

*[New Orleans Hilton  
Hotel, New Orleans, LA]*

**ORGANIZATION OF STUDENT REPRESENTATIVES**

**Business Meeting Agenda & Written Information Items**

- I. Call to Order
- II. REPORTS
  - A. Richard M. Peters, M.D., OSR Chairperson
  - B. David Baime, AAMC Legislative Analyst
  - C. Robert Beran, Ph.D., Director, AAMC Division of Student Programs
  - D. Joanne Fruth, OSR Central Region Chairperson, on OSR Survey of Health Promotions/Disease Prevention Teaching Activities
  - E. Ricardo L. Sanchez, M.D., M.P.H.
- III. Determination of Quorum
- IV. ACTION ITEMS
  - A. Approval of Minutes of 1985 Business Meeting.....1
  - B. Nomination of Candidates for Chairperson-Elect and Representative-at-Large
- V. Recess
- VI. Recall to Order
- VII. Determination of Quorum
- VIII. ACTION ITEM
  - A. Election of Chairperson-Elect & Representatives-at-Large
- IX. DISCUSSION ITEM
  - A. Preliminary Report of the ad hoc Committee on Graduate Medical Education and Transition from Medical School to Residency (see page 29 of annotated OSR Program)
- X. REMARKS
  - A. Robert G. Petersdorf, AAMC President
  - B. Christine Cassel, M.D., Chief, General Medicine, U. of Chicago, on Physicians for Social Responsibility

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REMARKS (Con't.)

- C. Leaders of Other Medical Student Groups
- D. Vicki Darrow, OSR Chairperson-Elect
- XI. Old Business
- XII. New Business
- XIII. Adjournment

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WRITTEN INFORMATION ITEMS

- A. OSR Member Responsibilities.....8
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ANNUAL BUSINESS MEETING MINUTES  
OF  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ORGANIZATION OF STUDENT REPRESENTATIVES  
October 25 and 27, 1985  
Washington, D.C.  
Washington Hilton Hotel

Remarks from OSR Chairperson

I. Dr. Ricardo Sanchez called the meeting to order at 4:45 p.m. and provided an overview of the OSR program. He invited all OSR members to examine the paper "Critical Issues in Medical Education" in which the OSR Administrative Board had summarized to the best of its ability its views of the goals of medical education. All members were asked to give their comments on the paper at the Sunday morning discussion session or in writing to the OSR Board. Dr. Sanchez read from the OSR Rules and Regulations that the purpose of OSR is "to provide a means by which medical students' views on matters of concern to the Association may find expression, to provide a mechanism for student participation in the affairs of the Association and ... for the interchange of ideas and perceptions among medical students and between them and others concerned with medical education." He noted that OSR members form a relatively small cadre who will become the defenders of the highest quality medical education in the years to come and that the success of OSR in this regard can't be measured by the number of pages in agendas or the number of hours of committee meetings.

Dr. Sanchez explained to the membership that the OSR Administrative Board has kept many balls rolling at its quarterly meetings and that over the year the Board has considered a bewildering spectrum of items--from the participation of investor-owned hospitals in the AAMC to review of the MCAT. In attempting to represent medical students' perspectives on all the items it is asked to consider, the OSR Board can't be sure it is providing the "mean" medical student opinion but does its best to articulate a tenable position; this is a difficult job and there is never enough time. Dr. Sanchez expressed the view that the Board this year has kept the channels of communication open and conveyed the impression that students are concerned and responsible people.

He reminded OSR members to use the General Professional Education of the Physician Report and the subsequent GPEP Commentary as tools for talking with their faculties and deans about medical education. GPEP has helped to create an atmosphere for discussions of promising curricular changes; because AAMC is respected and has widely distributed the Report, students can confidently point to the GPEP recommendations. He also drew students' attention to last spring's OSR Report which contains suggestions to students on implementing the GPEP recommendations. Another area of OSR activism mentioned by Dr.

Sanchez was the OSR-nominated student participants on the Liaison Committee on Medical Education and the NRMP Board of Directors.

He closed with the comment that it was a fantastic year for OSR and thanked the membership for having put the chance to serve OSR into his hands.

## **II. Report from Immediate-past-Chairperson**

Dr. Pamelyn Close described how she first got involved in OSR over four years ago as the representative from the University of Tennessee and was elected to be Southern Region Chairperson at the first OSR meeting she attended. She found that participation in OSR helps students get beyond their native selfishness by giving them tools to think about their medical school experience and about powerful organizations, such as the National Board of Medical Examiners, and by giving them ways to look out instead of continually in. OSR members build up a lot of energy at OSR conventions, then go home to rows of stone-faced students who may not want to think beyond the next examination. She noted that it is important for students to believe that change can happen, to take risks to effect needed changes, and to nurture their own creativity.

Dr. Close stated that this meeting would help OSR members acquire the muscles that need to swim upstream and that every fact and perspective they pick up at the meeting would prove of value in one context or another.

## **III. Report from Director of the Division of Student Programs**

Dr. Paul Elliott noted that his Division works for medical students from the cradle to the grave, in a sense, because it spans the admissions process and applicant pool studies, to the AAMC Graduation Questionnaire, and all student services in between. He offered an overview of AAMC's database on students, which now links data from the MCAT questionnaire to NRMP data. This database is a huge tool able to help the AAMC and medical schools dean knowledgeably and carefully represent medical students to a variety of agencies and government.

Dr. Elliott provided an overview of P.L. 99-129 which extends for three years the health training authorities contained in Title VII of the Public Health Service Act. The AAMC considers this a victory because of all the work that went into its passage and because it should buffer these important programs for the time being, allowing financial aid officers to turn their attention to other important matters. A few of the features of this legislation are an improved method of calculating delinquency rates in the Health Professions Student Loan Program, a new scholarship program for exceptionally needy students, and a decrease of half a percentage point in the interest rate students must pay on HEAL loans. (A summary of this legislation prepared by AAMC is available from Ms. Janet Bickel.) Dr. Elliott also commented on the AAMC position on the definition of independency for the purposes of Title IV student financial assistance;

AAMC adopted the position recommended by the GSA Committee on Student Financial Assistance that independent status should not be automatic based on age or degree program, but should be earned, so that responsibility for financing is not shifted from parents to the federal government. He also described plans to develop, in conjunction with the Higher Education Assistance Foundation, an alternative loan program for medical students which would cover GSL and PLUS loans. This new arrangement would replace HEAL loans for most students and provide the kind of loan consolidation medical students increasingly need. If plans proceed as hoped, this program may be available for students by next fall.

Finally, Dr. Elliott introduced Dr. Robert Beran, presently Associate Director, AAMC Division of Educational Measurement and Research, who will become Director, Division of Student Programs on January 1. Dr. Beran gave a brief overview of trends in the 1985 applicant pool. Compared with the 1984 group, this year's was less likely to be interested in family practice and more likely to be interested in surgery. He said that these and other changes warrant full discussion and much attention. Dr. Beran said that he looked forward to working with the OSR.

#### IV. Nominations for OSR Office

The following OSR members were nominated:

Chairperson-Elect:

Kent Wellish, Arizona  
 Vicki Darrow, Washington  
 Kirk Murphy, Hahnemann  
 John DeJong, Kansas

Representatives-at-Large:

Al Northcutt, Colorado  
 Edwin Rock, Pittsburgh  
 Mary Vistica, Oregon  
 Yolanda Colson, Mayo  
 Carol Lilly, Loyola  
 Vietta Johnson, Harvard  
 David Resch, Southern Illinois  
 Kim Dunn, Houston  
 Bess Bracken, Cincinnati  
 Joann Elmore, Stanford

V. The meeting recessed at 5:35 p.m.

VI. Dr. Sanchez recalled the meeting to order at 1:45 p.m. on October 27 and shortly thereafter declared the presence of a quorum.

VII. Elections

The OSR elected Vicki Darrow to the office of Chairperson-Elect.

The following additional nominations were made for Representative-at-Large:

- Kirk Murphy, Hahnemann
- Kent Wellish, Arizona (declined)
- John DeJong, Kansas
- Debra Weiner, Southern California
- John Balbus, U. Pennsylvania
- Robert Welch, Columbia
- David Levey, Case Western

The OSR elected the following OSR members to the office of Representative-at-Large:

- Vietta Johnson
- Kirk Murphy
- Kim Dunn
- Robert Welch
- John DeJong

VIII. Report on the Howard Hughes Medical Institute National Institutes of Health (HHMI-NIH) Scholars Program

Bob Mozayeni (OSR member from Albany) reminded the OSR of Doris Merritt's remarks at last year's business meeting about the HHMI-NIH Scholarship Program. He said that he and two other OSR members he was aware of pursued this possibility and were accepted for this salaried research training opportunity on the Bethesda campus. He said that this opportunity is exceeding his every expectation and offered to speak to anyone interested after the meeting (information about this program can be found on the last page of the Fall issue of OSR Report).

IX. Request from the Association of Teachers of Preventive Medicine (ATPM)

Dr. Sanchez described a recent request from the ATPM for OSR to cooperate with them in obtaining information on prevention-related teaching activities within medical schools. If ATPM obtains funding for this project, OSR members will be asked to assume responsibility for identifying these activities at their

schools. Dr. Sanchez requested those present to indicate if they would be willing to serve in this role, and there was a strong show of support.

#### **X. Report on American Society of Handicapped Physicians**

Xavier Castellanos (OSR representative from LSU-Shreveport) described this Society which is open to anyone, including the estimated 18,000 handicapped physicians, and which presently has about 1,000 members. He stated that handicapped physicians are an emerging minority and requested the OSR Administrative Board to study issues of importance to this group; the OSR membership supported this suggestion. Mr. Castellanos offered to provide more information to anyone and provided the address of the Society (137 Main St., Grambling, LA 71245).

#### **XI. Critical Issues in Medical Education**

Dr. Sanchez asked for and received the membership's approval of the basic document and explained that this OSR paper would now go to the new OSR Board with instructions for modifications as received from the membership. He requested the leaders of the morning's discussion sessions to summarize participants' views and also urged individual OSR members to give any additional recommendations in writing to Rick Peters or Janet Bickel prior to the January Administrative Board meeting.

**A. OSR Organizational Issues:** Kent Wellish reported the following suggestions which arose from this group's discussion:

- (1) delineate responsibilities of Representatives-at-Large early in their term;
- (2) broaden the base of regional leadership;
- (3) continue the practice of starting regional meetings with "show-and-tell" opportunities so students can share important developments at their schools;
- (4) help OSR members do a better job of communicating with each other and with classmates;
- (5) pursue the use of electronic bulletin boards by OSR Board members to improve communications at that level;
- (6) produce more frequent regional OSR newsletters; and
- (7) maintain flexibility of OSR member selection processes.

**B. Premedical Education and Admissions Issues:** Kirk Murphy reported the following recommendations:

- (1) expand the paper's discussion of the premed committee's role and how such committees can aid or thwart the selection of qualified students;
- (2) emphasize the need to lower barriers to non-traditional students;

- (3) devise a mechanism through which medical students and house officers can carry recommendations about preparation to premeds; and
- (4) give fuller consideration to the consequences of a declining applicant pool.

**C. Preclinical Education Issues:** Kim Dunn stated that her group recommended that the paper's tone needs to be more upbeat and that the paper should become shorter, more succinct and more specific. The following areas need more emphasis:

- (1) delineation of how problem-based, active learning differs from memorization;
- (2) changes in the approach of preclinical faculty to diminish artificial distinctions between basic sciences and clinical education;
- (3) efforts directed at residency program directors to help them improve their selection process so that they place less emphasis on National Board scores;
- (4) pressuring the NBME to change the scoring of the Boards to decrease their inappropriate uses; and
- (5) ease and improve the transition between basic science and clinical education by integrating the teaching of the basic sciences around clinical problems.

**D. Clinical Education Issues:** Vicki Darrow presented the suggestions from this group which included more emphasis on:

- (1) the concept of medical students as team members;
- (2) more attention to residents' teaching;
- (3) increased clinical exposure during the first two years of medical school and more clinical experiences in ambulatory settings;
- (4) institution of systematic policies regarding clerkships, including call schedules and hours;
- (5) more emphasis on ethics; and
- (6) increased guidance/career counselling throughout all four years.

## **XII. Remarks from Outgoing Past-Chairperson**

Dr. Close presented gifts to Dr. Elliott, Ms. Bickel and Dr. Sanchez for their contributions to OSR. She offered her perspectives on the many competing exigencies of medical education and on the brevity of the transition from first-year medical student to first-year resident. She expressed gratitude to OSR for helping her with this transition and for its continued help as a source of inspiration with her responsibilities now as a teacher of third-year medical students. She recommended to the OSR members that they grab on to the opportunities presented by OSR and that they remember their responsibilities as teachers and as health care team members. She thanked OSR for the opportunities afforded her during the last four years.

### XIII. Remarks from the New OSR Chairperson

On assuming the office of OSR Chairperson, Rick Peters thanked Dr. Sanchez for his powerful leadership over the year and expressed the view that the Administrative Board was a powerful team. He summarized the Council of Deans' meeting devoted to the National Boards at which he had just made a presentation and stated that students still have a long way to go in influencing the NBME because of the strong interests of many faculty in maintaining the status quo. Along with changing the way Board scores are used, Mr. Peters said that other key issues for the OSR in the coming year are: (1) finishing the "Critical Issues" paper, (2) studying and publicizing the advantages of problem-based learning methods, (3) improving the transition to graduate medical education, and (4) discussing with key individuals the financing of graduate medical education and showing that residents do not increase the cost of providing care in teaching hospitals. He said that individual OSR members have a lot of work to do and that they should remember Patch Adams' walking a mile in each patient's shoes instead of giving up in the face of obstacles.

XIV. The meeting was adjourned at 4:00 p.m.

## 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 OSR Report 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 seek funding also 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

## EXAMPLES OF OSR MEMBER SELECTION METHODS RECOMMENDED BY STUDENTS

### University of Southern California

The OSR representative is elected from the first-year class at the end of the year to serve the next two years. As a sophomore and OSR alternate, the OSR representative's responsibility is to chair five meetings/year of a coordinating committee composed of all students serving on any school curriculum committee and of other interested students. (students involved in political, ethical and service oriented clubs are strongly urged to attend). The role of the OSR alternate is to facilitate program development by coordinating medical student efforts. As a junior, the student serves as the official OSR representative, whose responsibilities are: a) maintain contact with other OSR members on a regional and national level; b) assist the OSR alternate with the coordination committee and act as the student voice to faculty and deans regarding issues of student concern. This arrangement helps make the OSR a productive organization at the school, helps keep students informed regarding national issues, and maintains continuity from year to year.

### University of Colorado

The goal at Colorado is to have one person representing the clinical years and another representing the basic science years. When he or she becomes a junior, the current OSR representative contacts the 1st year students about OSR and the issues that OSR deals with on a national level. The students who express interest are then given more details and asked to write a speech and present it to the medical student council. A discussion then follows, and the council decides who the representatives will be. OSR members are expected to remain active until graduation.

### University of Texas-Houston

Each medical school class selects one person to represent that class until graduation. The freshman is selected in time to attend the OSR Spring Regional Meeting. The process is as follows: 1) First-year students' mailboxes are stuffed with description of the OSR position; 2) Interested freshmen meet with current OSR representatives and class officers; 3) Class officers interview students and select one. Therefore, there are three OSR representatives who attend both regional and national meetings: in the Spring - MSI, II, III; National - MSII, III, IV. Who votes is left for the individual OSR representatives to decide among themselves.

## OPENINGS FOR STUDENTS ON COMMITTEES

An important way in which student perspectives are brought to bear on issues and opportunities facing medical educators is through their participation on national committees. Annually the OSR Board is asked to nominate students to certain committees; those with an opening in 1987 are described below. One does not need to be an OSR member to be eligible to apply to serve. Therefore, please broadcast this availability to other students, but also consider applying yourself.

Interested students may either complete the following, self-descriptive sheet or submit a curriculum vitae; a supporting letter from a dean is also helpful. These materials should be mailed to Janet Bickel at AAMC by January 5 (March 30 for the LCME opening). At its January meeting, the OSR Administrative Board will consider the applications received and make recommendations to the AAMC Chairperson. Students serving on these committees are responsible for keeping in touch with the OSR Chairperson on actions and proceedings.

1. Group on Student Affairs' (GSA) Committee on Student Financial Assistance:

This Committee is composed of financial aid deans who monitor in as proactive a way as possible legislation affecting and developments regarding provision of financial aid to medical students. It meets in Washington, D.C. usually in early February and June and in the fall in conjunction with the AAMC Annual Meeting. AAMC can cover travel to one of these meetings. Term begins in Spring 1987, ends with student's graduation from medical school. (Currently serving: John Muller, St. Louis U. OSR Member)

2. GSA-Minority Affairs Section Coordinating Committee:

Coordinates all the activities and functions of GSA-MAS, which advises the Association on all issues of concern to minorities in medicine. See #1 for additional information. (Currently serving: Vietta Johnson, Harvard OSR Member)

3. GSA Committee on Student Affairs

This new Committee will make recommendations to the GSA Steering Committee on the student affairs issues it considers of greatest concern. At its first meeting, the Committee identified the following areas as needing the most attention: transition from medical school to residency, student health, student advising, and the problem student. See #1 for additional information. (Currently serving: Vicki Darrow, OSR Chairperson-Elect)

4. GSA Committee on Admissions

This new Committee will make recommendations to the GSA Steering Committee only in the area of medical school admissions. At its first meeting, it

Admissions (Con't.):

identified the following of primary concern: Decreasing the amount of acceptance activity during the summer preceding matriculation, simplifying medical school prerequisites, and reaffirming affirmative action goals. See #1 for additional information. (Currently serving: Robert Welch, Columbia U. OSR Member)

5. Flexner Award Committee:

This Committee nominates an individual selected for "extraordinary contributions to medical schools and to medical education." Members are mailed dossiers on nominees and the Committee meets via a conference call in early summer. (Currently serving: Charles Weaver, U. Washington OSR Member)

6. Association of Teachers of Preventive Medicine Board of Directors:

The liaison representative for this group will serve as the primary link between ATPM and the organization he or she is named to represent and will serve as advisor to the Board in its development of policies. The spring meeting is held in Atlanta and the fall meeting is in conjunction with the American Public Health Association; ATPM will fund travel to one meeting. Term begins Summer 1987. (Currently serving: Mark Blumenthal, Rutgers OSR Member)

7. Liaison Committee on Medical Education (LCME):

The joint AAMC/AMA Committee is responsible for certifying the quality of American medical schools. It has established the following criteria for the appointment of a student member: a) have commenced the clinical phase of training by July 1987, b) be in good academic standing, 3) warrant the judgment that the responsibilities to the LCME would be capably executed. Demonstrated interest in academic medicine and participation on academic affairs committees are also important. This one-year term begins June 1987. The appointment entails extensive reading and attendance at four meetings per year. Contact AAMC staff member Bob Van Dyke (202/828-0677) for additional information.

Name: \_\_\_\_\_ School: \_\_\_\_\_ Class of: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: Day: ( ) \_\_\_\_\_ Evening: ( ) \_\_\_\_\_  
(area code) (area code)

Education: Degree Institution Year

Committee or Medical Education Area of Special Interest: \_\_\_\_\_

Research or Extracurricular Activities: \_\_\_\_\_

Committee or Medical Education Area of Special Interest: \_\_\_\_\_

Other Qualifications: \_\_\_\_\_

Name of dean who will supply a supporting letter: \_\_\_\_\_

RETURN TO JANET BICKEL, AAMC DIVISION OF STUDENT PROGRAMS  
1 Dupont Circle, Washington DC 20036

## SCHOOLS WITH UPCOMING LCME SITE VISITS\*

### Scheduled for 1987

Louisiana State	January 20-23
University of Miami	February 16-19
Eastern Virginia	March 3-5
Ohio State	March 3-6
Mercer	March 10-12
New York Medical College	March 30 - April 2
North Dakota	April 14-17
University of Missouri-Columbia	April 21-24
University of Arizona	May 4-8
University of Nevada	September 28 - October 1
Loyola	September 28 - October 1
University of Iowa	October 6-9
University of Colorado	October 6-9
UMDNJ - Robert Wood Johnson	October 19-22
Indiana University	October 12-23
Temple University	October 26-29
Medical College of Georgia	November 16-19
University of Texas Southwestern	November 16-19
Howard University	November 16-19
University of Illinois	November 16-20
Duke University	December 1-4

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\*A copy of "The Role of Students in the Accreditation of U.S. Medical Education Programs" will be distributed at the annual business meeting; if your school is listed here, be sure to obtain this booklet. The earlier planning can occur for student participation in the accreditation process, the better. Please call Bob Van Dyke, AAMC Division of Accreditation (202/828-0677) with questions. Taking a leadership role in this process is an OSR member responsibility.

SCHEDULED FOR 1988 (Dates not yet set)

University of Southern Alabama

California - San Francisco

Loma Linda University

University of Connecticut

Georgetown University

George Washington University

Rush Medical College

Louisiana State University

Boston University

Harvard University

Columbia College of Physicians and Surgeons

Cornell University

State University of NY - Stony Brook

State University of NY - Syracuse

University of North Dakota

University of Oregon

Temple University

University of Pittsburgh

University Central Del Caribe

University of Puerto Rico

Brown University

Northeastern Ohio

University of South Carolina

1988 (Con't.)

Texas Technical University

University of Washington

PATCH ADAMS & GESUNDHEIT INSTITUTE

One of the best received features of the 1985 OSR Annual Meeting was Patch Adams' presentation on pursuing one's dreams and finding joy in the practice of medicine. Following is a brief overview of his life and work and a page describing the kinds of presentations he gives. The OSR Administrative Board believes that Patch's message is an important one for medical students to hear, given their confusion and fear about many trends in medical practice, e.g., malpractice and competition for patients. The Board recommends that OSR members consider asking Patch to spend a day at their schools interacting with students and giving presentations. Over the past few years, many schools and student organizations have hosted him, including AMSA, AMA-MSS, Medical College of Virginia, Harvard, Tufts, SUNY Upstate, George Washington and Georgetown. Listed below are a few contact persons who can act as references and who can offer advice about the logistics of arranging a visit.

Alan C. Mermann, Chaplain, Yale U. School of Medicine, 333 Cedar St.  
New Haven, CT 06510 (203 785-2648)

Joanne Fruth, OSR member, Medical College of Ohio, 3217 Glanzman Rd.,  
#B-20, Toledo, OH 43614

Jim Stout, M.D., Pediatric Resident, U. of Washington, 4520 45th Ave., NE  
Seattle, WA 98105

Charles Weaver, OSR Member, U. of Washington, 409 Federal Ave., E, Seattle,  
WA 98102 (206/325-7829)

Dan Schlager, M.D., Emergency Medicine Resident, U. of Arizona, 5101  
N. 40th St., D201, Phoenix, AZ 85018 (602 840-5423)

LECTURES AND PLAYSHOPS  
BY PATCH ADAMS, M.D.

Patch Adams, M.D. is a physician who is the founder and director of Gesundheit Institute, a free health facility in operation for the past 15 years (described in the attached article). It is the only health facility in the U.S. addressing the four major issues in health care delivery (rising cost of care, dehumanization of medicine, malpractice suits and the abuses of the third party system) by action.

Patch travels around the country lecturing on his work and doing theater shows about many aspects of health - particularly dealing with self-care and prevention. He is a very enthusiastic, perceptive, and fun person. Wherever he goes he is committed to giving his time to the event, not only in the talks and shows, but informally or in special interest groups. Though he has prepared presentations, with enough advance time he will create a presentation for a specific subject.

The available presentations are:

1) Magic Elixirs of Life - Dr. Adams plays a 19th century snake-oil salesman character promoting his special tonics for healthy living: nutrition, exercise, wonder, curiosity, love, nature (18 elixirs in all). With each tonic there is a different experience presented which includes dancing, singing, laughing, eating. [1-3 hours long depending on numbers of elixirs] \*

2) How to Be Nutty - An extremely fun "playshop" that teaches the practical steps in being sillier. Great for stress reduction. At the end of 2 hours we go, costumed, out in public and act goofy. \*

3) Gesundheit Institute - Medicine for fun, not funds - A 1-2 hour talk, with questions and answers about a fascinating medical experiment. For 15 years Dr. Adams has directed a medical facility that has charged no money - carried no malpractice - accepted no 3rd party insurance - and lived with its patients in a large group home/farming setting. 15,000 people have been seen from all over the U.S. and many foreign countries. \*

4) Balance - A 1-2 hour multimedia introduction to the subject of balance and its role in our lives and health. Highlights include: a gorilla riding a unicycle and walking



**GESUNDHEIT INSTITUTE** \_\_\_\_\_  
**404 n. nelson st., arlington, va 22203**  
\_\_\_\_\_ **(703) 525-8169**



ACRONYMS USED FREQUENTLY IN

AND AROUND THE AAMC

Internal AAMC

CAS - Council of Academic Societies  
COD - Council of Deans  
COTH - Council of Teaching Hospitals  
OSR - Organization of Student Representatives

GBA - Group on Business Affairs  
GIP - Group on Institutional Planning  
GME - Group on Medical Education  
GPA - Group on Public Affairs  
GSA - Group on Student Affairs

AMCAS- American Medical College Application Service  
MCAT - Medical College Admission Test  
MSKP - Medical Science Knowledge Profile

CFMA and the "Liaison Committees"

CFMA - Council for Medical Affairs: AAMC is one of five members, along with the American Medical Association (AMA), American Hospital Association (AHA), American Board of Medical Specialties (ABMS), and Council of Medical Specialty Societies (CMSS). CFMA serves as a forum for discussion on all aspects of medical education.

LCME - Liaison Committee on Medical Education: There are two parent organizations: AAMC and AMA; Secretariat and Chairmanship rotate annually. Responsibility for accreditation of undergraduate medical schools.

ACGME - Accreditation Council for Graduate Medical Education: Same five parents as CFMA. Chairmanship rotates annually. Staffing services provided by AMA. Responsible for accreditation of graduate medical education programs.

ACCME - Accreditation Council for Continuing Medical Education: Same five parents as AFMA, plus Federation of State Medical Boards (FSMB) and Association for Hospital Medical Education (AHME). Staffing for ACCME provided by CMSS.

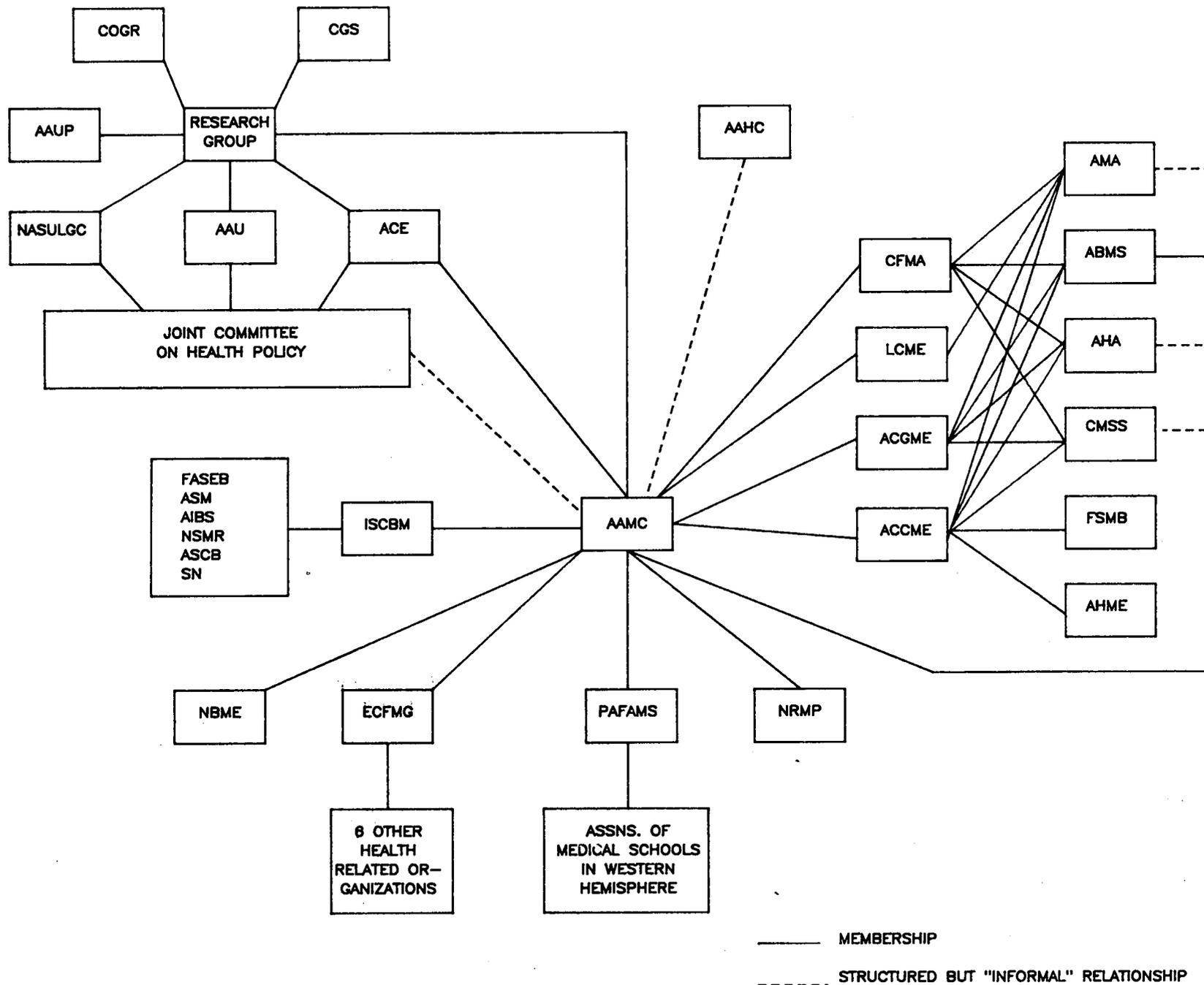
Educational organizations with whom the AAMC interacts

Representatives are asked to AAMC Executive Council meetings; various reciprocal arrangements exist.

- AAHC - Association of Academic Health Centers: Organization members are Vice Presidents for Health Affairs at academic medical centers.
- ACE - American Council on Education: Members are some 1,200+ institutions of higher education and 165 national and regional associations and organizations.
- AAU - Association of American Universities: Approximately 50 of the preeminent public and private institutions of higher education.
- NASULGC- National Association of State Universities and Land-grant Colleges: Membership is approximately 150 major public (land-grant) universities and colleges.

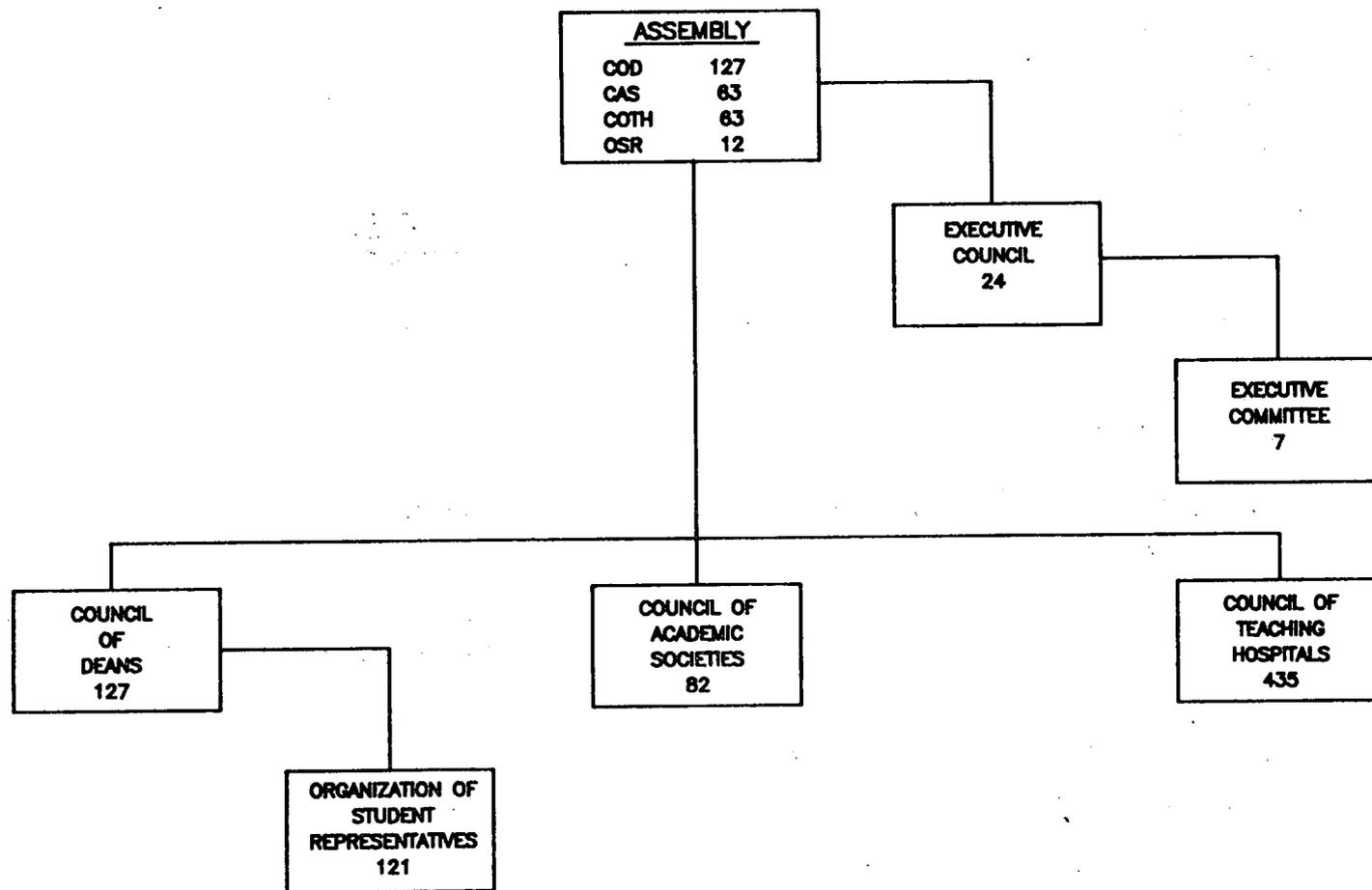
Health organizations with whom the AAMC interacts

- NBME - National Board of Medical Examiners: AAMC is a member organization and appoints two members to the Board. NBME is responsible for the three part examination that leads to licensure of physicians.
- ECFMG - Educational Commission for Foreign Medical Graduates: AAMC is a member organization and appoints two members to the Commission. ECFMG is responsible for evaluating the qualifications of foreign medical graduates seeking admission to the U.S. for graduate medical education.
- PAFAMS- Panamerican Federation of Associations of Medical Schools: AAMC was a founding organization. All organizations similar to AAMC throughout the Western Hemisphere belong to PAFAMS.
- ISCBM - Intersociety Council for Biology and Medicine: Composed of AAMC, American Society for Microbiology, American Institute for Biological Sciences, National Society for Medical Research, and Federation of American Societies for Experimental Biology (FASEB).



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# ASSOCIATION OF AMERICAN MEDICAL COLLEGES GOVERNING STRUCTURE



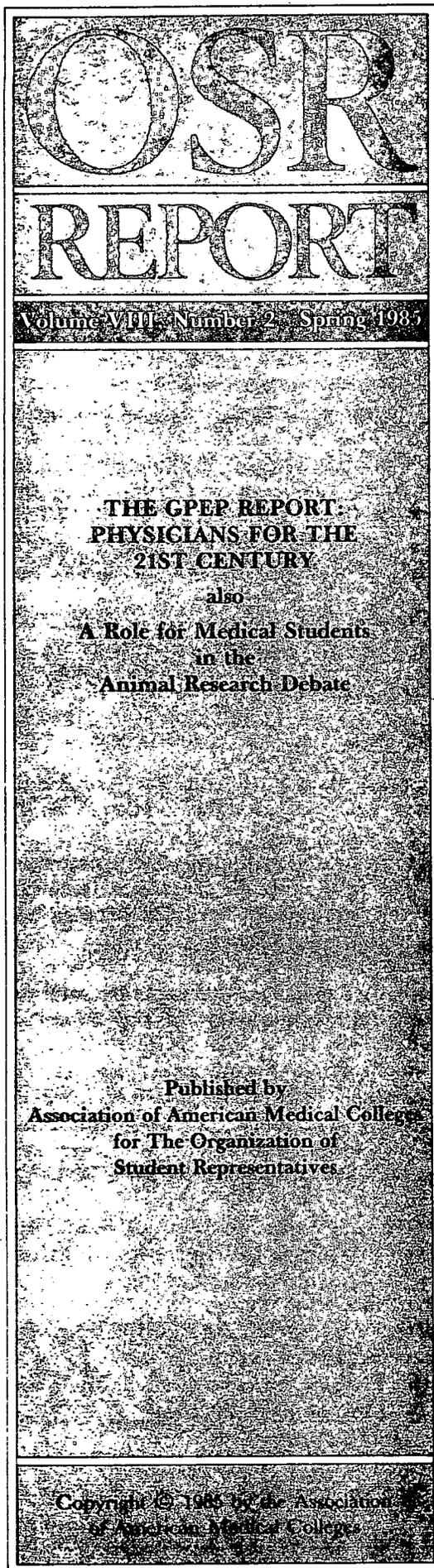
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Executive Committee: Chairman: *Virginia V. Weldon, M.D., Washington University School of Medicine*  
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 Immediate Past Chairman: *Richard Janeway, M.D., Bowman Gray School of Medicine of Wake Forest University*  
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 Chairman, CAS: *David H. Cohen, Ph.D., SUNY at Stony Brook School of Medicine*  
 Chairman, COTH: *C. Thomas Smith, Yale-New Haven Hospital*  
 President: *Robert G. Petersdorf, M.D.*

## GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN (GPEP)

The OSR is committed to keeping alive the recommendations released by the GPEP Panel in the Fall of 1934. Several of the OSR Annual Meeting sessions are responsive to these recommendations, particularly Sunday morning's program on problem-based learning. The OSR Report which summarizes the GPEP Report is reprinted here for those of you unfamiliar with this important study and for those who need a refresher. Following this is a timely article by Carol Mangione, M.D., former OSR member from U. of California-San Francisco.

Reading these may stimulate ideas and goals that could enhance your use of the OSR Network at the Annual Meeting and that could provide the basis for changes you help initiate with faculty at your school.



## CHAIRPERSON'S PERSPECTIVES

Last fall, the Association of American Medical Colleges (AAMC) published the final report of a comprehensive study of the General Professional Education of the Physician (GPEP). The specific objectives of the 3-year project were: 1) to assess current approaches to medical and pre-medical education in the U.S. and to develop recommendations to improve the instructional programs; and 2) to stimulate broad discussions about the philosophies and approaches of medical educators. Twenty-seven recommendations summarize the consensus of the project panel and its working groups. In developing its report, the project panel considered testimonies submitted by 84 U.S. and Canadian medical schools, 21 professorial organizations, and many other concerned groups that participated in a series of open hearings.

AAMC president, John A. D. Cooper, M.D., Ph.D., pointed out in the afterword to the report that many of the panel's recommendations were originally put forward by a similar committee over 50 years ago. This is indeed the case regarding recommendations to consider major reductions in lecture hours, to avoid requiring students to be passive recipients of information, and to encourage the development of analytical skills over the ability to recall memorized information.

Although all participants in medical education will not find every one of the GPEP recommendations directly applicable to their individual experience, it is undeniable that the panel of experts was able to address effectively many important features of medical education. As I look back to my experience as a medical student, I have no difficulty in identifying many areas in which the project's recommendations have great relevance.

The obvious questions that come to mind after reading the GPEP report are: what will become of the recommendations and will they have to be reiterated by some committee 50 years from now? Unfortunately, it is all too easy to concentrate on achieving success in medical school without pausing to consider the broader issues. Every one of us is tempted to avoid thinking about the meaning of the process to which we have submitted ourselves; but we know and we must never forget that there is something more to medical school than graduating and matching in a competitive residency program. At stake is our ability to contribute to the profession to which we have dedicated our best efforts, to prepare ourselves to take care of patients in an effective and humane way, and to continue learning as we face situations of higher complexity and responsibility. In short, at stake is our ability to make a difference.

Today, the opportunity for positive change may be broader than ever before. The process initiated by GPEP and by other efforts, the emergence of cost/benefit as a force in health care, and the advent of information technology are all factors pointing to a reassessment of the current approaches and practices in the health field in general and in medical education in particular. As physicians-in-training, we are engaged in a process that ideally takes us through stages of information, knowledge and wisdom. We owe it to ourselves and our patients to go beyond the information stage, which seems to capture the better part of our efforts in today's medical education. I hope the following article may contribute to your ability to make a difference.

Ricardo L. Sanchez (Brown '85)  
Chairperson  
Organization of Student Representatives

## WHAT NEEDS CHANGING?

The AAMC's decision to mount the GPEP study originated in the perception that the general education of physicians is inadequate (and will become more so) in preparing them to respond to this country's health needs. Contributing to the deficit are numerous pressures outside the control of most medical educators: 1) rapid advances in biomedical knowledge and technology which are increasingly complex and powerful; 2) patients' growing demand for advice about how to stay healthy and how to use specialized medical services; and 3) the heavy influence which agencies paying for medical services, e.g., Medicare, exert on the practice and education environments.

The GPEP report offers a series of conclusions about improvements needed in the present system. Its recommendations are summarized below:

### A) Purposes of a General Professional Education

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

### B) Baccalaureate Education

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

### C) Acquiring Learning Skills

1. Medical faculties should adopt evaluation methods to identify: (a) those students who have the ability to learn independently and provide opportunities for their further development of this skill; and (b) those students who lack the intrinsic self-confidence to thrive in an environment requiring independent learning and challenge them to develop this ability.
2. Attainable educational objectives should be set and students provided with sufficient unscheduled time to pursue those objectives.
3. Medical faculties should examine the number of lecture hours they now schedule and consider major reductions in this passive form of learning.
4. Faculties should offer educational experiences that require students to be active learners and problem-solvers.
5. In programs emphasizing the development of independent learning and problem-solving skills, the evaluation of students' performance should be based in large measure on faculty members' subjective judgments of students' analytical skills rather than their ability to recall information.
6. Medical schools should designate an academic unit for institutional leadership in the application of information sciences and computer technology to physician education.

### D) Clinical Education

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

### E) Enhancing Faculty Involvement

1. Medical school deans should designate an interdisciplinary organization of faculty members to formulate a comprehensive educational program for

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

These recommendations are best considered in the context of the full GPEP report<sup>1</sup>. Although it is not lengthy, space limitations prevent its reprinting here. A major benefit of examining the whole report (and the contributions of the three working groups on Essential Knowledge; Fundamental Skills; and Personal Qualities, Values and Attitudes) is the perspective gained about the most persistent problems in medical education. Pointing to all the less-than-optimal conditions and methods is easy, but actually disassembling the barriers to change is another story.

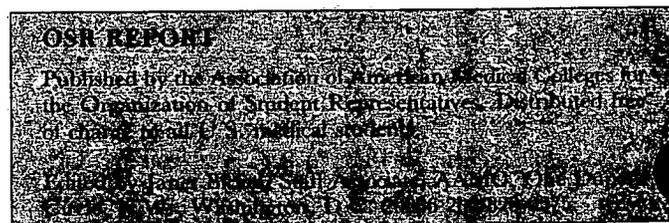
When taking stock of medical education, an important feature to keep in mind is the high priority that most medical faculty members give to research, patient care and the training of residents and graduate students. Moreover, faculty typically receive few visible rewards, e.g., promotion, for devoting their energies to undergraduate teaching. Were faculty to receive academic recognition for teaching excellence on par with that forthcoming for research results, perhaps more could "afford" to realign their priorities. Also remember that small group teaching geared toward problem-solving is labor-intensive and requires skills much different from those necessary to transmit facts in a lecture. Traditionally, faculty have not sought guidance in acquiring effective teaching methods. For these reasons, in any way possible, students need to encourage faculty to become willing to improve their skills. Achieving a learning partnership is the goal, stellar but reachable.

## WHERE TO BEGIN?

Essential to students with a serious interest in education is an appreciation of their school's mission and present political realities. For the next class meeting, why not ask the dean to present an **assessment of the directions in which the institution is moving?** Beyond this basic grounding, an **active student council and reliable**

**mechanisms by which students communicate with each other** are essential to students' ability to contribute. At schools lacking a strong student council, those committed to achieving change can inspire new life into existing mechanisms and can meet and **divide tasks**; perhaps one class more than others will rise to the occasion. Some students could concentrate on literature searches in areas of particular interest, some on dean's office liaison, some on networking with students from other schools. **Students active in national medical student organizations** should be especially prepared to pitch in, because such students have unique opportunities to exchange information about promising and disturbing developments at schools across the country. These students also develop skills in leading meetings, brainstorming, group process and facilitating communication within groups; they can share with other students what they have learned<sup>2</sup>.

But nothing fancy is involved with students taking a constructive interest in their education and in the present and future well-being of their school. Each medical school class has its own distinct personality and unique resources to tap and will have its own specific meat to hang on the general bones of the GPEP recommendations. OSR members provide a couple examples of ways to get started (see also below). At the University of Texas-Houston, two students obtained the dean's support (including funds to cover refreshments and photocopying) in developing a student contribution to the school's consideration of the GPEP report. Twenty-five of the most active students at the school read the report (on reserve in the library) and attended an initial meeting to review the recommendations. This group's **brainstorming yielded several concrete ideas to be incorporated into the school's ongoing comprehensive self-review**. At the University of Washington, student leaders met with the deans to discuss how to motivate faculty and students to give serious consideration to GPEP. An interview form was developed containing such questions as "how do you think our school is doing with regard to the recommendations on clinical education" and "what is your specific recommendation for needed changes in this area," and 25 students were recruited to **interview all the department chairpersons and medical directors of affiliated hospitals**. Responses to this effort have been very positive. At schools with upcoming site visits from the Liaison Committee on Medical Education (LCME, the body which accredits U.S. medical schools), a **student-generated response to GPEP's recommendations can be adapted to serve as the students' report to the LCME**<sup>3</sup>.



A cascade effect of students' working together in these ways and talking with deans and faculty is that they **learn more about a large variety of issues**—from the setting of tuition levels to problems with funding ambulatory clerkships to hospital strategies for attracting patients. Links to the world outside the classroom can elucidate what goes on inside.

## **FOCUSING ENERGIES: IDEAS FOR ACTION**

### **A. Generating Interest in Change**

Create opportunities to discuss the GPEP recommendations with department chairpersons (last September all were mailed a copy of the report) and other faculty, regardless of what you *think* their reactions may be. In conjunction with the dean's office, **try organizing an open forum** with speakers and a panel to air the school's priorities on educating physicians for the 21st century; the purpose would be to spur a renewed commitment to education, not to fire controversies. Luring a large number of participants would take a lot of imagination and footwork, but such evidence of student commitment could pay handsomely. Another idea which requires a lot of work and which is an excellent motivator of students is for the student council to put on a **convention for students, with workshops on topics not covered** in the curriculum, e.g., third-world medicine, social responsibilities, leadership training. At the University of Miami plans are for such a convention to become annual, with all four classes participating and funds from drug companies helping to underwrite the costs of speakers and a mixer. Last year's theme was "Creativity in Medicine."

### **B. Motivating Faculty**

Are resources available to faculty to help them improve their teaching and evaluation skills? Is there increasing awareness at your school of the importance of rewarding faculty who devote their time to teaching medical students? Is the faculty selection and promotion process under review? Would letters to, for instance, the president of the university or the board of directors about the impact of the present reward system help?

Intrinsic rewards are important too. Excessively grade- and test-oriented students and those looking for the "easiest" way to learn ("just tell me what I have to know") convince faculty that there is no point in improving their teaching and evaluation methods. The problem-based and small group learning modes place just as much responsibility on the learner as on the teacher. **Faculty/student retreats** can throw light on the conflicts and stumbling blocks to progress in these areas. But perhaps nothing beats frequent **positive reinforcement of teachers who are trying to introduce improvements**.

### **C. Improving the Transition to Clinical Education**

Since initial experiences with patients are so formative and since many schools' Introduction to Clinical Medicine courses are so inadequate, students especially

need to marshal their energies in this area. Discussions about what keeps the introductory course from working well and students' need for more supervision can lead to an **agenda of issues to be addressed with faculty and deans**. The student council can even **design a curriculum** to present, with ideas on obtaining necessary resources. Addressing the needs of students new to the wards, students at some schools (e.g., Temple) have designed practical and light-hearted handbooks; AMSA also has published "Survival Manual: A Guide to the Clinical Years." The focus, however, should be on changing rather than surviving the present wide-spread dearth of available assistance; the pace, complexities and cost implications of patient care activities in most teaching settings argue for medical student's receiving a carefully planned orientation to their responsibilities. At some schools, e.g., Southern Illinois University, **students have initiated the inclusion of such an orientation** by themselves planning a one-day program.

Frequently, with the new stresses at this juncture, students become aware of other gaps in their education, for example, the relationship between medical decisions and the cost of procedures, how a patient's emotions and home life influence outcomes, and the ethical dimensions of medical choices. While many schools offer electives in these areas, most students appear to need more assistance early in the transition to clinical medicine. Students can work with faculty in seeing that such subjects are more frequently addressed in the clinical setting. Also, students experience a variety of emotional responses as they learn to interview patients about intimate subjects, to give families difficult news, to cope with death. Opportunities to discuss disturbing feelings with a sympathetic physician and on-going **seminars on "retaining your humanism"** can be very useful early in the third-year, as well as books written specifically for students undergoing this transition<sup>4</sup>. Other ideas are student **support groups** and **presentations on handling stresses**, self-care, and impairment prevention<sup>5</sup>.

### **D. Evaluation**

A recurring theme of the GPEP report is the unfortunate influence of evaluation methods, such as the National Boards, on students' approach to learning. One OSR member writes: "Over-reliance on multiple-choice examinations has removed the ability of the faculty to promote thinking and reduced preclinical education to the point where it can be taken by correspondence (and is by many in our school via note services)." Students have made little headway in facilitating progress in this area because evaluation methods that encourage independent learning and problem-solving rather than recognition and recall are harder to design and more time-consuming to use. Students can, however, when appropriate, **question the uses of the National Board examinations** at their schools. This issue can provoke strong feelings because some preclinical faculty fear a devaluation of the basic sciences in medical education if schools stop requiring passage of Part I; also many faculty ap-

pear to gauge the strength of their departments on their students' Boards performance.

The issue of letter grades vs. pass/fail is also debated among and between students and faculty. Students at the University of Cincinnati successfully **fought the reinstatement of letter grades** in the basic sciences. Even after it had been approved by the faculty, students at University of California, San Diego, blocked implementation of a four-tiered grading system. But there is no unanimity among students on this subject. While many shun any force creating competition among class members, others seek out chances to earn the highest marks and continually imagine the eyes of residency program directors scanning their applications for numerical evidence of "excellence". While students understandably wish to maximize their chances of obtaining the most desirable graduate position, in this pursuit some neglect their own general education; ultimately this a no-win situation for students and patients alike.

Students have maintained that, if clinical teaching and evaluation were more thorough and individualized, an appropriate de-emphasis of basic science grades and Part I scores could occur. It is not easy for students to facilitate such improvements. However, the AAMC Clinical Evaluation Project has ascertained that a large number of faculty are also unsatisfied with current clinical evaluation methods, and self-assessment materials are being developed to help schools to upgrade their evaluation strategies<sup>6</sup>. A related area is residents' need for assistance in carrying out their responsibilities as educators and evaluators of medical students. This gap is beginning to attract more attention, and students can perhaps add momentum by **lobbying for the addition of structured sessions to help residents improve their teaching abilities** and by starting to work on their own. Finally, in the face of lures to specialize prematurely, students can offer each other support to **pursue a broad clinical education**, augmenting their experience when possible with research and community activities.

The other side of the evaluation coin is **student evaluations of courses** and faculty. Students can be instrumental in improving their design, collection and use. Good examples are available. University of Miami has recently strengthened its use of student evaluations of clerkships. Students are now asked numerous questions on the feedback they receive from faculty and house staff and on the frequency with which clinicians observe and critique their performance and discuss their write-ups with them; results are carefully reviewed with department chairpersons.

### WHAT IS A REALISTIC GOAL?

Each medical school class should be able to expand on and beyond the above suggestions. And each individual will personally compose an inventory and agenda. In setting priorities for professional growth, what are realistic goals? And what does becoming the finest possible physician entail during this era of burgeoning scientific knowledge and shrinking resources for education? The answers that today's medical students' give to these questions have

broad implications for the quality of health care available in this country. Society in general is becoming more and more specialized. Temptations are many to view medicine as primarily an array of powerful diagnostic devices and state-of-the-art technology. Attaining a medical education system that can withstand such forces and that is better than the present one at shaping compassionate healers will take the efforts of everyone involved. Persistent patience is needed—and keeping the eye focused on the human dimensions of medical care.

Skepticism about reshaping educational methods is infectious—but so is faith. And faculty and deans may be more amenable to the changes suggested by GPEP than students in the prolonged adolescence of medical school might think. But if the students, the most immediate beneficiaries of an improved educational system, do not come forward, silence is interpreted as approval of the status quo and its regressive influences. Numerous national and local magazines and newspapers have published articles about GPEP. Interest within the profession, at the schools and at large is wide. As the Director of the American College of Surgeons writes: "It behooves every member of the profession and especially those active in medical education to read, ponder, and act on this landmark study"<sup>7</sup>.

### NOTES

1. Most schools appointed a GPEP coordinator who may have a number of copies of the GPEP report which could be placed on reserve in the library or student lounge. Some schools requested hundreds of copies. Ms. Barbara Roos at AAMC (202/828-0553) retains records on who received these. The most complete resource is the November 1984, Part 2, issue of the *Journal of Medical Education*, containing not only the GPEP report but also reports from the working groups and very useful appendixes.
2. There is quite a lot of literature on group process and communication within groups available at most libraries, e.g., David W. Johnson's *Joining Together: Group Theory and Group Skills*. In paperback, try E. Schindler-Rainman's *Taking Your Meetings out of the Doldrums*.
3. A copy of a student guide to influencing the accreditation process, titled "The Role of Students in the Accreditation of U.S. Medical Education Programs" can be obtained from Ms. Janet Bickel at AAMC (202/828-0575).
4. Two of the best are: James Knight's *Doctor-to-be: Coping with the Trials and Triumphs of Medical School* (E. Norwalk, Conn.: Appleton-Century-Crofts, 1981) and David Reiser and David Rosen's *Medicine as a Human Experience* (Baltimore, Md.: University Park Press, 1984).
5. Some hospitals and state medical societies have committees on physician impairment that may want to provide presentations. The Center for Professional Well-Being in North Carolina is an even better resource (919/489-9167). A ground-breaking program at the

University of Tennessee is AIMS (Aid for the Impaired Medical Student) which relies on students' looking out for each other and assures confidentiality of intervention and treatment. Another kind of pro-active approach is being tried at the University of Louisville, i.e., a four-day Health Awareness Workshop preceding the beginning of classes; Stanford offers an elective with similar content, e.g., exercise, relaxation, time management, nutrition.

6. An earlier phase of this AAMC project produced a very useful overview titled "The Evaluation of Clerks: Perceptions of Clinical Faculty" (available from Dr. Xenia Tonesk at AAMC (202/828-0561).
7. C. Rollins Hanlon, "Directors' Memo", *ACS Bulletin*, December 1984.

## A ROLE FOR MEDICAL STUDENTS IN THE ANIMAL RESEARCH DEBATE

Helen Jones is president of the Society for Animal Rights, a 20,000 member "abolitionist" organization which totally opposes experimentation on all animals for any reason.

Sam Shuster is a physician/scientist who relies on animals in his own research. "The debate on animal research is phoney. The public has been conditioned to respond to animal research without being aware of either its factual basis or its consequences," writes Shuster. "What gargantuan ignorance!"<sup>1</sup>

Ms. Jones and Dr. Shuster are but two of the many participants in this on-going debate. Few topics are able to elicit such moral vehemence and passion. Accusations fly back and forth; laboratories have been vandalized; and lobbying efforts on both sides of the issue are fierce. Yet, despite the emotions and egos surrounding animal experimentation, it is wrong for *either* side to underestimate the sincerity and thoughtfulness underlying much of the noise and rhetoric. It is wrong for Ms. Jones to suppose that all researchers are unconcerned about the effects of their work on their animal subjects. It is equally wrong for Dr. Shuster to assume that all animal activists are ignorant. Many simply advocate stricter standards for the humane care of laboratory animals. Only through a mutual respect of each other's commitment can the channels of communication be opened and issues surrounding animal experimentation resolved.

What is your role in this issue? Should you even be concerned? As a medical student, you are aware that virtually every advance in medical science has been based upon knowledge gained through experiments involving animals. The medications you will prescribe, the vaccines you administer, and the surgeries you perform all required initial experimentation on animals. By the very nature of your training, you have become a participant in the animal research debate. As such you should be:

**Informed:** Start looking at both the popular and scholarly literature. You may be surprised to find to what degree

the critics of animal research dominate the literature. However, the New York Academy of Sciences devoted an entire volume (#406, 1983) to the role of animals in biomedical research, providing an excellent discussion of current perspectives and the future directions in this field. Also, the National Association for Biomedical Research (1275 K Street, N.W., Suite 900, Washington, D.C. 20005; 202-371-6606) publishes a weekly update describing in detail events surrounding the animal experimentation debate.

**Concerned:** Animal welfare and animal rights groups are claiming growing momentum behind their efforts to impose stricter controls on—or even eliminate—the use of animals in research. Over 400 animal rights organizations are currently active in the United States. Representatives of these groups have already scored some legislative victories at the state level, and support for federal legislation is increasing. In Nevada, new legislation has been drafted by the Las Vegas Humane Society which would make it "...unlawful for any person to sell, exchange, give away or possess a live animal to be used in scientific research"<sup>2</sup>.

**Involved:** Misconceptions about the practice of animal experimentation can only be dispelled by actively educating those who have expressed concerns. Since letters to legislators from animal activists far outnumber those written by the scientific community, there is a big role here for medical students to play. Perhaps even more important is medical student involvement in informing the public about how and why animals are used. **Please read the accompanying brochure** published by the Association of Professors of Medicine, and share it with friends and family both within and outside of the medical community.

The debate on animal research is not "phoney". It is very real and important. Try to imagine where we would be now without the benefits provided by animal research. Imagine where we might be in the future if animal activists have their way. As a medical student, you should feel compelled to become informed, concerned and involved. To do otherwise could severely retard the growth of medical knowledge.

Roger Ian Hardy (U. of Cincinnati)  
OSR Representative-at-large

## NOTES

1. Shuster, S., "In Ignorance Arrayed", *Br. Med. J.*, 1:1541-42, 1978.
2. *Update*, Vol. VI, No. 1, Washington, D.C.: National Association for Biomedical Research, 1985.

### LOOKING FOR AN EXCITING SUMMER EXPERIENCE?

The American Medical Student Association Foundation is placing more than 50 medical students in community and migrant health centers for a summer experience assisting the centers in health promotion and disease prevention. The project is funded by the Bureau of Health Care Delivery and Assistance, DHHS. Application deadline is March 20, 1987. For an application and additional information contact: HPLP Project, AMSA, 1910 Association Dr., Reston, VA 22091 (703)201-6600.

1987 OSR MEETING DATES

OSR ADMINISTRATIVE BOARD

January 20-22

April 15-16

June 17-18

September 9-10

OSR/GSA REGIONAL MEETINGS

Northeast	April 8-10	Boston, MA
South	April 15-18	St. Simons, GA
West	April 26-29	Asilomar, CA
Central	May 3-6	Minneapolis, MN

AAMC ANNUAL MEETING

Washington D.C. November 6 - 12

