support;
- counseling and providing emotional support to patients suffering from disease and to their families; and
- counseling to effect behavioral and lifestyle changes necessary for good health.

Effective physician-patient communication in emotionally sensitive areas depends as much on the personal comfort and emotional development of the physician as on knowledge of and experience with specific interviewing and counseling techniques. Programs that provide opportunities for medical students and residents to explore their feelings about various aspects of patient care, such as human sexual behavior, death and dying, and

^{††}Marcus R, CDC Cooperative Needlestick Surveillance Group. Surveillance of health care workers exposed to blood from patients infected with the human immunodeficiency virus. *N Engl J Med* 1988;319:1118-1123.

patient characteristics and lifestyles different from their own, are important to the development of communication skills.

PUBLIC HEALTH/EPIDEMIOLOGY

Risk assessment for HIV infection and counseling for risk reduction highlight the value and importance of training in public health and epidemiology in general professional education. Attention in educational programs to the risk factors associated with various diseases and accidents will enable medical students and residents to be more effective in preventing illness and disability through their professional practices. In addition, the role of the physician as a partner with official public health agencies, for example, in the reporting of disease, collaborating in partner notification, and educating the public, should be well developed at a basic level and reinforced throughout training.

PSYCHOSOCIAL ASPECTS OF DISEASE

HIV/AIDS draws attention to the need of medical students and residents to understand the links among poverty, minority status, access to health care, and disease and death. It reinforces the importance of understanding the roles of the family and of social and community networks in coping with illness and disability. Medical students and residents should learn how to enlist family, social, and community resources in helping patients with nonacute medical problems and in providing psychological support and assistance with the needs of daily living.

MEDICAL ETHICS

HIV/AIDS provides a new dimension and complexity to traditional ethical issues in medical practice. Some examples of issues are patient confidentiality, informed consent, duty to warn, the use of unrelated decision-making surrogates for incompetent patients, and issues associated with the conduct of clinical research trials. The epidemic also highlights the difficulties involved in decisions to initiate or terminate life-support systems. Medical students and residents need to become versed in the ethical traditions within medicine, to develop skills in thinking through complex ethical dilemmas, and to become comfortable with the ethical uncertainties that they will confront as physicians.

HUMAN SEXUALITY

HIV/AIDS underscores the importance of the study of human sexuality as a part of general professional education in medicine. Medical educators should not limit instruction to the biological aspects of reproduction but should give specific consideration to the psychological and social aspects of human sexuality and its expression in modern society, including an understanding of homosexuality and bisexuality as well as heterosexuality, and should increase the levels of comfort and competence of medical students and residents in obtaining a sexual history.

SUBSTANCE ABUSE

The association of HIV infection with intravenous drug abuse is a reminder of the latter as a major medical and social problem. Medical educators should ensure that medical students and resi-

dents understand the psychological and social determinants of substance abuse, in addition to its medical consequences, and develop skills in recognizing, counseling, and treating substance abusers.

MULTIDISCIPLINARY TEAM APPROACH TO CARE

HIV/AIDS highlights the value of the multidisciplinary team approach to health care delivery. The total care of the HIV-infected person over the course of the disease often requires the contributions of nurses, physician assistants, social workers, mental health workers, and others in addition to physicians, and the use of ancillary care systems, for example, home health care, visiting nurse care, hospice care, and family counseling, in which these professionals are expert. Medical students and residents should understand the special services and expertise provided by other members of the health care team and the pivotal role of the physician in assisting the patient to gain access to needed ancillary services.

HIV/AIDS Knowledge and Skills

Medical students and residents should also gain fundamental knowledge and skills in areas specific to HIV/AIDS. Educational objectives that should be incorporated into the medical education program at appropriate stages include the following aspects of HIV infection:

- Basic science—an understanding of the basic features of retroviruses, the pathogenesis of immunodeficiency associated with HIV infection, and the immunologic consequences of such infection.
- Epidemiology—an understanding of the mechanisms of viral transmission and recognition of the types of behavior identified as risk factors for spread of infection.
- Clinical manifestations—an understanding of the clinical features of HIV infection, including the natural history of HIV infection, characteristic opportunistic infections, malignancies and neurologic manifestations of disease, and recognition of the different characteristics of the disease in children.
- Diagnosis—an understanding of the tests that are used for establishing the presence of HIV infection, including the limitations of serologic diagnosis and recognition of other means of establishing the diagnosis by identification of the virus, viral proteins, or viral nucleic acid.
- Treatment—an understanding of the indications, use, and toxicity of antiretroviral agents and other modes of therapy that may be developed and an understanding of the treatment and prophylactic approaches used for opportunistic infections and malignancies.

RESOURCES NEEDED FOR EFFECTIVE HIV/AIDS EDUCATION

Any discussion of the requirements for developing effective education programs to prepare medical students and residents to address the challenges of the HIV epidemic must include a candid appraisal of resource needs.

Clinical and Community Resources

The opportunities for medical students and residents to develop clinical skills in the care and treatment of HIV-infected persons and patients with AIDS vary according to the geographic distribution of cases. As the epidemic evolves, responsibilities for the care of HIV-infected persons will become more widely dispersed. Certain medical education programs, however, will have to consider developing or acquiring alternative teaching materials, for example, simulated patients or videotapes. Institutions that have developed model patient care and educational programs for HIV infection should consider making short-term training opportunities widely available.

Most of the current patient care experiences with HIV provided by medical school and residency programs occur in the inpatient hospital setting. Ambulatory clinical training is necessary to achieve a broader perspective of the disease and its various stages. The range of patient experiences ideally would extend from seronegative persons engaged in behaviors putting them at high risk for the disease to persons with AIDS, suffering from extreme immunosuppression and with one or more opportunistic infections. To offer this range will require extending medical education programs to community clinics, centers for the treatment of sexually transmitted diseases, substance abuse treatment centers, and other community health care programs and official public health agencies. Ambulatory care training in HIV infection should be under the direction of faculty and attending physicians in model programs offering continuity of care with links to community support services.

The psychosocial, ethical, and legal aspects of HIV infection underline the special importance of community resources in managing the epidemic and in caring for the growing numbers of infected persons. Medical educators should enlist the participation of community volunteer support groups organized around HIV/AIDS in their training programs, as well as social and public health agencies.

Faculty Resources

Faculty who can address the educational needs of medical students and residents in the areas related to HIV/AIDS will be needed. Fortunately, faculty expertise specific to HIV infection is developing rapidly, particularly at institutions located in the geographic epicenters of the epidemic. Nevertheless, faculty development and training grants and fellowships are needed, particularly in primary care, with additional positions earmarked for HIV infection.

Of particular importance are faculty resources and expertise in those psychological, social, behavioral, and ethical/legal aspects of medical care on which HIV/AIDS has focused attention in the education of physicians. These include interviewing and communication skills, psychosocial aspects of disease, mental illness and substance abuse, epidemiology and preventive medicine, psychological and social aspects of human sexuality, ethics and law, home health care, death and dying, and community support agencies and services, to name a few. The integration of these topics into the medical education program rests heavily on the contributions of other disciplines, for example, nursing, social work, psychology, sociology, ethics, and law. Medical educators

should be encouraged to call on these disciplines in the development of training programs.

SPECIAL ISSUES

In addition to the demands placed on the medical school curriculum and residency training programs by HIV/AIDS, the Committee has addressed its attention to three special issues of concern. Two deal with questions concerning the impact of HIV/AIDS on career choices: first, has HIV/AIDS contributed to the decline in the attractiveness of medicine as a profession; and second, has HIV/AIDS contributed to the decline of interest in internal medicine and/or is it influencing the choice of residency program. A third issue concerns whether the increasing numbers of AIDS patients in major teaching hospitals and affiliated programs are creating a distorted educational experience for medical students and residents. While data that might help to answer these questions are limited, some preliminary observations may be made.

HIV/AIDS and the Attractiveness of Medicine as a Profession

The number of applicants to the nation's medical schools peaked in 1974, when 42,624 individuals competed for 14,579 first-year positions. Since that time the applicant pool has steadily declined, to a point in 1988 when 26,721 persons applied to fill 15,969 seats.¶¶ Clearly, a large-scale trend such as this decline, which notably predates the HIV epidemic, has a complex etiology. Various factors have been posited to account for it: changing student values, lowered prestige of medicine and decreases in professional autonomy, rising medical school tuition and debts, and length of training program in comparison with other professions, to name just a few. In more recent years, a general disaffection for medicine has been exacerbated by simple demographic changes—fewer 22-year-olds in the population.

It is unlikely that the HIV epidemic has been a significant proximate cause of declining interest in medicine as a profession. Undoubtedly, the specter of AIDS that pervades the popular media may be a factor in individual cases in dissuading young men and women from choosing a medical career. It is equally likely, however, that in other cases the epidemic has served as a motivating force for people to enter the profession. The image of medicine and its continued ability to attract the best and brightest to its ranks will be served by the profession's example of service in the face of the epidemic.

HIV/AIDS and the Choice of Specialty and Residency Program

The decline of interest in residency programs in internal medicine, the specialty identified most with the ongoing care of patients with AIDS, has also been attributed in part to the HIV epidemic. Yet the beginnings of this decline of interest predate the time when AIDS entered the public consciousness. As with the decline in the medical school applicant pool, the trend in internal medicine appears to reflect a number of factors: dissatisfaction with technological growth in internal medicine prac-

tice; the emotional intensity associated with the care of current-day medical inpatients with cardiac problems, cancer, and other chronic conditions; and concerns about a relatively lower income potential in the face of rising educational debt. There is not yet convincing evidence that HIV/AIDS has contributed significantly and directly to the trend away from internal medicine practice. To the contrary, the most recent data from the AAMC graduation questionnaire, distributed to all U.S. medical school graduates, show a recent upturn in interest in general internal medicine as well as in the subspecialty of infectious diseases.§§

Evidence of a systematic avoidance by medical students of residency programs that have high percentages of patients with AIDS, other than an occasional anecdotal report, is lacking. Fears of HIV transmission and concern about a distorted and skewed residency training experience may appear as logical bases on which to expect an effect on application patterns. Yet no consistent trend has been demonstrated in the residency match success of programs known for their care of patients with AIDS or of those located in the epicenters of the epidemic.

The various factors that account for patterns of changes in career choices should be an ongoing concern of medical educators. The AIDS epidemic is of such magnitude and significance that its potential impact on choice of specialty or of location of residency program deserves continued study.

Educational Imbalances in Clerkship and Residency Programs

Regardless of whether the increasing number of patients with AIDS in certain teaching hospitals influences the career choices of medical students away from certain specialties or deters them from applying to particular residency programs, educational balance in clerkship and residency programs is a concern in its own right. The issue now is relevant to a number of urban teaching hospital in epicenters of the epidemic, but it could in time extend to others.

Problems of educational imbalance in medical education are not specific to HIV/AIDS. They arise from an ongoing tension generated by attempting to meet both the service and the educational missions of academic medical centers. The teaching hospital's attention to its patient care and community service missions is primary. Teaching hospitals should be leaders in fashioning the community response to the AIDS epidemic and play a major role in that response. Teaching hospitals require, however, a sufficient diversity of patients to support educational and research objectives. Medical schools and their faculties, on the other hand, must attend first to the educational needs of students and residents. Medical education programs need to provide a variety of clinical settings and experiences, including ambulatory as well as inpatient settings, to achieve educational objectives.

The issue of educational balance requires continual attention and management by medical school deans and hospital directors. Medical school deans and hospital directors, particularly in academic medical centers caring for large numbers of HIV-infected patients, should address specifically the impact of HIV/AIDS on educational programs.

¶¶Source: AAMC Division of Student Services.

§§AAMC, 1988 Graduation Questionnaire Results, 1988.

ROLE OF THE AAMC

The response of medical education to the AIDS epidemic, according to the suggestions made in this report, can be aided significantly by AAMC leadership. Specific responsibilities it should assume in fulfillment of this mission include:

- The AAMC should serve as a clearinghouse for HIV curriculum materials and provide forums in which to discuss and disseminate information about innovative educational programs and methods.
- The AAMC should study the influence of HIV/AIDS on the choice of specialty and location of residency program, through

its own analyses and in concert with other interested groups. should also monitor the impact of HIV/AIDS on the clinical experiences of medical students and residents.

- The AAMC should direct advocacy efforts to seek federal support for faculty development and training grants that will increase the qualifications of faculty to teach about HIV/AIDS and, in particular, the associated psychological, social, behavioral, and ethical/legal aspects of patient care.
- The AAMC should encourage and cooperate with the American Board of Medical Specialties in studying the evolving impact of HIV/AIDS on the practices of specific medical specialties.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

**AGENDA FOR THE
ORGANIZATION OF
STUDENT REPRESENTATIVES**

**ADMINISTRATIVE BOARD MEETING
September 26, 1990**

1776 Massachusetts Avenue
2nd Floor Conference Room
Washington, DC 20036

ORGANIZATION OF STUDENT REPRESENTATIVES

1989 - 1990

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ORGANIZATION OF STUDENT REPRESENTATIVES
Administrative Board Meeting

September 26, 1990
8:00 a.m. - 5:00 p.m.

AGENDA

- I. Call to Order

- II. Consideration of Minutes of June Administrative Board Meeting *

- III. Regional Reports
 - A. Central *
 - B. Northeast
 - C. Southern
 - D. Western

- IV. Information Items
 - A. Consortium Report
 - B. Housing Exchange Network
 - C. Videotape of Problem-Based Learning Presentation
 - D. President's Report ** (Petersdorf)

- V. Discussion Items - Old Business
 - A. Annual Meeting Plans *
 - B. 1990 Priorities
 - 1. Counseling
 - 2. Medical Education
 - 3. National Boards *
 - 4. Societal Responsibility
 - 5. National Legislation ** (Goode)
 - C. Fall OSR Newsletters' Contents
 - D. Committee Representative Responsibilities *
 - E. OSR Representative Responsibilities *
 - F. Health Services and Health Policies/AAMC Position on HIV-infected Medical Students */** (Beran)
 - G. Future Student Award in Health Promotion/Disease Prevention */** (Bergeisen)
 - H. Proposed Accreditation Standards Changes */** (Kassebaum)

* Background material(s) enclosed

** Guest(s) invited to provide background information

I. Proposal for Selection of Representatives to ORR

J. Proposal for Educational Video on Issues of
Discrimination */** (Martin, Nickens)

K. OSR Representative to American College of Physicians (ACP)
Graduate Medical Education Subcommittee *

L. Establishing Contact with Romanian Medical Students *

VI. Discussion Items - New Business

A. Executive Council Agenda Items (separate booklet)

VII. Adjournment

* Background material(s) enclosed

** Guest(s) invited to provide background information

ORGANIZATION OF STUDENT REPRESENTATIVES
Administrative Board Meeting

September 26-27, 1990

SCHEDULE

Wednesday, September 26

8:00 a.m. - 5:00 p.m.	OSR Administrative Board Meeting	<u>1776 Massachusetts Avenue</u> 2nd Floor Conference Room
6:00 p.m. - 7:00 p.m.	Joint Boards Session with Guest Speaker	<u>Washington Hilton</u> Map Room
7:00 p.m.	Joint Boards Reception and Dinner	<u>Washington Hilton</u> Conservatory Room

Thursday, September 27

7:00 a.m. - 8:15 a.m.	Joint Boards Continental Breakfast -- Speaker: Dr. James Holsinger, VA Chief Medical Director	<u>Washington Hilton</u> Conservatory Room
8:15 a.m. - 12:00 noon	Council of Deans Board Meeting (*)	<u>Washington Hilton</u> Caucus Room
12:00 noon - 1:00 p.m.	Joint Boards Lunch	<u>Washington Hilton</u> Jefferson East Room
1:00 p.m. - 3:30 p.m.	Executive Council Business Meeting	<u>Washington Hilton</u> Jefferson West Room

* Caroline (Chair) and Lawrence (Chair-Elect) only

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.

A

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

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.

**REGIONAL REPORT
FOR THE SEPTEMBER ADMINISTRATIVE BOARD MEETING**

CENTRAL REGION

Submitted by: Amy Davis, Central Regional Chair
 University of Missouri-Columbia School of Medicine

1991 Regional Meeting

Kevin Baskin, Central Regional Chair-Elect is coordinating the 1991 Central OSR Regional Meeting to be held April 11-14 in Indianapolis, IN. Plans are well under way. The focus is "evaluation" from all perspectives (i.e., of teaching, of students, of curriculum, of standardized tests, etc.).

Annual Meeting

The Central Region will be hosting a social at the Annual Meeting in San Francisco; it is open to all groups (details to follow).

The Career Counseling/Mentor Lunch: a buffet lunch with "mentor" physicians from the San Francisco area and a speaker that will address career counseling. The speaker, William Pancoe, Ph.D., is Assistant Dean for Student Affairs at Creighton University. Suggestions for mentors would be appreciated. The number of students is limited to 100. Without assurance that the event is being funded by an external group, there would be charge for the students (amount not determined...), per Caroline's instructions.

Legislative Update: a small-group discussion format. Due to lack of funds, Capitol Hill folks will not be going out to San Francisco. Leslie Goode, and the new legislative analyst Jessica Sutin, will be present and Sarah Carr plans to attend as well.

OSR ANNUAL MEETING ASSIGNMENTS

<u>DAY/DATE</u>	<u>FUNCTION/SESSION</u>	<u>AD BOARD MEMBER(S)</u>
TH, 10/18	AMA - FREIDA Presentation OSR Social	Lawrence Lawrence and Krishna
FR, 10/19	NCI Training Ad Board Meeting New Member Orientation Regional Meetings Opening Session Business Meeting Reports: Counseling Medical Educ. Nat'l Boards Societal Resp. Nat'l Legisl. Plenary Reception	Lee + Reps-at-large Regional Chairs Caroline Amy Tom Krishna Cindy Lawrence Caroline Clay
SAT, 10/20	Plenary Committee Reps' Sessions LCME Lunch Mentor Lunch Workshops Financial Aid Minorities... Ethics Cultural Awareness Legislative Update Peer Counseling Problem-based... Indigent Care Chair-Elect Speeches Evening Program	Cindy, Andrea, Lee Caroline Clay Anita, Amy Lawrence Tom, Andrea Phillip Ashleigh, Cindy Amy Krishna Tom, Phillip Lee, Andrea Lee Caroline
SUN, 10/21	OSR/GEA Breakfast Regional Meetings Speeches, Elections Business Meeting Ad Board Lunch Joint Plenary	Regional Chairs Lee Caroline Caroline

**Submitted by the O.S.R. Task Force on the NBME Examinations
and Approved by the OSR Administrative Board on June 27, 1990**

We, the members of the Organization of Student Representatives of the Association of American Medical Colleges, as representatives of the students of United States medical schools, are concerned with the implications of the current usage of examinations developed by the National Board of Medical Examiners. The NBME Part I examination, designed for the purpose of licensing physicians, is currently used for many other purposes; these include the assessment of curriculum strengths and weaknesses by medical school faculties using annual comparisons of aggregate student performance and the assessment of applicants for post-graduate residency positions.

As representatives of United States medical students, we are concerned by the negative ramifications of the current score reporting process for NBME examinations on the residency selection process. Regarding this, we have come to the following conclusions:

1. The use of NBME numerical scores in the residency screening process undermines the significance of the evaluation of students by medical school faculties and deans over the extended course of their basic science and clinical education.
2. The use of NBME Part I numerical scores in the residency screening process devalues the importance of excellence in clinical performance, as these examinations primarily emphasize the basic sciences.
3. The use of NBME numerical scores as a cut-off for residency consideration eliminates students regardless of personal attributes and is antithetical to the humanistic ideals of the medical profession.

For these reasons, we stand resolved that:

Individual student scores for NBME examinations, including the new Comprehensive examinations, should be reported on Pass/Fail basis only.

The Executive Staff recommends that the Administrative Boards and Executive Council discuss this report and refer it for action to the full COD and CAS at their Annual Meeting in October.

**Background Discussion:
Position Paper on Score Reporting for NBME Examinations
Organization of Student Representatives, AAMC**

Introduction

Much has been written about the utilization of examinations developed by the National Board of Medical Examiners (NBME) for the purposes of licensing physicians. With the impending institution of new Comprehensive examinations and the advent of a single pathway to licensure in the United States, interest has been refocused on the role of such examinations in evaluation of medical students, with regard to licensure decisions and for other purposes. One important aspect of this discussion is that regarding a proposed change in score reporting procedures for NBME examinations to a pass/fail basis. The Organization of Student Representatives approved on July 27, 1990 a resolution advocating such a change. The following is a summary of salient points considered by the O.S.R. prior to adopting that resolution.

Use of NBME Scores in the Residency Selection Process

The most central issue in the development of the O.S.R. position on pass/fail reporting of NBME examination results relates to their use (and misuse) in the process of selecting medical residents. The National Board itself has clearly declared that *"It is important to understand, however, that the examinations have not been developed for the purpose of assessing preparation for postgraduate education."*¹ Despite this disclaimer regarding the purpose of the examinations, the use of NBME examination scores by residency programs remains widespread. It has been shown that 86% of residency directors require passing scores on NBME Part I as a criterion for ranking.² Several surveys indicate that NBME scores are an important part of the selection process.^{2,3,4} The use of NBME Part I scores in the selection process is even more prevalent in those specialties considered to be highly competitive. A survey of nearly 90% of U. S. residency program directors in ophthalmology and otolaryngology revealed that more than half of these programs used these scores as a means of deciding who to interview.⁵ Similarly, a study of applicants to orthopedic residency programs revealed that scores less than 400 or greater than 650 on NBME Part I examinations were absolute for predicting rejection or acceptance.⁶ It is clear from these results that NBME Part I scores have become an important part of the selection process for U.S. medical residents.

One frequent argument encountered by medical students advocating pass/fail reporting of scores is that "medical students simply do not want to be evaluated." Evaluation has, and will continue to be, an important part of the learning process in medicine just as it is in other fields of learning. The real issue lies not with the aversion medical students face toward examination or evaluation, but with the relevance of these particular examinations in the selection of students for residency

programs. If performance on NBME examinations clearly correlated with success in clinical performance, no resistance to numerical score reporting would be justified, and the rationale for using NBME exam scores in screening of applicants would be sound. However, review of the literature examining such correlations does not support the use of NBME examinations in this manner. The AAMC Group on Educational Affairs (GEA) conducted an exhaustive review of the literature on this topic. That review of over 20 separate studies examining the relationship of NBME scores to medical school and residency performance led to the conclusion that "studies have fairly consistently showed low to moderate positive correlations." 7-25 A further study demonstrated that correlation of clinical performance to Part I scores was the lowest and correlation to Part III scores was greatest. 14 These data indicate that while NBME numerical scores may have limited utility in predicting success in postgraduate medical training, their widespread use in the selection process today, often as a cutoff for consideration, is clearly not justified.

Effects of a Normative Method of Generating Numerical Scores

Another issue related to the use of numerical scores in the residency selection process stems from the statistical methods used by the NBME in scoring. Because the NBME uses a normative method of score generation, the performance of a student is determined relative to that of a comparison group--namely a reference group of test takers of four previous administrations, and not by absolute performance. The net effect of this method of analysis may be to magnify the apparent differences between individual test-takers. An example (outlined in 26) derived from a mean and standard deviation from an NBME examination several years ago, serves to illustrate this point. For that administration, the standard deviation (which determines a score difference of 100 points) was 7.4% of the total number of answers. This relatively small increase in absolute score would have distinguished a student scoring 450 from one scoring 550, effectively moving that student from close to the bottom third to nearly the top third of test-takers. This analysis also demonstrates why factors such as "practice effects,"²⁷ and medical school administered review classes²⁸ can have a significant role in influencing numerical scores.

Influences on Curriculum

Comprehension of the major issues related to the influence of NBME examinations on curriculum content requires some understanding of the competencies expected of medical school graduates. One accepted framework of these competencies was created by the NBME in 1981 and later adopted by the AAMC.²⁹ This model consists of a 50 cell framework relating tasks and abilities required of physicians. The NBME estimated that its examination questions measured twelve of 50 measured competencies. Among areas not assessed by NBME examinations are those related to development of technical and interpersonal skills as well as work habits and attitudes. Despite the inherent limited scope of these examinations, use of NBME

numerical results to gauge curriculum effectiveness remains widespread. AAMC data indicate that 81.9% of medical schools use performance on NBME exams or other national standards to evaluate the overall curriculum, while only 71.6% use residency performance of graduates as a standard. One problem with using such a benchmark is discussed in a 1989 AAMC document on medical education. The use of NBME examinations as a prominent indicator of curriculum strength leads to a situation in which "the 25% of competencies for which students and programs are presently compared on a national basis tend to receive a disproportionate emphasis in the medical education program."³⁰

A similar conclusion was reached in the Report of the Project Panel on the General Professional Education of the Physician:

"The present, passive system of medical education is based largely on memorization and recall. In over 70% of U.S. medical schools, students are required to take the nationally standardized, multiple-choice examinations provided by the National Board of Medical Examiners; in more than 50 percent, promotion and/or graduation are contingent upon passing them. To a limited degree, multiple-choice tests can be used to assess problem-solving abilities, but they largely measure a student's store of memorized information. They do not assess learning skills that medical students should acquire in order to keep pace with medical progress.

Standardized examinations cannot replace reasoned, analytical, personal evaluations of the specific skills and overall abilities of students. The objectivity of standardized examinations is often lauded in defense of their use. Scaled scores, measured against the performance of a large population, are considered more valid than subjective judgements by faculty of students' work. Yet, such personal judgements are essential if future medical school graduates are to be analytical, critical problem solvers who know how to manage information rather than simply to recall it. Personal judgement is characteristic of evaluations of performance in the clinical phase of medical education as well as in the actual practice of medicine."³¹

Reporting of NBME examination scores on a pass/fail basis would help to refocus the academic medical community on improving methods of teaching and assessing the broader spectrum of competencies expected of a physician.

Justification for Elimination of Numerical Scores

Proponents of the current score reporting process for NBME examinations point to the necessity of numerical scores for standardized comparisons of students. One underemphasized point is that at present, students are continually evaluated by their own medical school faculties and administrators. Students must pass rigorous examinations in basic science courses and are scrutinized closely on clinical rotations by residents and teaching faculty who also judge their performance. As

stated in the conclusion of the GPEP report mentioned previously, the importance of these "subjective" clinical evaluations and evaluations by basic science faculty can not be dismissed. Indeed, improvement of such evaluative methods has likely been hampered by the existence of a numerical measure which is easy to utilize in the residency selection process. Efforts to develop standardized clinical exams and other testing methods which evaluate a broader spectrum of competencies expected of new physicians would be encouraged by reporting of NBME scores on a pass/fail basis. It would also provide increased incentive for further changes leading to increased standardization of dean's letters and faculty evaluations--important variables which deserve prominence in the process of selecting residents.

It is unlikely that reforms in the problem areas identified previously will occur spontaneously. An argument proposed by many proponents of numerical reporting of NBME scores is that the logical answer to the problems presented lies in the simple elimination of the misuse of scores. Unfortunately, despite the fact that the arguments put forth here have been repeated many times before, change has been elusive. Already, nearly six years have passed since the appearance of the recommendations of the GPEP report, and four years have passed since the O.S.R. first requested discussion of this issue by the AAMC. One observer has noted that "it is unreasonable to expect residency committees to reject or ignore numbers so long as they are available. When class rankings were provided by schools, they were used."⁵ Without a change in the score reporting procedure, it is unlikely that significant reforms can be expected in the near future.

The importance of NBME examinations in providing quality examinations for the purposes of licensing physicians is clear. However, the presence of numerical scores for NBME examinations continues to have effects which are not compatible with the best interests of the academic medical community. For these reasons, the Organization of Student Representatives recommends that:

Individual student scores for NBME examinations, including the new Comprehensive examinations, should be reported on Pass/Fail basis only.

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Representative 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

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.

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".

<u> </u> (1) Degree of impairment	75.6 (1); 2.2 (2)
<u> </u> (2) Cost of treatment	3.3 (1); 20.0 (2); 14.4 (3); 8.9 (4); 3.3 (5)
<u> </u> (3) Academic standing	4.4 (2); 7.8 (3); 14.4 (4); 8.9 (5)
<u> </u> (4) Location of facility	13.3 (2); 14.4 (3); 8.9 (4); 3.3 (5)
<u> </u> (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		Mental Health		Substance Abuse	
	Yes	No	Yes	No	Yes	No
Is medical documentation required prior to a LOA?	54.4%	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%