

1988



**association of american  
medical colleges**

January 22, 1988

TO: OSR Representatives

FROM: Wendy H. Pechacek *WP*

SUBJECT: Attached summaries

Attached are summaries of most of the sessions held during the November annual meeting of the OSR. The Northeast region submitted most of the entries, with the remainder provided by the Southern region. Thank you to all of you who contributed to this effort.

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"LEARNING TO LOVE THE QUESTIONS: CLINICAL LESSONS FROM CREATIVE LITERATURE"  
Summarized by Robert O'Shea, University of Rochester

At Northeastern Ohio University College of Medicine (Neo-Ucom), students are required to obtain a certain number of credits in the humanities, which is most often accomplished during a one month block in their senior year. The course options exist in a wide variety of disciplines, ranging from medical ethics, to a course in opera, to literature, with reading lists heavily slanted toward medical writers (John Stone, William Carlos Williams, Richard Selzer and Lewis Thomas) and medical topics (Camus' The Plague). The university has even hosted performances by the Ohio Ballet at the medical school. Three students presented their opinions on the usefulness of being required to learn humanities in medical school. Their answers ranged from reading as a means of escape to reading to gain some deeper insight into their patients.

Katharine Hunter, an Associate Professor at the University of Rochester, described a program here which is considerably less formal in terms of course requirements. There is a required course in the first year, part of a psychosocial medicine course that spans the preclinical years, called "The Patient, Physician and Society", that is similar to Neo-Ucom's program. She also described some of the electives available. In general, there is a great deal of interest throughout the school, with lunchtime programs, lectures, and music recitals by faculty and students. Students have also organized poetry reading and writing groups. As an aside, I can vouch for the interest at the school. I had a wonderful time during my surgery rotation, in part because I was frequently involved in heated discussions about life, death, and Shakespeare with the attendings in the OR - though I can't claim that this is a typical experience at U of R. She finished by involving the seminar participants in a discussion to uncover the layers of meaning of a poem by John Stone, as a demonstration of a typical session.

Lastly, Lou Bogenricht, a Salt Lake City pediatrician and self-described "pediatric fisherman", discussed some of the ways this approach has been useful to him, and how he has been able to gain an understanding of his patients through literature. As a summary of his perspective, he finished by reading another John Stone poem, "Gaudeamus Igitur".

"BECOMING AN INFLUENTIAL CHANGE AGENT/DESERT SURVIVAL WORKSHOP"  
Summarized by Julie McCann, Jefferson Medical College

This session provided a means for an introspective look at our decision-making skills via an exercise in desert survival. Each participant was asked to rank 15 given items most important to their survival in a desert plane wreck. The 12 participants then came together as a group to rank those items and decide on a survival plan. Group leaders Cynthia Carlson and Dr. Daniel Hunt, both from the University of Washinton, observed members of the group for their approach to problem-solving as a group. The major mechanisms were "process" and "content". Process refers to statements aimed at promoting group interaction and how to make the group decision. Content indicates statements of opinion or definitive notions about the importance of particular items. Afterward, participants received feedback on their knowledge of desert survival as well as how "proces versus content" oriented they were. Overall, it was a fun learning experience, even though our group would never have survived the perils of the desert. I personally hope to use what I learned to help with the decision-making that goes on in my Student Council.

"PREVENTIVE MEDICINE IN THE CLINICAL SPECIALTIES"  
Summarized by Julie McCann, Jefferson Medical College

Members of four areas of medicine spoke of Preventive Medicine as it relates to the clinical specialties. First, Dr. Joseph Barbaccia (Family Medicine) spoke of Preventive Medicine as a unique clinical specialty. He pointed out that Family Medicine residents are continuing their graduate medical education learning about Preventive Medicine and its relation to Public Health. He emphasized the need for a health care system which provides care not only for the unhealthy but also education and screening for the healthy population as well.

Dr. Robert Cefalo (Maternal and Fetal Medicine) provided an interesting slide show which pointed to Ob/Gyn as a Preventive Health Care victory, as much progress has been made in the area of prenatal health care and screening. He emphasized that residents in his field need a firm foundation in health prevention and maintenance care.

Dr. Alan Cross (Pediatrics) showed Pediatrics as an example of a specialty which has its very foundation in preventive health and well-patient care. He asserts that a greater proportion of the Pediatrics Residency needs to be aimed at improving knowledge and use of information for well-baby care and prevention of illness.

Dr. Richard Owen (Internal Medicine) presented an interesting view of the preventive aspect of our health care system. He reminded us of the amount of time necessary to truly teach good preventive health care measures for a large number of patients. He sees the need for a specialized health care worker to provide for a large part of patient education.

"ORIENTATION TO CAREER DECISION-MAKING"  
Summarized by Carol DeCosta, SUNY at Buffalo

This workshop focused on familiarizing the medical students with the transition from medical school to residency programs. In addition, issues were raised regarding the tools used to evaluate applicants. The aspect which I found most exciting was the portion entitled "Closing the Deal: Practical Points for a Perfect Interview". The following suggestions were made to the applicant:

1. Apply to at least 10 programs to ensure a better chance of being accepted.
2. Treat your fellow interviewees with respect and support (no interviewer likes a potential back-stabber as a future team member).
3. Make sure your spouse is in agreement with the location you choose for a residency.
4. Go to the interview with prepared, well thought out questions.
5. Be aware that the aggressive interviewer may be a "hidden friend" and the supportive interviewer may be a "hidden enemy".
6. Take notes on your likes and dislikes about the program as soon as you return from your interview, as you will need to differentiate the various programs.
7. Write a second letter or go for a second visit to the program of your choice to let them know you are really interested.

"LIFE IN THE MEDICINE LANE"

Summarized by Beth Manning, George Washington University

This seminar was given by the husband and wife team of Barry Rosen, M.D. and Sally Rosenstone, M.D. In a very sincere, personal and enthusiastic way they spoke of the joys and pains of being a physician today as well as the importance of maintaining one's own identity and philosophy of life through the process of becoming a physician.

Rosen began with a poem by Dag Hammarskjold, "Thus It Was". This poem symbolizes the frustrations and uncertainties all of us experience in modern medicine. We are driven to do and learn more and are all too familiar with the delayed gratification inherent in the pursuit of a career in medicine. Rosen teaches that we must learn to stop and celebrate each accomplishment along the way.

He also spoke of the prevalence of physician impairment today, and included the overall dissatisfaction many doctors are experiencing with their work and lives as part of the impairment, in addition to substance abuse and suicide. He believes that one way to avoid any form of impairment is to develop a support structure/system and use it. He recommends creating time to get together with fellow students to process some of the difficult events we, as students, are exposed to.

Finally, he discussed the problems physicians have in dealing with death and dying. He related personal experiences which showed that although there is a lot of pain involved in caring for a dying person, there could also be a lot of joy, humor and love. If we learn to help patients to live with, rather than die from, their diseases, we will be doing ourselves and them a great service.

Rubenstone spoke next and shared her path to medicine with us. She had been a nurse for many years prior to entering medical school, and from her perspective, benefitted from her exposure to patients as a nurse. She learned to feel comfortable around dying people, and also viewed patients as more than just a disease to be cured or a case to be solved.

She spoke of the "process of impairment" that begins with our first day in anatomy lab. We learn early to do the job and not admit that we are affected by our experiences. By the time we begin our clinical rotations, it can become all too easy to lose sight of the ultimate importance of our intense human interactions with patients. We must allow ourselves to interact with patients on more than just a superficial level. To do this we must first learn about ourselves, to understand and fulfill our own needs and desires and to face our fears of death and pain head on, rather than pretending that they do not exist.

"THE SECOND TREE FROM THE CORNER: HOPES, DREAMS AND REALITIES IN THE LIFE OF ONE WHO SERVES"

Summarized by John Cianca, Albany Medical College

Dan Morrissey, O.P. (from Columbia) directed this workshop, with the aid of Sarah Johansen (from Dartmouth), challenging those present to explore their thoughts and feelings about themselves and their chosen profession. Fr. Morrissey was introduced by Sarah as a person who intimately touches those with whom he interacts. This became evident by his thoughtful and gentle manner of speaking. He spoke of his own experiences which set the stage for further sharing by the audience.

Next, as we sat in a large circle of chairs, we addressed the issue of why we wanted to be physicians by anonymously responding on paper. Sarah randomly chose responses to read aloud. Fr. Morrissey commented on these and invited us to do the same. As this continued, there was an increasing amount of verbal contributions from participants.

The written responses were varied but many of them touched on the desire to affect others. I find it interesting that this has become a sublimated thought in us, one that is only comfortably expressed anonymously. The discussion became centered on the expression of emotion as a physician. There was open and varied thought about the appropriateness and timing of emotional expression by the physician.

Fr. Morrissey made the participants feel comfortable by utilizing anonymous written responses to disarm a sensitive area in order to elicit frank sharing of emotions. He unlocked doors that are not often opened in our current educational system. We openly shared experiences that we were not sure how to handle at the time and that had caused anxiety within us. We found that many of us had had similar experiences and anxieties. Most importantly, we discussed these episodes and through this discussion, we were able to come to terms with our own emotions.

#### "TRANSITIONS INTO RESIDENCY AND PRACTICE"

Summarized by Jeralyn Bernier, Brown

David Nash, M.D., M.B.A., author of Future Practice Alternatives, presented information about the much talked about future physician oversupply, and a wave of panic rushed through the assembled group. He made it clear that he recommends that we have to be "business-wise" to be successful and that it is important to us to realize that there are many options available to physicians today.

Pamelyn Close, M.D. was more calming in her outlook. She assured the audience that we will make informed decisions, as it is the natural result of our education and training process. Time and available resource people are on our side. The most important thing is to know oneself in order to figure out one's particular role. No longer can we afford to sit idly by and watch our lives unfold before us; however, the options are plentiful.

#### "HEALTH CARE FOR THE INDIGENT"

Summarized by Brian McGrory, Columbia

David Hilfiker, M.D., a family practice physician who was a key organizer of the Community of Hope Health Service and who lives and works at the Christ House in Washington, D.C., spoke of his work with the indigent. He told of his life of sacrifice and service and represented a physician that saw a problem and took action. The 40 bed Christ House operates solely on charitable donations and offers health care for patients who are excluded from our present health care system.

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Victor Sidel, M.D., a well known and respected speaker, opened his talk by stating, "I think, Dr. Hilfiker, that you are part of the problem." The rest of Dr. Sidel's lecture concerned his desire to revamp the health care system in the US to include all socioeconomic classes in a single, unified system. Dr. Sidel cited various other countries as having viable systems and suggested that we incorporate ideas from them to remodel the system in the US. He stated that men of action, like Dr. Hilfiker, were part of the failing system in the US in that they accepted the current system and tried to work in conjunction with it.

Dr. Sidel represented an intellectual but impractical view of how to remodel our system; Dr. Hilfiker represented a man of sacrifice, a rare doctor that is willing to make incredible personal sacrifices that many of us admire but could not make.

"THE CURENT DEBATE ON EDUCATION AND TRAINING OF PHYSICIANS: SUPPLY, DEMAND AND OPPORTUNITY"

Summarized by Sarah Johansen, Dartmouth

Deborah Prout, Director of Department of Public Policy for the American College of Physicians addressed a broad spectrum of issues. These included the current need for more primary care physicians as opposed to specialists. She also discussed the concept of an oversupply of physicians and its relation to geographical (mal)distribution of physicians.

She also discussed the current method of funding of Graduate Medical Education (GME) and the many proposals considered prior to achieving this final result. Curenly, Medicare supports GME in the following way:

1. Based on hospital-specific FTE per resident amounts
2. Weighted by which year of residency a person is in; i.e.
  - during initial residency (board certified + 1 year  $\leq$  5 years) - rated at 1.0
  - after above, rated at 0.75 (for 1986 - '87), then at 0.50 for 1987 and beyond.
  - exception: can get up to 2 additional years of payment for geriatric training.

The Council on Graduate Medical Education (COGME) is a federal council which must report by 7/1/88 and every 3 years after to begin establishing principles and setting national policy to direct the future of medical education. The issues being addressed include: supply and distribution, current and future shortages or excesses, foreign medical graduates, changing the financing of undergraduate and graduate medical education.

These issues are of central importance to the AAMC and thus the Task Force on Physician Manpower was established to participate in this process. Other concerns include: declining applicant pool, underrepresentation of minorities, quality maintenance, decreasing attraction of medicine as a profession, reasons for shift from primary to specialty care, increasing indebtedness with decreasing salaries, the need for emphasis on practice options, the implications of women in the work force, and the implications of AIDS on medical education and training.

"WOMEN IN MEDICINE BREAKFAST PROGRAM: PARENTING LEAVE" (MONDAY AM)  
Summarized by Beth Malko, U. of Connecticut

The following resolution was made and submitted to Janet Bickel (Women's Coordinator) to push for action:

"Because there are variable and inconsistent policies on parental leave and child care for parents who are medical students, residents and faculty, the Council of Deans, Council of Teaching Hospitals, and Council of Academic Societies should establish a task force to address these issues. The task force should study parental leave and child care and make recommendations for policies which will relieve parental stress and provide optimal child care for all the medical schools and hospitals in the US."

I've asked Sarah Johansen and Jeralyn Bernier to discuss this at the Ad Board level. I would like to see the OSR make this a major issue and push for it. If anyone has an interest in this or ideas in getting this going, please contact me.

"GME: COUNSELLING 4TH YEAR STUDENTS - A WORKSHOP"  
Summarized by Beth Malko, University of Connecticut

Overall, little substantial information was presented. The problems that were raised are, I suspect, universal. They include the following:

- Students don't get enough of a variety of experiences to make an informed career choice.
- Students often get advice instead of counselling.
- Counsellors are rarely trained.

Some good ideas that were shared:

- A 200 name book of local MD's who have agreed to talk about their careers with students interested in that field.
- An alumni-published panel of MD's who will do career counselling.
- Nuts and bolts seminar mandatory for each department, regarding applying for residency in that field.
- A visit to an MD in a given field with spouse that includes dinner in their home, followed by a day in the office, with dinner again that evening.
- Psychological counselling, with the idea that knowing yourself, your needs, and your goals will help you and your counsellor with choosing your career.

Please let me/newsletter know if you have a good counselling program at your school. The rest of us really need ideas. I'll compile any information I get on the subject; I also had asked for similar info via the OSR Network.

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"GME: NORTHEAST STEERING COMMITTEE"  
Summarized by Beth Malko, U. of Connecticut

The main agenda item at this meeting was planning the Spring Meeting. The Plenary session scheduled for Monday, April 11 will be "Recent Developments in Evaluating Clinical Competence - an Update and Overview". The second Plenary on Tuesday, April 12 will be "Assessment of Innovative Programs - an Update and Overview." These are truly interesting and pertinent topics which I'll be reporting on at our NEOSR Spring meeting. Anyone who would be interested in attending these meetings should contact me for details.

The Northeast Chairman, Dr. Berg, is very enthusiastic and very happy to have a student involved. The Steering Committee will meet again in April. At that time, I'd like to share your ideas with them about areas they should be addressing.

Finally, they pointed out that GSA will be having their Spring, '89 meeting in Florida in conjunction with the Southern region GSA. We usually have NEOSR in conjunction with the GSA; we may have to revise that in '89 since it's not very likely that most of our Deans are going to send us off for a spell to Florida. We have some options:

1. We can talk to our Deans and find out what their feelings on Florida are.
2. We can have our own meeting in '89.

If we want to meet with GME in '89 we need to have input in April. Their initial thoughts are a "retreat-like" meeting at Brown's dorms during Spring break. PLEASE, PLEASE drop a line to the next newsletter with your thoughts on this so I can discuss it with them in April. Then we can make our decisions at our meeting in April.

AAMC PLENARY SESSION (MONDAY AM)  
Summarized by Jeralyn Bernier, Brown

Alvin R. Tarlov, M.D., contributor to the GMENAC report, stated the case for physician oversupply. Briefly, with an increase in the size of our graduating classes to 16,000 M.D.'s/year, and only 8,000 M.D.'s/year retiring, we increase our supply by 2%/year, while the population increases by less than 1%/year. Thus, we leap from 140 M.D.'s/100,000 population in 1965 to 280 M.D.'s/100,000 population in 2010. He stated that these statistics will result in a decreased patient workload, and alternative practice groups (PPO, ambulatory surgery, HMO's, etc.). He described this as an evolutionary change in the health care system that will work to the detriment of physicians (fixed income, universal insurance, limited individuality and increased regulation). He sees these changes as leading to a decreased interest of young students in medicine as a career.

He believes we can no longer look at illness and physiology alone. We need to see the bigger picture in order to do our job more appropriately. He sees a windfall of opportunity to carve a new role for ourselves.



D. Walter Cohen, D.D.S., who led a revitalization of dental training, spoke from his experience in the hope that history does not repeat itself. The number of dental school applicants fell off between 1975 and 1985, from a peak of 15,734 to 6724. This occurred because of the cost of training, increased competition among dentists, basic demographics, competition with other fields for good applicants (e.g., computer sciences, business and engineering), and the practice of dentistry itself becoming successful in prevention and thereby reducing tooth decay and the need of the population. As a result of this, many dental schools were forced to close. Dr. Cohen stated that the barriers to change (i.e. decreasing the size of classes) are powerful - schools lose funding, power, prestige. He recommended adjustment of academia to the changing health care system to provide a more appropriate education to an appropriate number of people and warned of an outside catalyst if we fail to police ourselves.

Uwe Reinhardt, Ph.D. (Economics) dotted his speech with humor and gently ribbed the assembled group with, "Doctors love to be paranoid." He stated that there is an unnecessary panic on the part of physicians. He evaluated the situation from an economic point of view, where demand is equivalent to willingness to pay and supply assumes "ordinary morals". Thus he looks at rising physician fees and dollars available for health care from such groups as yuppies and the aged, and deduces that there must be a shortage!

On the supply side, with increasing numbers of physicians come increasing numbers of female physicians, and he plainly stated that the calculated productivity (with no statement regarding quality) is 70% visits/year as compared to that of their male counterparts. Thus the raw data of number of physicians/100,000 population should be corrected to this viewpoint.

Of course he recognizes that this would all be different if need was not equal to willingness or ability to pay, if one could negotiate the dollar worth of health care, if we could hold to productivity norms. In that case, a national health insurance plan might work. However, in our present environment, he believes the proper approach is to train more physicians and encourage competition. Most importantly, he told us not to contribute to our own professional demise - to recognize our prestige and financial privilege instead of bemoaning our woes.

Self Directed Learning, A Seminar on Student Tutoring  
Presented 11/8/87 at the AAMC Meeting in Washington,

D.C.  
OSR Section

The seminar was a presentation by Amy Justice, a fifth year student at Yale University School of Medicine, and George Askew, a second year student at Case Western Reserve School of Medicine, of their school's respective student tutoring programs.

The title of the seminar was chosen to point out that tutoring should be designed to better equip students to teach themselves, rather than fostering dependence upon "spoon feeding".

The Case Western program has been in existence for well over a decade and currently provides tutors to well over half of the first year class and about one third of the second year students. Tutors are paid seven dollars an hour and are self selected. Extensive feedback (both formal and informal) is given by tutees so that poor tutors are "weeded" out. The school budgets about \$25,000.00 a year for this program. The program is administered out of the Dean of Students' office. Marsha Wile, Ph.D. has done several studies of this program. She and George Askew are excellent contacts for more information about the Case Western approach.

Yale's program has just gotten underway this year. There are currently 20 tutors available from the second, third, fourth, and fifth year classes as well as some MD/PhD candidates. Yale pays eight dollars an hour and the program is administered by a student coordinator, Amy Justice. The coordinator is paid a fellowship of \$8,000.00 for the year. The school has budgeted \$30,000.00 this year for the program. The office has a phone line and answering machine and the coordinator keeps regular office hours. There are currently eight students receiving tutoring with several others having come in for one shot "time management" sessions. Requests have recently been increasing so we still have no clear sense of how many people will eventually request tutoring. Tutors are recruited by recommendations from the directors of the basic science courses as well as the Dean's Office, but other tutors simply volunteer. The confidentiality of tutees is protected by the student coordinator (i.e. no one on the faculty knows who is getting tutored unless the tutee him/herself admits it. Robert Gifford, MD, is the Dean of Medical Education and Student Affairs. Both Dr. Gifford and Amy Justice are contacts for more information on the Yale program.

For more information READ:

"Students Teaching Students: A Medical School Peer Tutorial Program," Marcia Z Wile, PhD, et. al. ( a presentation made by Dr. Wile, available by request- see below.)

"Equal Educational Opportunity Programs in American Medical Schools," John Wellington, PhD and Pilar Montero, PhD, Journal of Medical Education, 1978, 53: 633-9.

"A Model for Peer Tutoring in the Medical School Setting," Leslie A. Walker-Bartnick, et. al. Journal of Medical Education, 1984, 59: 309-315.

For more information CONTACT:

Amy Justice, YMS V  
Student Mail Room  
333 Cedar Street  
New Haven, CT 06510  
(phone: 203-785-6558)

George Askew, CWRMS II  
c/o Marsha Wile, PhD  
(see below)  
(phone: 216-791-5134)

Marsha Z. Wile, PhD  
Director of Educational  
Evaluation and Research  
Case Western Reserve University  
School of Medicine  
Office of Medical Education  
Cleveland, Ohio 44106  
(phone: 216-368-2831)

**LEARN TO LOVE THE QUESTIONS: CLINICAL LESSONS  
FROM CREATIVE LITERATURE**

In the session "Learn to Love the Questions" the rationale and strategy for implementing humanities studies into medical school curriculum was examined with emphasis on how the study of literature may be a resource in the development of the skills needed to sustain a commitment to patients. Janet Bickel, Staff Associate in the Division of Institutional Planning and Development of the AAMC, opened the session by pointing out that while the study of literature may not provide the technical answers and may even increase one's confusion over issues such as death, dying and rights to life, it will at least be confusion at a higher level and so urges us towards <sup>deeper</sup> understanding. Janet Bickel has prepared a 37-page study entitled "Integrating Human Values Teaching Programs into Medical Students' Clinical Education." In this study the results of surveys and interviews of 113 medical schools are reported under the headings "Progress in Making Human Values Courses Part of the Curriculum; Barriers to Progress; Evaluating Human Values Teaching; and Human Values Teaching Programs for Residents." In addition, the study includes 21 summaries of programs with innovative teaching methods which may be of potential interest to those seeking to expand their human values programs. A copy of this report is available through the AAMC.

Delese Wear, Ph.D., Coordinator for the Human Values in Medicine Program (HVM) at Northeastern Ohio University's College of Medicine described NEOUCOM's program as unique in that it was built into the medical curriculum from the beginning. It requires that medical students accumulate 30 human value credits—15 of which must be acquired exclusively during one month out of the senior year. Course topics in the HVM program include literature and philosophy as they relate to medicine and medicine as depicted in operas and in film. Students may begin accumulating credits as early as their freshman year through weekend lecture seminars or during clerkships through clinical reading groups which are co-taught by a physician and humanities scholar. Dr. Wear introduced Marc Snelson, Brian Graham and Denis Lunne, students at NEOUCOM who shared their experiences and views of the HVM program. Marc Snelson admitted that the HVM requirements were not always enthusiastically received by medical students but in looking back most would agree it was a very valuable course - providing not only "constructive escapism" but insight into the patient's prospective towards their illness, their treatment, and their doctor. Both he and Dr. Wear mentioned that there is an assumption in the reading groups to keep reading assignments short and they are often reread aloud prior to discussion. Marc Snelson added that if possible the HVM courses should be taken at the beginning of clinicals. Dr. Wear took the opportunity to announce that NEOUCOM will sponsor a Literature and Medicine Conference May 6-8, 1988. Among those present will be John Stone, M.D., David Hilfiken, M.D. and Perri Klass, M.D.

Kathryn Hunter, Ph.D. is Coordinator of Humanities in Medicine at the University of Rochester School of Medicine. She explained that during the freshman year students at Rochester are required to take a course entitled "The

Physician, the Patient, and Society" directed through the Department of Preventive and Family Medicine. Included in this course are discussions of the history of medicine as well as legal and ethical issues in medicine. During the second year a psychosocial medical course is required which includes patient presentation as part of the introduction to clinical skills. Informally there are lunch seminars, evening gatherings and poetry groups to stimulate discussion of the humanities. Dr. Hunter mentioned a few literary works which in her experience medical students have found to be most valuable. Among them is Anthony R. Moore's The Missing Medical Text, a collection of snippets from fiction novels and short stories in which reference to and observations on medicine were made. Each excerpt is accompanied by a discussion in dialogue form. Dr. Hunter also noted that of all the literary genres, poetry most resembles medical thinking. Like a patient history a poem must often be deciphered. As an example, Dr. Hunter read and led audience discussion of John Stone's poem, "Talking to the Family." She pointed out that first year medical students often found the physician in this poem to be somewhat distant and cold while she has seen fourth year students brought to tears by it.

#### Talking to the Family

My white coat waits in the corner  
like a father.  
I will wear it to meet the sister  
in her white shoes and organza dress  
in the live of winter,

the milkless husband  
holding the baby.

I will tell them.

They will put it together  
and take it apart.  
Their voices will buzz:  
The cut ends of their nerves  
will curl.

I will take off the coat,  
drive home,  
and replace the light bulb in the hall.

- John Stone  
The Smell of Matches, Rutgers Univ. Press, 1972

Dr. Lou Borgenicht, M.D. is a practicing pediatrician in Salt Lake City. As a developmental pediatrician he has taken a special interest in the concept of nature vs. nurture. Dr. Borgenicht explained that it is in general the nature of medical students to be active in problem solving and to want to be in control of their situations. Medical training and environment - the biomedical model - teaches us that everything is comprehensible in terms of scientific law. The biomedical model is linear with little or no room for free association. Seldom is critical thinking encouraged through different perspectives. Rather, our practice teaches us to compartmentalize - first

ruling out the organic and only then dealing with the inorganic. The study of the humanities can temper this set thinking so that we come to see life as a series of conflicts - uncertainty vs. certainty, active vs. inactive, idealism vs. reality and ourselves vs. other - that must be dealt with as a whole.

In conclusion, the feeling of the discussants and most present in the audience can be summed up with an analogy made by Brian Graham, senior medial student at NEOUCOM. A Chinese philosopher once observed that it was the empty space within a clay pitcher which made it a vessel and gave it meaning. Likewise, it is the humanities which fills and gives meaning to all other pursuits.

*Submitted by Sandra Baltz  
University of Tenn., Memphis*

## **SUMMARY: Influencing the Legislative Process**

Mary Vistica, the Western Region Chair, introduced Richard Knapp, Ph.D., and Sarah Carr, from the AAMC's Office of Governmental Relations. Ms. Carr then provided the participants with facts about some of the latest budget developments. Due to the recent stock market crash, there is an economic summit in progress, composed of delegations from the White House, the Congress, and Budget Officials, whose purpose is to reduce the deficit in the budget before November 20. If they fail to reach agreement, then on that day, the Gramm-Rudman-Hollings Bill (GRH) will go into effect. If the GRH is enacted, there will be an across-the-boards funding cut, and Health and Education programs will be seriously affected (i.e. heavily slashed). The GSL and other Student Financial Aid programs will be directly affected. To stimulate the economic summit, the House passed a Reconciliation Bill (Oct. 27), which increased revenues by \$11 billion and reduced spending by \$2 billion (the Senate is working on its own bill). A provision of this bill also stipulates that when tuition is waived the cash value of that tuition is not included as taxable income. Regarding this entire issue, one of the problems we as students and residents face is that Reagan and his cronies believe that there is a physician over-supply, therefore there is no need to finance the education of more physicians (e.g. GSL, Medicare).

The discussion then focussed on the National Health Service Corps (NHSC) and the Peace Corps Pilot Program (PCPP). Both the House and the Senate have approved the reauthorization of the NHSC with some major changes in the program. Up to now the physician shortage in certain areas was addressed by using undergraduate scholarships as incentives. However, there has been a high rate of default or renegeing on the commitment to work in those areas after graduation. The reauthorization establishes that loan repayment does not require a student's commitment to the NHSC until at least the final year of their residency. The program will repay \$20,000 of loans per year for each year served. Primary care physicians are preferred, but specialists would be eligible at the discretion of the program officer. (For a more complete description, please see the AAMC Weekly Report, Vol. 1, No. 46, November 5, 1987.) The PCPP proposes to send teams of 12 health professionals (physicians must be licensed) to countries currently served by the Peace Corps to provide health care for the people and train locals in modern health care techniques. They will be salaried (i.e. no incentives like those of the NHSC). It was noted in the discussion that although student indebtedness is increasing (ave.=\$35,000), there is no hard data linking this to either choice of specialty or geographic distribution.



Next the GSL resident deferment and default rates were briefly discussed. Since 1980 the resident deferment on GSL repayment had been 2 years. However, last year the Department of Education tied deferment to length of licensure in your state, which is usually 1 year. So if you received a GSL before July 1, 1987 you only have a 1 year deferment. However, Congress has moved to correct this (and is continuing to do so) by specifying that medical residents receive a 2 year deferment. Furthermore, if you have a residency in a Medical School Hospital, you can be classified as a student and can have a deferment for as long as you are so classified. In addition, the question of open-ended commitment to funding residency training programs regardless of length is now being re-examined in an effort to cut spending. The present arrangement, which has not yet been fully clarified and which is specialty specific, states that residents will be paid in full by Medicare up to 5 years, but there will be decreased funding (%age) in subsequent years. Thus, the hospitals stand to lose money to train their residents in programs lasting longer than 5 years (by having to pay up to 50% of the costs).

The workshop ended with stimulating discussion about how to influence the legislative process led by Dr. Stephen Keith, Senate Staffer to Senator Edward Kennedy. There are various phases that a bill must go through before becoming a law. The best time to affect a bill is before the bill is

introduced. Although there are later stages when one can affect that bill, it becomes increasingly difficult to do so as the bill progresses up the legislative ladder. The way to best affect the process is:

1. **Have accurate information** about what the issue is.
2. **Know who the players are.** Get to know the staffers on the appropriate committees.
3. **Frame the issues.** In a 1-2 page typewritten letter present cogent, concise arguments of your ideas, both as to what's wrong with the bill, and how you want it changed. Mass mailings do not carry much weight, but 1000-2000 people saying similar things do. University Presidents have a lot of pull with senators and representatives, so get them to champion your cause. Also, get to know your school's governmental relations officer, so he/she can contact the staffers.
4. **Follow up with phone calls, letters, and testifying at hearings** to insure your interests are being represented.

The bottom line is: the more the work is done for the staffer, the more likely the bill will be changed the way you desire.

## "Issues in Women Physicians' Development"

Mavis Jaworski

These points were presented by individuals and not necessarily representative of the group.

### 1. Coping with stress:

- o Must have some inner resources.
- o Support can be in the form of organizations or just ONE individual.
- o Weekly pizza date with a "nonmedical" friend.
- o Blow off steam/cry on a shoulder during a brief phone call to a fellow classmate or intern when having a crisis period and being available to the friend for the same.
- o Weekly pot-luck dinner support group without an agenda.
- o Bring up topics of concern in community areas for group discussion (cafeteria, lounge, etc.)

### 2. Women with women:

- o Sending invitations to mailboxes instead of public better attendance less yokes are made by males announcements.

### 3. Problems encountered with other women:

- o Not enough female role models
- o Some women are negative about everything.
- o Some women are patronizing to other women.
- o Some female nursing staff resistant to working as a team with female residents/physicians. This is prevented by extra effort initially by the female resident/physician to build a good relationship with the health care team.
- o It's frightening to apply to a residency program when all of the previous females (12) quit to have babies.
- o Some medical school classes have such a diverse group of women that it is difficult for these women to build relationships with each other.

### 4. Women with men:

- o Female medical students feel that many males are "turned off" from dating them when it is revealed that they are medical students, especially if they are in the Uniformed Services College.
- o Male female differences should not always be viewed as detrimental. There are many positive "female characteristics" that women can contribute to medicine.
- o When the sole female in a group of 4 surgery residents "still feel like I'm not one of the guys".
- o A group of women took turns graciously informing a particularly verbally abusive individual when he was inappropriate in behavior. He changed for the better.

### 5. Children:

- o Quality child care is a big problem.
- o Feeling guilty about leaving infant at home.
- o Feeling jealous of husband's time with the children.
- o Feeling guilty for taking 1 month off after having a baby.

## "Initiating Changes in Your Medical School Curriculum"

Summarized by Debbie Capko, UMDNJ

Dr. Gerard Escovitz (Medical College of Pennsylvania) spoke about the role of students in making curriculum changes and how to work within the administration. He first addressed the issue of why it is tough to make curriculum changes. These changes result from goals, rewards and evaluations. The reward system becomes very important and the greatest priorities become research and patient care. Research is a top priority because it is a source of funds and researchers are supported by peer review committees (emphasizing number of articles published). Teaching is lowest on the list of priorities.

Dr. Escovitz compared an academic medical center to business and showed it to be a unique institution. Running rampant is the issue of autonomy - each department or committee feels strongly about this, leading to unclear reporting lines. Each group works separately and not toward a common goal. As compared to business where one official policy comes from the top, in an academic medical center, there are many policies which adds to the confusion.

As for what can be done about this by medical students, Dr. Escovitz stresses the idea of generic and achievable goals. Before this can be done, the most important thing is to gather data. Students must go through the system with strength coming from faculty allies. Persistency and consistency are also important.

He stresses that it is important to talk to and listen to many points of view on an issue. Often these are not what the students want to hear, but this may lead to re-evaluation of goals. It is also important to remain timely; concentrate on issues that are presently being discussed where you might offer strong and useful student input as opposed to issues which have been dead for some time.

"The Second Tree From The Corner: Hopes, Dreams, and  
Realities in The Life of One Who Serves"

by John Schulte

(Moderators: Daniel W. Morrissey, Sarah Garlan Johansen)

This was an informal session during which Father Morrissey, a Roman Catholic priest and consultant to the Vice President for Health Sciences of Columbia University, related several interesting anecdotes and posed many stimulating questions for thought and discussion.

Father Morrissey opened the session with the story of a personal encounter he had had with Mother Teresa several years ago. He described how uncomfortable he felt in her presence because he felt he didn't "measure up" to the "norm" of a religious person which Mother Teresa represented. He asked us if we sometimes found it difficult to be ourselves yet still measure up to the medical "norm".

We were then encouraged to consider how the decisions we make in both clinical and non-clinical settings affect us personally. We also were invited to consider several components of our professional role: secrets, sexuality, and suicide. What happens when we receive secrets? How do we handle secrets? How do we respond to the sexuality of our patients as well as our own sexuality in all of its dimensions? How is the passion for living within each of us nurtured?

We then were asked the question: "Why do you want to be a doctor?" Our anonymous responses were then shared with the group and discussed. Several questions arose out of these responses: Is it okay to share emotions such as grief, anger, and fear with our patients or with our peers? How do we distinguish between what is "me" and what is "the medical profession"? Is it okay to love or to serve in order to receive love or service in return? These and other questions prompted lively interaction among the attendees of the program.