

Southern Region OSR NEWSLETTER

Index:

Meeting schedule at St. Simons (topic)	pps 1-5
Info about St. Simons	6-7 (courtesy of Bill Kapp)
Housing Program	8-10
Survey Idea for	11 St. Simons
"News from Billy Rice"	12
AAMC organization scheme	13
Transitionitis	14-19
Preventive Medicine Survey	20-22
Articles	23-30

TENTATIVE SCHEDULE #2
GSA-MSA-OSR SPRING MEETING
KING AND PRINCE HOTEL
ST. SIMONS, GEORGIA
APRIL 15 - 18, 1987

- News:*
- (1) Bring casual clothes; Thursday seafood buffet, semi-dressy.
 - (2) Bring an old pair of running shoes to walk/jog on the beach.
 - (3) Bring: bathing suit, jacket, beach towel

* * * * W E L C O M E * * * *

Wednesday, April 15

1:00 - 5:00	Registration	
4:30 - 5:00	OSR New Member Orientation -----	Linn Mangano West VA
5:00 - 6:00	Opening Session "Washington Reports"	
6:00 - 8:00	GSA-MSA-OSR Mixer Cocktails by the Pool	
7:00 - 9:00	<u>OSR ROUNDTABLE DISCUSSION</u> ----- with Information Exchange - Announcements/Handouts - Networking/Information Exchange: Projects working & projected needed at individual schools	Jill Hankins Arkansas Red Starks San Antonio

* Still in planning

Thursday, April 16

6:45 a.m. * Walkers/Runners meet on the Beach

7:25 a.m. Minority Affairs Breakfast

8:30 - 11:15 KEYNOTE ADDRESS on
"Admissions/Financial Aid"
Keynote Comments: Cheryl Wilkes
Billy Rankin
Small Group Discussions:
Moderators: Paul Mehne
Dan Trevino
Grace Epps-Puglisi
Julian Dwornik

11:15 - 12:45 OSR - Box Lunches on the Beach ----- Ann Reynolds
Small Groups based on M1-M2-M3-M4 Medical College
(Lunch sponsored by Univ. of Arkansas of Georgia
Medical Sciences Campus) Jill Hankins,
Arkansas

12:45 - 3:30 KEYNOTE ADDRESS on
"Transitionitis/Career Counseling/Curriculum"
Keynote Comments: Sid Huggins
Small Group Discussions:
Moderators: Paul Mehne
Dan Trevino
Grace Epps-Puglisi
Julian Dwornik

4:00 - 6:00 * Possible Car Caravan Tour of Island *

7:00 - 8:00 Cocktails - GSA-MSA-OSR

8:00 p.m. Seafood Buffet - by the Beach (see program notes)

* Still in planning

Friday, April 17

6:45 a.m. * Runners/Walkers meet on the Beach

8:30 - 11:15 KEYNOTE ADDRESS on
"Professional Conduct/Code of Ethics"
Keynote Comments: Lenny Lawrence
Small Group Discussions:
Moderators: Dottie Brinsfield
Mary Jo Miller
Dave Shapiro
Leah Dickstein

12:00 - 2:00 Lunch on your own or Women in Medicine Luncheon

12:45 - 3:00 KEYNOTE ADDRESS on
"Student Impairment/Drug Screening/Support Groups"
Keynote Comments: Pat Wall
Small Group Discussions:
Moderators: Dottie Brinsfield
Mary Jo Miller
Dave Shapiro
Leah Dickstein

5:00 - 5:30 Nominations for Southern Regional Chairperson

6:00 p.m. * OSR Cookout on the Beach ----- David Watson
Raised so far: \$50 Merrill Dow Arkansas
Dan Shapiro
Emory
Bill Kapp
Medical College
of Georgia

Saturday, April 18

8:00 - 10:00 Business Meeting: OSR
- Slide Show: New Orleans/Washington, DC
- OSR Ad Board Report ----- Andy Spooner
- Selection of Editor with discussion
about topics for Newsletter
- Critical Issues: Conclusions?
- Survey
- "PR for OSR" ----- Jill Hankins
- Elections for Southern Region Chairman

10:00 - 11:00 Meeting of OSR Small Group Facilitators
Debriefing

* Still in planning

TOPICS FOR SMALL GROUPS AT ST. SIMON'S

ADMISSIONS/FINANCIAL AID

1. Screening for Emotional Stability as a Part of the Admission's Interview Process.
2. Enrollment Cut Back.
3. Non-Cognitive Factors and Training to Recognize Such.
4. Debt Management Counselling at the Undergraduate Institution.
5. Medical Advisors (physicians) for pre-med students
6. Students + Recruitment

CURRICULUM/TRANSITIONITIS

1. Fragmentation Caused by the Senior Elective Process.
2. Selection Criteria for Post Grad Med Education, and Their Impact on the Developing Physician (GPA, MCAT, NBME).
3. Selection of Minorities and Women into Post Grad Training Programs.
4. Deans' Letters - "Truth or Consequences".

PROFESSIONAL CONDUCT, MORAL AND ETHICAL EVALUATIONS

1. Definition of Nature of Principles and Source of Concern. What are the Expectations and How are they Communicated?
2. Abuse of Patients - Is It Learned or Is It Innate?
3. Social Responsivity as a Professional Medical Obligation.
4. The Impact of Illegal Behavior on Student Status.

IMPAIRED STUDENTS

1. Intervention and Treatment (Public Facility - Private - School Based).
2. Prevention Methods (Passive or Coercive)/
3. Impaired Status vs Patient Care Responsibility.
4. Responsibility to Communicate Impaired Status to Post Graduate Training Institutions.

To: Southern Region OSR Members
From: Bill Kapp, MEDICAL COLLEGE OF GEORGIA
RE: SOUTHERN REGIONAL MEETING ON ST. SIMONS ISLAND

For those of you who have never seen the coast of GEORGIA, it is my distinct pleasure to inform you that it will indeed be a special treat, for the "GOLDEN ISLES" are one of GEORGIA's best kept secrets. St. Simons Island is located approximately half way between Savannah, Georgia and Jacksonville, Florida on the seaward side of I-95. Although getting to the Island requires a little effort, you will undoubtedly find that your efforts will be well rewarded. The accommodations for the meeting will be provided by the KING AND PRINCE BEACH HOTEL AND VILLAS, perhaps the finest hotel on the Island. The hotel, with its Spanish-Colonial style and recent renovation, is reminiscent of a by-gone era complete with its own unique charm and elegance. Swimming, sunning, fishing, sailing, tennis and an 18-hole golf course are a few of the many activities provided. You can expect the temperature to be warm and breezy with average daily highs in the upper 70's, so bring your swimsuits.

Beyond the confines of the King and Prince, the Island offers a rich historical past for even the most ardent history buff. Founded by General James Oglethorpe in 1736, St. Simons Island and Fort Frederica have served as key military strategic locations as well as active trading posts. Self guided tour pamphlets are available for those interested.

Where to dine on St. Simons? Fortunately, for any seafood lover, the Georgia coast offers a bountiful selection of some of the best seafood on the east coast. Some local favorites include the Crab Trap, Emmeline and Hessie, C. J. McPipes, and the 1733 Shrimp House and Raw Bar. Further restaurant information will be available at registration.

As far as nightlife is concerned, there are two choices. First, you can supply your own entertainment, or second, you can select from Emmeline and Hessie's or Spanky's. Both of these clubs offer terrific atmosphere, reasonable prices and some of the hottest entertainment on the island. In addition, we are currently in the process of trying to obtain a beach-fire permit so that we might be able to have a beach party one night. Further information on this topic will be available at the meeting.

All in all it promises to be a terrific meeting. The warm sunshine, relaxing atmosphere and superb company should prove to be a winning combination. See you at the beach.

Cordially,

Bill (signed by Jill)

Bill Kapp

Thanks Bill!
JTH



St. Simons Island CHAMBER of COMMERCE



1987

WELCOME TO ST. SIMONS ISLAND! We are delighted you want to know more about our area and are enclosing those materials we think will be of special interest to you. If you have requested special information about certain items we hope we have chosen those which will benefit you. In the space below we have listed the answers to some of our most often asked questions.

AVERAGE TEMPERATURES

	<u>MAX.</u>	<u>MIN.</u>		<u>MAX.</u>	<u>MIN.</u>
JANUARY	62	43	JULY	89	74
FEBRUARY	64	45	AUGUST	89	74
MARCH	69	50	SEPTEMBER	85	81
APRIL	76	58	OCTOBER	77	61
MAY	83	66	NOVEMBER	70	51
JUNE	88	72	DECEMBER	62	43

Although ST. Simons Island has no campground, neighboring Jekyll Island offers the Cherokee Campground. Reservations are accepted by mail with deposit. Cherokee Campground, Jekyll Island, Ga. 31520. Telephone No. (912) 635- 2592.

St. Simons Island is midway between Jacksonville, Florida and Savannah, Georgia. The Island and surrounding area may be reached from US-17 or I-95. The McKinnon Airport on St. Simons has daily charter flights.

Rental cars are available at the airport through three national car rental agencies.

St. Simons Island is subject to the government of Glynn County under the direction of the Glynn County Board of Commissioners and a county administrator. Brunswick, Georgia is the County Seat.

Recreational opportunities include beach activities, golf, tennis, boating, fishing and bicycling. Groups and convention arrangements may be made through individual motels and hotels.

Golden Isles Touring Company provides group bus tours and provides excellent specialized tour service that includes historic sites. Stylized to make special arrangements for luncheons or other interests you may have. Arrangements may be made with Golden Isles Touring Company, St. Simons Island, Ga. 31522, Telephone No. (912) 638-8092.

ST. Simons Sojourns, Inc. provides motor coach guide service. The three hour sojourn includes a visit to the Fort Frederica, a stroll on the grounds of a beautiful Christ Church and the ruins of the once gracious plantation of a bygone era contrasted with the stately magnificance of Sea Island. Arrangements may be made with St. Simons Sojourns, Inc., P. O. Box 1767, St. Simons Island, Ga. 31522. Telephone No. (912) 638-1585/

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Greetings!

I hope your year is going well. The OSR administrative board met in January and we began planning the fall meeting to be held in Washington, D.C. The theme will be "Manpower," dealing with the supply and distribution of physicians. At the meeting, Bill Kapp was elected to the AAMC Financial Aid Committee. Congrats!

IMPORTANT! We voted in October 1986 to repeat our housing project for interviewing seniors.

- (1) Bring a list of students at your school willing to house a senior while interviewing. (Print names on page provided with this newsletter.)
- (2) The number (N) of names you need to submit:
N = 10% of one class size
or 15, whichever is smaller
ex: Arkansas has 150 students in each class, therefore we will submit 15 names.
- (3) Page B is provided for you to hand out to your classmates for them to fill out. You then will copy this information onto Page A.
- (4) If a classmate wants to charge a fee (like for bed and breakfast), just add that to the list. Or if someone is willing to rent out a room for a month's rotation, then indicate that information.
- (5) BRING YOUR LIST OF NAMES TO THE SPRING MEETING OR MAIL TO ME BY APRIL ¹⁴ 1987.
- (6) Try to enlist classmates who will not be moving. Also, if you have trouble getting your quota of names, call me (501) 663-9664.

Jill

Jill

P.S. If there is any information that you want to get from other schools, bring self-addressed envelopes to hand out at St. Simon's.

The OSR (Southern) is setting up a network for students interviewing (and doing electives). A list will be compiled of students willing to share housing with visiting seniors, or at least willing to help find housing. In order to receive the other medical school's housing list, we must submit a certain number of willing hosts/hostesses (20% of one class size). The new list will be effective until June 1, 1987. Please fill in the information requested below and return it to:

Put your name, address and phone number here.

PLEASE PRINT OR TYPE

Name _____ Phone #() _____

Address _____

Any restrictions on type of visiting students (Circle all that pertain)

Male or Female

Smoking or Nonsmoking

Other: _____

Describe Accomodations Available (i.e. Sleeper Sofa, Spate Bedroom, etc.):

Be sure to include info about whether someone wants to rent rooms for students doing rotations.

The Southern Region OSR has voted to repeat its efforts in "Beating the Interview Blahs".

To Participate:

① Hand out this form (clean copy provided) to your sophomores and juniors.

② The number of students required is 20% of one class size (100 → 20) or 20 → $\frac{20}{100}$ (if class size over 100). There is no need to exceed 20 names.

SCHOOL _____

PLEASE PRINT OR TYPE

Name _____ Phone #() _____

Name _____ Phone #() _____

Address _____

Address _____

Any restrictions on type of visiting students
(Circle all that pertain)

Any restrictions on type of visiting students
(Circle all that pertain)

Male or Female

Male or Female

Smoking or Nonsmoking

Smoking or Nonsmoking

Other: _____

Other: _____

Describe Accomodations Available

Describe Accomodations Available

(i.e. Sleeper Sofa, Spate Bedroom, etc.):

(i.e., Sleeper Sofa, Spare Bedroom, etc.):

This is the form you should fill out neatly to bring to the meeting at St. Simons or mail to me (Jill Hankins, 314 S Oak, Little Rock, AR 72205) by April 1, 1987.

Name _____

Phone #() _____

Address _____

These forms will be run off and sent to each school which participated.

Any restrictions on type of visiting students
(Circle all that pertain)

Male or

Smoking or Nonsmoking

Smoking or Nonsmoking

Other: _____

Other: _____

Describe Accomodations Available

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Male or Female

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Smoking or Nonsmoking

Other: _____

Other: _____

Describe Accomodations Available
(i.e. Sleeper Sofa, Spate Bedroom, etc.):

Describe Accomodations Available
(i.e., Sleeper Sofa, Spare Bedroom, etc.):

SAMPLE

SURVEY ON THE SENIOR YEAR
(For Jill Hankins, UAMS)

1. Do you have any required courses? If so, please specify name of course and length of time.

2. Are these courses (or even your electives) graded? If so, are these subjective or objective grades?

3. How long :
If you have a survey idea that would benefit your school, send a copy of your survey to me (Jill Hankins, 314 S Oak, Little Rock, AR unive 72205). I will prepare a packet of all the surveys to handout at Registration. Then, Friday we will designate a time and place to turn the surveys in. ☺

5. How long are your courses (electives)?

6. Are there any special requirements (or problems) associated with scheduling off-campus electives?

or bring copies to hand out at St. Simons

your

GETTING READY!!

News from Billy Rice at Bowman Gray:

DRUG POLICY

An issue on the forefront of medicine today is that of the impaired physician. Certainly our medical institutions have an obligation to give society as much assurance as possible that we are turning out competent, unimpaired physicians. The major question with which our medical schools must wrestle is how to isolate and offer help to the impaired students and physicians without infringing upon personal rights. The question is by no means easy. A delicate balance exists somewhere and must be found.

At Bowman Gray we have begun to wrestle with this question by seeking to establish a policy that would maintain this balance. There was a consensus at a recent Faculty Executive Committee (FEC) meeting that any policy that might be formed should apply to faculty as well as to students. Presently, no policy has been drawn up. The administration has begun "collecting data" by discussing the issue with the student council and the faculty. The main goal at this point seems to be to increase everyone's awareness of the problem and to urge people to begin thinking of possible solutions. Certainly most people involved are against any idea of random urine sampling--an option that seems highly unlikely to be pursued.

The problem is real and serious. The solution seems difficult. As a medical community, we must put our heads and our hearts together to seek an answer.

PROBLEM-BASED LEARNING

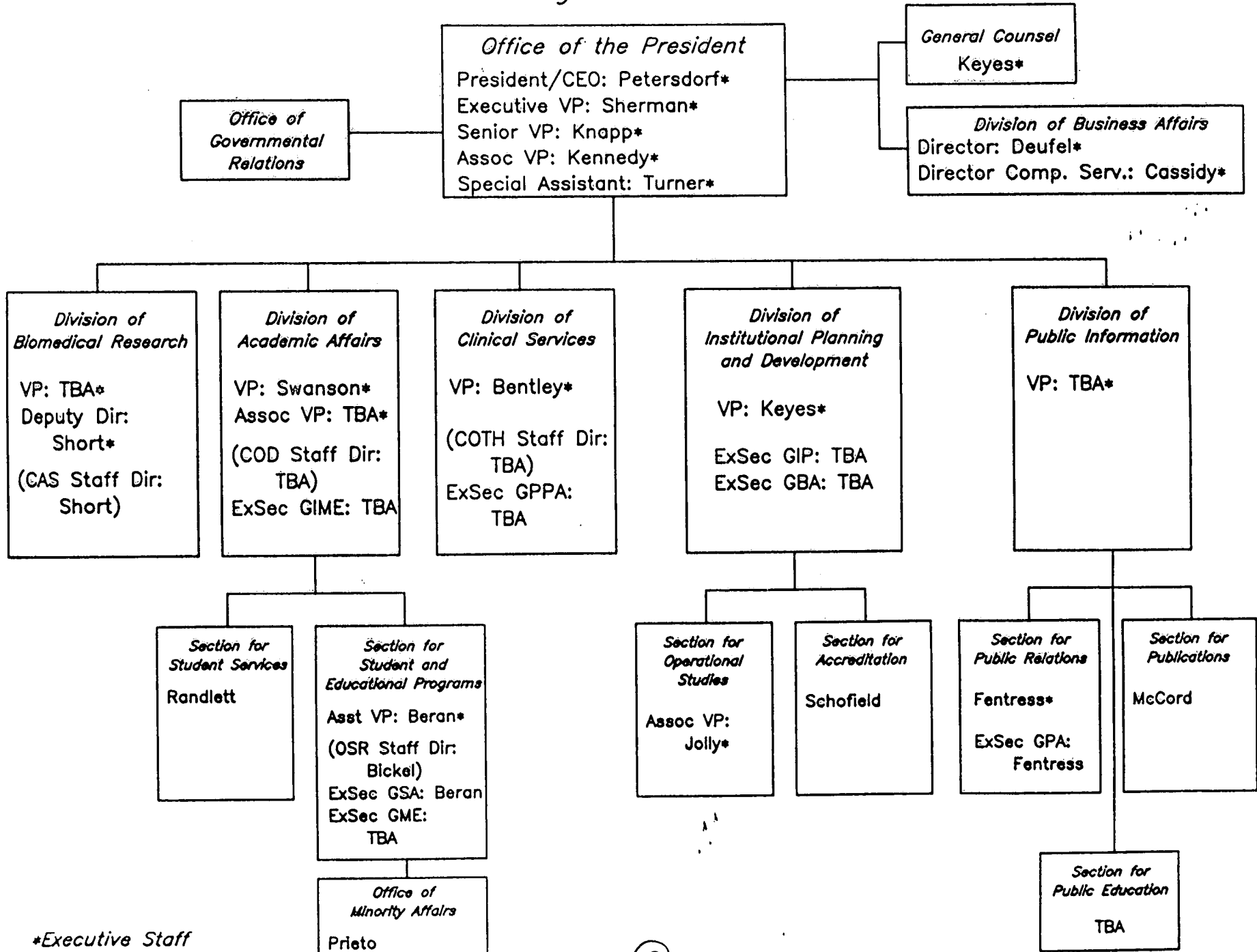
The big news at Bowman Gray is that we will be starting a parallel curriculum with 18 of the incoming freshman class of 108. The curriculum revolves around the problem-based model that we caught a glimpse of at our meeting in New Orleans this past October. The administration has put in a lot of time and effort into developing these plans and everyone seems excited about this transition in medical education.

FUND RAISER FOR HUNGER

We're having another fund raiser for hunger. All four classes and the P.A. students are selling tickets for some great prizes (top prize is a weekend for two in Charleston, S.C., airfare included!). The proceeds will go to the local food bank.

1987

AAMC Organization Chart



*Executive Staff

ad hoc Committee on Graduate Medical Education and the
Transition from Medical School to Residency

TOPIC AT ST. SIMON'S

Final Report

The Executive Council of the Association of American Medical Colleges asked the committee to examine the effect of the selection process for residency positions on medical students' education and to recommend what steps should be taken to lessen any disruptive effects on students' general professional education. The committee found that competitive pressures for residency positions are causing undesirable effects on medical students' education and that the resultant educational disruption is amplified by systemic, organizational defects. These defects cause communication failures and misunderstandings among those responsible for the general professional education of medical students and those who select students for graduate medical education programs.

The committee set forth a number of recommendations. Among them was that the AAMC should convene a meeting of the Council of Academic Societies, the Council of Deans, and the Council of Teaching Hospitals during its 1986 Annual Meeting to discuss the preliminary report. On October 26, 1986, over 900 persons attended the meeting convened for this purpose. (Appendix A). Participants were provided with a report entitled The Experiences of Medical Students in Obtaining a Residency (Appendix B).

Information obtained through that meeting and from extensive discussions of the preliminary report by the Council of Academic Societies and the Council of Deans at their annual business meetings confirmed the committee's conviction that both medical school and graduate program faculties are devoted to providing the finest quality education to both students and residents. There is evident willingness within the academic medical community to work toward ameliorating the deleterious effects of the residency selection process on medical students' general professional education.

The wide ranging discussions stimulated by the preliminary report also made clear that some of the committee's recommendations are universally subscribed to and should be implemented as soon as possible while others will require further exploration of their effects on the selection process. Therefore, the committee's final recommendations are placed into two categories:

- recommendations that are widely accepted
- recommendations that require further exploration.

Recommendations That are Widely Accepted

Change the National Residency Matching Program Schedule

The committee recommended that the period between submission of rank order lists by both students and programs and the announcement of the match results be shortened to one month and that the final date for submission of lists be March 1, with the match results announced on April 1. Subsequently, the NRMP has developed a procedure that will eliminate the need for students and programs to verify the computer coding of their selection preferences. This procedure will shorten the period between rank order list submission and the match results announcement to 3 1/2 weeks. The NRMP has undertaken a survey to determine the most preferred dates for submission and announcement.

- The committee recommends that the AAMC work closely with the NRMP to facilitate the introduction of the new match schedule in 1988.

Improve the Universal Application Form

The Universal Application Form, which was developed by the AAMC and is distributed by the NRMP, reduces the burden on candidates by providing a common format for the information generally required by all programs. During the six years since its introduction, it has not been widely used.

- The committee recommends that the AAMC revise the form after soliciting suggestions for modification from deans, program directors, and teaching hospital NRMP coordinators. Use of the revised form should be promoted vigorously.

Improve Dean's Letters

Discussions confirmed the committee's view that program directors have a low regard for the student evaluations provided by "dean's letters." Deans also believe that the quality of the evaluation of students' knowledge, skills, and attitudes must be improved. Teams from over 40 schools will have attended AAMC Management Education Workshops on Systems for the Evaluation of Clinical Students during 1986 and 1987.

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

Recommendations that Require Further Exploration

Improve the Coordination of PGY-1 and PGY-2 Selections

In its preliminary report the committee recommended that the timing and coordination of residency selection could be improved if all of the specialties that select graduating seniors for PGY-2 or PGY-3 positions were integrated into the National Residency Matching Program. Discussions have brought out that because many programs in these specialties cannot provide the PGY-1 year in their institutions, the coordination of the selection process is complicated for both candidates and programs.

- The committee recommends that the AAMC convene a task force composed of representatives of specialties that select candidates to begin training in their second or third postgraduate years, representatives of specialties that are the predominant providers of the preliminary training of residents for these specialties, representatives of the National Residency Matching Program, and members of the Council of Deans and Council of Teaching Hospitals to explore how access to preliminary training for residents who begin their specialized training in their second or later postgraduate years can be accommodated more effectively.

Uniform Timing of Release of Deans' Letters and Transcripts

The committee found that there is great variation in when programs in the various specialties require candidates to submit their deans' letters and transcripts. For some specialties, the predominant period is July, August, and September. For others, these credentials are not required until November and December. Deans are concerned about the restricted amount of evaluative information that is available early in the senior year. The extension of the date for submission of rank order lists to the NRMP provides an opportunity to extend the time for evaluation of students' senior year performance.

- The committee recommends that after consultation with representatives of the various specialties, the timing for the release of students' academic credentials be established by the Council of Deans, and that the Council's decision be communicated to all programs and teaching hospital directors.

Institutional Responsibility

In the course of its deliberations, the committee observed that the selection practices among the specialties were determined principally by the program directors of each specialty with little or no institutional oversight. The lack of

- The committee recommends that the AAMC convene an annual forum involving representatives of program director organizations, representatives of other sponsors of the ACGME, representatives of the NRMP, and members of the Council of Deans, Council of Academic Societies, and Council of Teaching Hospitals to review the progress that has been made in improving the transition. Data on the experiences of medical students in obtaining a residency, derived from the AAMC's Graduation Questionnaire, should be available to assess the status of the transition.

SURVEY OF EXCELLENCE IN TEACHING OF PREVENTIVE MEDICINE
Association of Teachers of Preventive Medicine - OSR

- Preventive Medicine Fam. Pract. and Com. Med. Univ. of Texas (Huston)
Elective survey course of different aspects of the field of Preventive Medicine
- Mechanisms of Disease (6 hrs) Fam. Pract. and com. Med. Univ. of Texas
Two sessions where students meet in small groups with a faculty member to discuss how to approach such things as behavior modification (smoking, wt. loss)
- Nutrition Pharmacology Univ. of Texas
Elective Survey course on different nutritional requirements for different stages in the life cycle.
- Clinical Electives School of Public Health Univ. of Texas
- Epidemiology and Biostatics Community and Family Medicine Georgetown
One hour of lecture 2x/wk followed by 1 hour of small group discussions and problem solving.
- Health and Human Values Medicine Univ. of Miami
Includes concepts of health, epidemiology, biostatistics, risk, prevention in medical practice. medical activism, environmental and occupational health, tertiary prevention, organization of health services.
- Course in Human Sexuality Fam. Med. and Psych. Univ. of Cincinnati
Includes family planning, infectious disease control, sexually transmitted diseases, adolescent sexuality, homosexuality, rape, sexual dysfunction and sex therapy, sexuality and aging, sexuality and disabilities..
Main resource and force is local office of Planned parenthood.
- Health Promotion Community Medicine Univ. of Tennessee
Overview and discussion of nutritional, fitness, and health appraisals, methods for behavioral change, cancer prevention, injury control, nutrition, immunization, exercise and fitness, impaired physicians.. Emphasis in teaching students how to take care fo themselves.
- Nutrition Dept. of Human Nutrition Columbia (New York)
Importance of adequate nutrition in the promotin of health and recovery from disease. Attention on proper dietary components during stages in life and needs of hospital patients. Highly recommend. model from this course.
- Psychiatry Core Curriculum Psychiatry/Behav. med. Bowman Gray Sch. of M.
Includes cardiovascular risk reduction, smoking prevention/cessation, alcohol and drug abuse, prevention, and control, control of stress and viloent behavior. Special experience is afternoon in the biofeedback lab trying these techniques.
- Preventive Cardiology Medicine BGSM
Purpose is to identify family members at risk for heart disease and to heal educate medical students in preventive cardiology. Work with patients in clinic setting: intial assessment, follow up, and program perscription (nutrition, exercise, psychology).

Community Medicine Fam. and Com. Med. BGS
Students spends scheduled time during each week of the rotation discussing general principles of nutrition as well as specific therapies. Time is also spent with a patient education expert learning specific communication and motivational skills.

Community Medicine Family and Community Med. BGS
Objectives include: outline the historical evolution of preventive medicine and its contemporary relationship to clinical medicine; recognize effective preventive medicine strategies in the clinical setting; define the roles and responsibilities of the physician, allied health personnel and the patient in health promotion activities. A case study is done exploring the student's community experience.

Environmental Medicine Sem. Env't and Comm. Med./Fam. Pract. UMDNJ - Rob. Wood john
Individual elective to study screening for clinical prevention.

Clinical Preventive medicine Loma Linda Center for Health Promotion
Clinical prevention at a busy clinic.

Sex Week - Human Sexuality Community Med./Psych UMDNJ - R.W.J.
Full week of lectures, reading, multimedia and seminar

Family Practice Preceptorship Fam. Pract. UMDNJ - R.W.J.
Alcohol abuse, hypertension (cardiovascular risk reduction), health screening, clinical prevention, geriatric primary care.

Microbiology/Public Health Public Health Oregon Health Sciences
Sexually transmitted diseases with emphasis on procedure for reporting.

Biostatistics Public health and Prev. med. OHSU
Statistical analysis, basic statistics and critiquing of medical literature.

* Preventive Cardiology Medicine Univ. of Missouri
Risk factors and risk factor screening: smoking, HTN, Diet & weight control. Exercise, behavioural modification, identification of signs and symptoms of cardiac disease; EKG interpretation. Special features include investigator who is screening first year medical students for risk factors.

Family Practice Preceptorship Family and Comm. Medicine U. of Mo.
Teaches students approaches to preventive medicine, health maintenance and disease screening in primary care, including how they may be enhanced through various measures of patient education.

Social and behavioral sciences Fam. and Comm. Medicine U. of Mo.
Extends through first and second years. Includes child development family stress, cost effectiveness, and patient coping as well as many other hp/dp issues.

Family Medicine Fam. Medicine Mayo Medical School
Health Education, behavior Sciences, administrative and planning of health services, immunization, disease control. STD, Second year course with preceptor experience.

Alcoholism Family Practice Med. Coll. of Ohio
Six week seminar style course meeting once per week. Deals with issue of alcoholism and addiction. Highlights include the video tape series by the KROC institute and panel discussions with therapists and members of AA.

Alcoholism Family Practice MCO
Elective 2 to 4 week clerkship at one of two area hospitals that have inpatient services for alcohol withdrawal and detoxification. Outpatient counseling also included.

Nutrition Family Practice MCO
Two or four week elective clerkship with either patient exposure in Family Practice Clinic setting doing nutrition counseling, with some in-patient consultation.

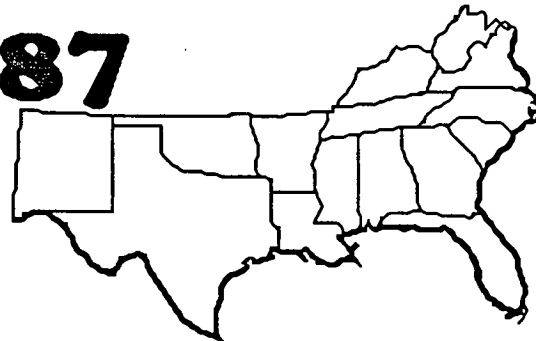
Current Concepts in Preventive Cardiology and Hypertension-
Medicine Yale
To provide students with more information about what is going on in the field of preventive cardiology and how to best evaluate and treat the hypertensive patient. Course is a 2 month elective offered to senior students and residents and is a seminar style format.

Nutrition Nutrition UC - Davis
Required course for second year students presented in lecture and case study format. Content includes basic applications of metabolism to nutrition, current issues involving nutrition and cancer, TPN, dietary assessment and counseling with a clinical nutritionist. Instructional materials include a syllabus, book, and dieticians.

Behavioral Medicine Behavioral Science U of MN - Duluth
Required second year lecture/reading format presenting issues including issues in compliance/noncompliance, risks and course of coronary artery disease, essential hypertension and cardiac arrhythmias, migraine and vascular headaches, pain phenomena, smoking and asthma, obesity and GI systems. Evaluation was by written examination. The course was poorly attended by students. A stress survey was a particular highlight of the course. The students had the opportunity to apply the survey to an assessment of HTN including cholesterol levels, and medical history.

Psychosocial aspects of cancer control
Community Medicine U. Conn
First year elective open to medical and dental students. Course is 20 hours of seminar style contact addressing issues surrounding breast self examination and how to increase physician and lay person expertise. Papsmears and the problems in encouraging minority women to attend screening programs, smoking and smokeless tobacco issues were also covered. Course emphasized self learning. Most notable feature was the emphasis on discussing preventive strategies and real world problems versus measurement of disease and interventions as in an epidemiology course.

OSR - Southern Region Newsletter Summer 1987



Included in this issue:

- 1. Greetings from Danny Shapiro and Kim Dunn**
- 2. Summary of April Meeting**
- 3. Informational Directory**
- 4. "Transitionitis" - from Southern COD**
- 5. Government Budget Update**
- 6. Medical Care for the Indigent**
- 7. Medical Student Abuse**



Be sure to get involved with the new OSR computer network!

GREETINGS ALL

Ah, May in Atlanta. Yes, spring has sprung. It is a time for firsts and beginnings. How appropriate then that I should make this first attempt at communicating. Actually, Tom sent me a gentle but specific reminder to get my butt to a typewriter and compile something remotely printable. Here it is....

Jill gave me a pretty thorough run down on what's coming for the OSR in the next twelve months before we left St. Simons. The topic for the national meeting will be 'Manpower' and associated issues. I thought it might be a good idea for current third year students to compile a list of specialty choices for their classes. We could use these as a basis for discussion in Washington. Any thoughts on the subject would be greatly appreciated....I too should have some clearer idea of what to plan for Washington after the June Ad Board meeting.

Our 'interview housing list' should be out soon. Many of my classmates have shown great interest in the idea. Five or six wish to go one step further and have offered their apartments to swap for 'away-electives'. If you or any of your classmates are interested in doing electives at Emory please feel free to call any Emory student listed on our soon-to-be-published-list. Even if you don't want to do an elective at Emory, please send me your name, address and time you are thinking of being away from your own school. I'll contact Wendy and see if we can't get a crude directory out by early July.

Lastly, I want to thank all of you again. I am flattered to be serving as your chairman and hope that I can live up to the example set by my predecessor. If you need anything or want to share any news, please write me or Tom Pajewski and we'll spread the word. I am

Gratefully yours,

Danny
Danny Shapiro

Joke of the month

P.S. (Surgery leaves much to be desired.....)

Q: How many Surgeons does it take to change a light bulb?
← (note capital 's')

A: Three; 1 to take it out, 1 to report on lightbulb morbidity and mortality and 1 to report the new bulb to be afebrile & vital signs stable.

Dear Southern Region,

GREETINGS!!! It sounds like you had a terrific Regional meeting. I wish I could have been there. I think Dan will do a terrific job as Regional Chairperson next year. However, it's going to be tough following Jill!!!

I just wanted to write a note for the Newsletter to say what I would have said at the Regional Meeting. (And you thought you wouldn't have to listen to my yap!! Some things never change.) A lot of this you probably heard from Andy Spooner.

A. Problem-Based Learning Project - Yeah, it's finally getting started. The student appointment to this committee is Jennifer Hoocke. She took a year off last year from medical school and travelled to several PBL schools to learn how the curriculum is different. Please direct any comments you may have to her. Address is 2413 Pickett Road, Durham, NC, 27705. Phone is (919) 493-7187. I know she is excited about this project and wants to hear from us.

B. Prevention

1. Association of Teachers of Preventive Medicine - Students will have a part of their national program next spring in Atlanta. The student coordinating this activity is Michelle Birdseye, OSR representative from Mercer. Her Address is 1500 Coleman Avenue, Box 72, Macon, GA, 31207. Number is (912) 744-1833.

2. T-Shirt presentations - Recently at the April Ad-board meeting, Vicki and I got our hot little hands of T-Shirts from the Prevention 87 Meeting and during the discussion with the Council of Deans we presented them with the T-Shirts. The upshot of this was that there will be a joint meeting with the OSR and the COD to discuss ways to implement preventive medicine into the curriculum.

C. Computers - Andy Spooner is heading up the way to computerizing the OSR. The Ad-board is scheduled to communicate via computer before the June meeting.

D. National Meeting - Looking great, see attached proposed outline. Plan on meeting your representative while in Washington.

E. Indigent Care - This area of medical care health policy is becoming an increasingly important one. Attached is the current AAMC policy stand on indigent care. Hopefully, this will become a major issue with which the AAMC will take the lead in addressing. What are your thoughts? Let me know.

F. Assuring quality in patient care - At the April meeting with the COD, we discussed how to insure the clinical competence of graduating medical students. This is becoming increasingly important. Any ideas, let me know.

G. Reporting NRMP abnormalities - At the consortium meeting in March, all the medical student organizations met and agreed that there should be a mechanism for students reporting NRMP violations. It was agreed at the time to approach Dr. Gus Swanson at AAMC to see if the Graduation Questionnaire could be used as a mechanism for reporting. Gus thought it would be a good idea. I guess it can be considered to be in the planning stages at this time.

H. Student abuse project - Dr. Silver approached the OSR last fall to help him in conducting a national survey about the extent and types of student abuse that are occurring. We are joining forces with AMSA in doing this. Attached please see a copy of the letter he sent and the article he wrote.

I. Medical Manpower Task Force - Dr. Petersdorff has set as an AAMC top priority the issue of Health Manpower-training, specialty mix, and geographic distribution. I will be serving on the Steering Committee of this and Sarah Johansen will be serving on the Committee on Medical Education. Please send any questions and comments to us. Sarah's address is Dartmouth Medical School, Box 56, Hanover, NH, 03756. The first meeting of the Task Force was May 27-28. So, much more will follow.

Well that's all for now. Let me know what's going on with you.

Kim Dunn

SURVEY RESULTS FROM REGIONAL OSR MEETING
ST. SIMONS, GEORGIA

APRIL, 1987

1. Almost without exception, everyone enjoyed the small groups and the interaction with the other groups, i.e., GSA, MSA, Financial Aid Officers, Admissions, AAMC. Since no formal survey was done of the GSA, etc., I am unsure of their cumulative response, but overall I heard positive comments about OSR's input. Perhaps each Regional Meeting should include one joint session with a breakdown into discussion groups following since the students appeared to need more contact with the Deans (discussions may be "few and far between" at each school).
2. Also mentioned as enjoyable activities were the box lunches, volley ball games on the beach and seeing friends made at previous meetings.
3. Specific information that was found to be useful included AIMS programs (majority of comments) and facts about Ethics/Professional Conduct (#2). Besides having an AIMS program, the University of Tennessee has a Peer Counseling Program and a course "Becoming a Professional"; both were mentioned. Other information found to be helpful:
 - A. NRMP changes.
 - B. Curriculum that has more patient contact during the first two years.
 - C. Ideas about good Physical Diagnosis Courses
 - D. Information about the senior year
4. Most of the constructive criticism focused on the mechanics of moderating a small group and organizing the material presented. Therefore I have formed a list of ideas about leading a small group based on OSR's comments:
 - A. Each small group should be directed toward specific resolutions (perhaps set aside the last 10 minutes).
 - B. The discussion topics should be well defined and all tangent discussion and storytelling should be minimized.
 - C. Do not let the meeting run overtime. All that is remembered is how long they sat in the room.
 - D. Try to discuss topics that are interesting to all different groups present.
 - F. Prepare handouts listing the concerned topics; have info from other schools readily available. Handouts are often crucial.

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5. The concensus was divided about St. Simons. Many enjoyed the King & Prince Hotel but did not enjoy the cloudy weather; "no-see-um" bugs and the lack of nightly activities.
6. Overall, I was pleased with the amount of information exchange that occurred. Thanks to everyone who helped make this meeting a great one.

Jill

Jill Tilley Hankins
University of Arkansas

NOTES FROM THE WOMEN IN MEDICINE LUNCHEON (by Ann Reynolds, MCG)

Janet Bickle will be the new coordinator for the Women in Medicine section of the AAMC.

Dr. Leah J. Dickstein, from the University of Louisville, will be the new chairperson.

Topics Discussed

- In the last few years there has been a decline in the number of female medical students joining women's organizations. Although many women may not feel the need to belong to a women's group during the first few years of medical school, there was a feeling that as those women come closer to leaving the academic world where discrimination is restricted, that they will realize there are still many challenges facing women physicians in the community. There challenges may be easier to deal with as a group. There was a concern that female medical students may be "burying their heads in the sand" when it comes to the problems they will face as women in a traditionally male dominated profession.
- Many female medical students feel that their social life ends when they enter medical school. (Sorry, there were no solutions!)
- There is an increase in the number of medical students who are transferring from one school to another in order to be with a spouse.
- Mary Jo Miller from the University of Tennessee, Memphis reported on a program called "Journey".

Female medical students spent six Saturday's teaching sex education, etc. to 9-11 year old girls from a housing project in Memphis. The project was coordinated through the Girl's Club and has been extremely successful. Both the girls and the medical students enjoyed the experience.

- There will be a Women in Medicine breakfast meeting on Monday, November 9 at the Annual Meeting in Washington. Some of the proposed topics are:

Sexual Harassment
Promotions for Women in Academic Medicine
Co-mentoring
Role Conflicts
Woman Students Who are Parents
House Officer Training Process

The meeting was very interesting. I would encourage more students to attend the breakfast at the Annual Meeting

M-1 Box Lunch Discussion @ St. Simons

ORIENTATION

Although the first year students did not intend to follow the "box lunch" instructions to the letter, we did very much enjoy our lunch together. One of the topics we focussed on in our leisurely talk concerned our orientation for Medical School. The time spent in orientation ranged from one day to one week. None of us thought that the time spent was beneficial or that the orientation better prepared us for our upcoming experiences. Some of us who had a shorter orientation time had to pay our fees during that time, so the actual orientation was even less than previously described. Despite all the negatives, the one positive aspect of this time was that it gave some of us time to better get to know our classmates. For those of us with 1 to 1.5 day orientations, we really regretted not getting to know our classmates better before school started. None of us had any concrete suggestions to improve our first year orientations.

FINDING TIME FOR FAMILY AND FRIENDS.

A second major topic of discussion was how to find time for your family or significant other. One of us stated that being single with no ties was no problem, and he did what he pleased any time. It was a general consensus that we had decided that it was important to us to spend time with our families or others. Therefore, in practice we did not let our medical studies take us away from these important interactions. Furthermore, we felt that maintaining some kind of outside activities was very important to our general well-being. However, we all did have concerns about how we could maintain these activities as our load and responsibilities in medical school increased. Needless to say, no concrete suggestions were proffered, but we all felt that somehow we all would cope quite successfully.

M-3 Box Lunch Discussion @ Regional Meeting

I) Ward Orientation.

There are numerous mechanisms working at various schools to orient incoming clinical students to the wards. UT San Antonio, USF, and UF all have "how to" sessions to teach basic procedures such as IV's, ASG's, LP's, etc. Emory has a very well-received program that involves taking underclassmen on rounds/orientation on Saturday mornings once a month. Programs using lecture/didactic methods (such as WVa) are felt to be ineffective. Others rely on "trial by fire" with formal orientation. Duke employs a skills achievement record that students are required to complete while on a particular rotation.

II) Clinical Evaluations.

Several grading schemes are in effect to assign clinical evaluation grades ranging from 100% reliance on NBME "miniboard" exam results (i.e. LSU Shreveport) to totally subjective evaluation by residents/attendees, or some combination of the two. In general consensus reached is that a policy statement by the OSR or AAMC regarding determination of clinical grades will have no bearing whatsoever at the individual institutional level.

III) AIDS.

There appears to be no special problems with treatment of AIDS patients, but there is significant variation regarding the issue of testing for HIV and obtaining informed consent prior to doing so. Access to t_____ results is also a significant legal consideration. The screening of medical students for AIDS was discussed but no consensus was reached concerning appropriate measures should a student be found to be HIV +. The group agreed that a national policy concerning this situation would be desirable.

IV) Residency Selection.

Although discussed only briefly, there seems to be uniform agreement that "lifestyle" considerations weigh very heavily in the process of selecting career goals and residency programs.

M-4 Box Lunch Discussion @ Regional Meeting

I) "How did you choose your specialty?"

Bruce Mitchell, Morehouse: "It was a process of elimination. I'm a thinker and I like a challenge."

Choice: Internal Medicine

Chuck Breen, Kentucky: "I started undecided but I began to work for the Eye Bank during my second year and started meeting the physicians."

Choice: Ophthalmology

Joe Andrezik, Oklahoma: "I enjoyed consulting on patients, not long term management. I am image-oriented and was a neuroanatomist."

Choice: Radiology

Jill Hankins, Arkansas: "I enjoy talking with patients, dealing with the entire family and treating a variety of age groups as well as illnesses. I also like preventive medicine."

Choice: Family Practice

Each said: 1) Be Happy, 2) Consider type of practice as well as lifestyle; 3) Nothing is irreversible.

II) Two of the Four schools (Arkansas and Morehouse) provided good residence selection preparation.

III) Bruce:

8 interviews
2 away rotations

Chuck:

20 applications
10 interviews
2 away rotations (neither where he matched)

Joe:

15 weeks Radiology at home school, matched there

Jill:

3 week E.R. rotation at Fort Smith (where matched)
2 away rotations

Summary of
topics discussed:

Participants in the GSA/MAS/OSR Program
Southern Region Spring Meeting 1987

Financial Aid - Cheryl Wilkes O'Keeffe

1. Financial Counseling - The Ideal Versus the Reality
 - Who pays? The student or the school
 - Reaching students, the importance of staff competence
2. Recruiting with Scholarship Dollars
 - Are funds needed to reduce debt burden?
 - Are scholarships of real value to the school?
 - Merit scholarship: to facilitate enrollment or to buy students?

Admissions - Billy Rankin

1. Required Courses - What can we agree on nationally which will be in concert with GPEP?
2. Traffic Rules - Do they serve well in their current form or are changes in order?
3. The Decline in the Number of Applicants and Overall GPA/MCAT of the Pool - What can or should we do about this Phenomenon?

Curriculum and Career Counseling - Sid Huggins

1. Are you a curriculum manager or a curriculum innovator or leader?
2. What are you doing to create an excitement for teaching and learning in years 1 and 2. What would you wish to do and what do you think you should do?
3. Whose responsibility is it to develop new systems of clinical teaching and evaluation in years 3 and 4. (Inpatient, ambulatory, Community Medicine).
4. What does the Millis Report and the preridency syndrome have in common?
5. Are elective auditions really compromising the 4th year of medical school?

Professional Conduct, Moral and Ethical Evaluations - Lenny Lawrence

1. Definition of Nature of Principles and Source of Concern. What are the Expectations and How are they Communicated?
2. Abuse of Patients - Is it Learned or Is It Innate?
3. Social Responsivity as a Professional Medical Obligation.
4. The Impact of Illegal Behavior on Student Status.

Impaired Students - Pat Wall

1. What are the realities of impaired students - Are some of us overreacting or should others open their eyes?
2. How far should faculties go identifying students who use illegal substances - are we justified in initiating drug screens?
3. Once identified, how should the impaired student be handled - helped or hindered?
4. If we help, how aggressive should we be in helping and who should decide how far we go?

IMPAIRED STUDENTS

OSR Facilitator: Billy Rice

LSU-Shreveport and Alabama were the only schools in our group who have any type of drug screening policy. Their policy is to "screen for cause", based on the recommendation of a faculty member. The LSU policy, which was agreed upon after many drafts and with significant student input, states that a student must have 3 positive tests before treatment will be required.

The questions of the "rights" of a physician vs. the rights of the rest of society was discussed. By choosing to practice medicine, do we waive certain rights in certain conditions that the rest of society retains? How do we respond to our unique role in society of direct responsibility for the care and welfare of our patients? Is it really an invasion of our privacy to test us for drugs - especially when there is cause for concern?

These thoughts were discussed with no consensus reached. However, one noteworthy idea that surfaces was that it is a privilege to be a physician - not a right. Perhaps we do give up certain "rights" by choosing to be a physician.

The idea of being our brother's keeper was discussed. It was generally agreed upon that we do have an obligation to each other as human beings to try to help and care for each other - even in the tough situations.

Any policy that might apply to students should apply to faculty as well.

PROFESSIONAL CONDUCT

OSR Facilitator: Billy Rice

There is a need to better education students on professionalism beginning early in medical school. This could be viewed as preventive medicine in the sense that by teaching and hopefully instilling in students an idea of what being a professional involves, one might avoid the potential unprofessionalism in later years.

This education would need to be a tangible part of the curriculum, perhaps as an aspect of existing ethics courses (please note however, that professionalism is distinct from ethics). Content area could include overcoming personal biases (part of a University of Tennessee - Memphis course on becoming professional deals with physicians speaking on "Patients I Don't Like") and the social responsibility of physicians. Hopefully this concept would be incorporated into teaching rounds during the clinical years.

This focus on education was not an attempt to disregard the need for a code of conduct that could be enforced. However, our group felt that the initial focus should be on preventive education rather than on "putting out existing fires" of unprofessional conduct.

ETHICS/PROFESSIONAL CONDUCT
OSR Facilitator: Bill Obremsky

The recommendation of our group (Red) are as follows:

- 1) Formal instruction in professional conduct is important to be taught in a required course as well as emphasized in all clinical clerkships.
- 2) Given that abusive/unethical behavior is often learned, medical schools should formulate a written policy outlining professional conduct expected of students, residents, and faculty in all clinical settings. This conduct must supercede all social, ethnical, and gender biases. A method of evaluation of professional conduct needs to be developed of students along with an evaluation of their clinical skills. Furthermore, students should have an opportunity and mode of evaluating the conduct of residents and faculty with this information forwarded to an appropriate source.
- 3) We also recommend a procedure for counseling and/or disciplinary action for students found to transgress professional/ethical behavior.

IMPAIRED STUDENTS
OSR Facilitator: Bill Obremsky

Our session on aid for impaired medical students was less productive as a wide variety of conflicting opinions arose. This was our consensus: 1) We recommend a confidential program for identification and treatment of impaired medical student be developed by AAMC schools. In addition a system of due process for students reluctant to submit to testing and/or counseling should be installed as well.

PROFESSIONAL CONDUCT

Moderator: Leah J. Dickstein, M.D.

OSR Facilitator: Jill Tilley Hankins

In summary, the "Yellow" group decided that professional conduct (defined as "concern about the welfare of the patient") should be evaluated. But before an evaluation would work, students must be given adequate definition and explanation of expectations. Introduction of these expectations could begin with integration into physical diagnosis, freshman/clinical orientation programs or existing Ethics Courses. Evaluations should include verbal communication, as well as, in written form.

The group also communicated that abuse of patients does occur, especially emotional abuse that can occur unintentionally. Perhaps a behavior or professional code of conduct, as well as good example, could have positive results for patients and students. In response to item #3 of Dr. Lawrence's list, the group felt that students should be responsive to 1) the local community, 2) the larger "community" and 3) peers. Many of the schools already have community-oriented, student-led projects in action. Medical education should be involved in preparing students for social responsibility.

IMPAIRED STUDENTS

Moderator: Leah J. Dickstein, M.D.

OSR Facilitator: Jill Tilley Hankins

Most of the schools in our group had some type of intervention program: 1) Aims, 2) Student Affairs Office, 3) clinical psychologists on salary, 4) psychiatrist through the Dean's Office or 5) a stress committee. Several issues were discussed such as informing post graduate programs, dean's letters and enforcement for the noncompliant student (many require leave of absence with a professional letter for restarting). Ways of prevention were discussed and Dr. Dickstein told us about the University of Kentucky at Louisville's program "Health Awareness Workshop", a four and a half day program with talks and meals for freshmen and spouses before classes begin.

The group discussed drug screening and seemed to agree that "for cause" screening was okay.

Summary - Workshop on The Impaired Student

Discussion

Many questions were raised. All agreed there is a drug/alcohol problem; many had direct knowledge of problems on their campus.

On the question of drug testing, who should be tested?

1. Only those whose impaired functioning offers "cause"?
2. Only former users who are being rehabilitated?
3. Or should we randomly test all health professionals?

Drug testing creates a lot of problems. There is the question of violation of civil rights, the destruction of relationships between students and teachers, the effect on recruitment of students, and lack of definition of "cause", to name a few. What action will we take with those testing positively? What about positives who are not impaired? There was generally a negative feeling about drug testing except for random testing of persons undergoing drug rehabilitation. There was also concern that testing yields false positives.

Drug screening does not address other types of impairment such as alcohol abuse and mental illness. On alcohol use, schools give double messages. They allow, even pay for, alcohol at social functions, often without guidelines. Administrators should control social functions to see that alcohol is not abused. Schools should have a policy on the use of illegal drugs and alcohol abuse and communicate this policy to students from day one.

Having identified drug/alcohol abusers, what should we do with them?

1. Rehabilitate
2. Suspend while rehabilitating, or
3. Suspend/dismiss

Do medical schools have obligation to report illegal drug use? Should the problem be identified in the Dean's Letter? The success rate for rehabilitating MDs is not good.

Finally, how do we handle professionals who are not impaired but who use drugs (illegal) or abuse alcohol (legal) outside of their professional activities, or who are involved in other illegal or anti-social activities that bring disrepute to the medical profession? What does the school/profession expect of the professional's personal life?

Positive Conclusions

The group was in general agreement about the following:

1. Schools should have a policy statement on drugs/alcohol.
2. Schools need to identify and help students who are impaired.
3. There should be an advocacy program.
4. Schools should attempt to rehabilitate their impaired students.

David M. Shapiro, Ph.D.
OSR Moderator: Red Starks

4/29/87

Summary of Workshop on Professional Conduct,
Moral and Ethical Evaluation

Discussion

Many in the group were uncomfortable defining a professional code of conduct and using it in the evaluation of students.

- A. Students were concerned that they would be evaluated by standards of behavior which are general and subject to interpretation. Students were not uncomfortable with honor code guidelines since these deal with specific defined acts. They also point out that they need good role models. The residents are too often guilty of lack of concern for the welfare of the patient. Students should not be the only ones subject to a professional code.
- B. Faculty were reluctant to define a code of professional conduct. Reasons given:
 1. Professional behavior should not be defined by specific acts; on the otherhand, it is hard to enforce non-specific behavior.
 2. Professional conduct cannot be taught, people come to medical school with different values of conduct.
 3. Behavior (virtue) is too hard to define.

Positive Conclusions

There was general agreement about the following:

1. There is a need to define and enforce professional conduct guidelines.
2. Even though we are not willing to define it, we all understand what we mean by professional conduct.
3. Standards of professional conduct should be broad and not specific. A good example of a broad statement would be "concern for the welfare of patients."
4. Standards of professional conduct apply to all health professionals, not just students.
5. Any disciplinary action resulting from infractions of professional code guidelines must follow "due process" procedures with appropriate documentation.
6. Students have a responsibility to enforce professional standards of conduct.

David M. Shapiro, Ph.D.
DSR Moderator: Red Starks

4/29/87

OSR Small Group Discussions

ADMISSIONS/FINANCIAL AID

Moderator: Paul Mehne

OSR Facilitator: Danny Shapiro

The focus of our discussion was on the implementation of GPEP recommendations to the application process. Some felt that the GPEP report was to be loosely interpreted and tailored to the needs of the individual institution. Others felt that the report should be followed closely; i.e. schools should require only a bare minimum of science courses.

After much discussion our group recommended that all schools adopt minimum requirements that include only 1 year each of biology, physics and math and 2 years of chemistry. It was also agreed that no school should recommend any other courses as this encouraged pre-med students to load up on sciences to the exclusion of humanities.

We also discussed the traffic rules of admissions. Some suggestions: 1) Financial aid applications should be made at the time of application to med school to expedite the awards process and thereby assist applicants in their choice of schools. 2) Establish a centralized application process tied to financial aid, 3) All medical schools should offer enough acceptances equal in number to one class size no later than April 1. 4) Medical schools should refuse to hold places for applicants holding more than one acceptance after a) May 1 or b) notification of financial aid awards.

TRANSITIONITIS/CAREER COUNSELING/CURRICULUM

Moderator: Paul Mehne

OSR Facilitator: Danny Shapiro

Discussion was limited to "transitionitis" as this topic evoked the most passionate discussion. An informal survey of the 19 schools represented in our group revealed that about half allowed their students to spend the entire fourth year at other institutions while others had a mixture of required on-campus courses and away electives.

Our group felt that away electives were generally a good thing as they allowed students to test their abilities in new environments. However, we agreed that "audition electives" encouraged students to focus their elective time on only one aspect of medicine and should therefore be limited. Bill Obremsky of Duke University pointed out that the biggest problem with the current system of away electives is that many students take the same course at many institutions. Subsequently he suggested that we recommend that students be limited to two or three away electives and that the Deans of each medical school disallow schedules with repeat courses.

ADMISSIONS/FINANCIAL AID

Bill Pietra

Discussion by our group (green) included the following:

ADMISSIONS

- 1) Required Courses. Group agrees that minimum required courses 1 year Bio, Chem, Physics be established, and that "recommended" courses be abolished. Also it was pointed out that as long as the MCAT remains in its current format that it will dictate what courses students must take in order to prepare.
- 2) Traffic Rules. Violations for this past year were discussed and it was disclosed that most of these occur between private --> to --> public schools, occurring late in the admissions process. Very high deposits which would be non-refundable were discounted. Recommendations were to move the final dates for admission back to June or July and that any late admissions of students admitted to any other school be preceded by a call from school wishing to accept the student to the school in which he had been accepted previously.
- 3) Decline of the Number of Applicants. This topic was discussed in terms of its possible etiology and possible significance. Implicated as enology were decline in number of 22 year olds, decline in the image of medicine due to financial and legal considerations but most importantly, it was felt that counseling of students considering a career in medicine has been significant. No concrete recommendations as to what could be done or even should be done were addressed.

FINANCIAL AID

- 1) Financial Aid Counseling. It was recognized that financial aid/ indebtedness counseling plays a vitally important role at every medical school but is typically lacking. It was recommended that the AAMC provide training for financial aid counseling; that each school should have 1-2 counselors; that financial aid staff be rewarded with higher salary because of the important role they have and are currently underpaid. Also, it was recommended that the AAMC set standards for the entire financial aid office in terms of personnel, training and services at each school.
- 2) Recruiting with Scholarship Dollars. The issue of merit scholarships was discussed, their role and whether they should in some way be based partly on need. It was felt that merit scholarships were not used with the primary intent of increasing a school's national board scores. No consensus was achieved on whether need should be a consideration of merit scholarships was achieved.

CURRICULUM AND CAREER COUNSELING

Bill Pietra

Discussion by our group (green) included the following:

CURRICULUM AND CAREER COUNSELING

- 1) Evaluation - Reward of Teaching Faculty. It was noted that student evaluation of faculty is not the best way because students tend to like the charismatic lecturer who is easy to take notes from and provides bite-sized chunks of info that are easily _____. The two track concept of research oriented and teaching oriented faculty, which are separate in their responsibilities but equal in importance, was promoted.
- 2) The idea of good broad base of relevant basic science and clinical material was endorsed. But it was noted that as long as the National Boards remain in their current form, teaching "for the Boards" will continue.
- 3) The character of today's medical student was also discussed and it was noted that his/her goal in medical school is not to get a well balanced general education in medicine but to "get a job" (residency). Some of the blame was put on the program directors. But it was also pointed out that this seems to be an attitude problem among medical students and the article which appeared in New England Journal was referred to. It was also pointed out that this idea of trying to get the medical student to be a life-long learner and have an independent thirst for knowledge be a goal of medical education. Teach them to learn.
- 4) Decline of the Ambulatory Care opportunity in medical school since the rise in HMO, etc. and their association with medical schools was discussed. All were in general agreement that the ambulatory care setting was vital to the learning experience in medical school and its decline has contributed to decrease in some primary care specialties like internal medicine.
- 5) The group agreed with AAMC's changes in senior year.

FINANCIAL AID
OSR Facilitator: Clayton Ballentine

FINANCIAL AID

Since the federal guidelines for financial aid change so rapidly, the key variable is well-informed, active, competent financial aid officers. The deans have to be convinced that money spent to hire good people is worth it for the student's sake and for its potential aid in recruiting good students. This June's conference in Washington D.C. for developing financial aid counseling programs and "tools" should be attended if possible and followed up at least by the financial aid officers. The approach should be broadened to include debt management and general financial information as well as being started as soon after acceptance as possible. This help should start at the door to med school, not 2 weeks before internship.

There is support for both want and need based financial aid from a variety of sources. Several programs were described such as U. of Tenn. offering a few full-ride merit-based scholarships to 20-30 students as bait for follow-up visits to U.T. which aids in recruitment of all 20-30. Overall, a balance needs to be struck between paying to recruit talented students and paying to ensure that not-so-rich students can still afford to go to medical school.

ADMISSIONS

OSR Facilitator: Clayton Ballentine

REQUIRED CLASSES

The general opinion of the group was that the required classes for medical school admission should be kept at a bare minimum.

"Recommended classes" lists should be eliminated. Since many students take these out of compulsiveness and much of that material will be completely re-taught in medical school. This will free up most student hours for taking other important classes to develop communication and problem-solving skills.

The MCAT is dictating the bare minimum now by its content. Some subjects may be on the MCAT merely as hoops to be jumped through and the exam itself bears re-evaluation.

The dangling questions are: how should the MCAT be changed; and how does the struggling student do in med school if he/she does not get the advantage of pre-exposure to the subjects that may present academic hurdles?

ADMISSIONS

OSR facilitator: Clayton Ballentine

TRAFFIC RULES

The main problem is a matter of scheduling. The last minute flurry of acceptances right as classes are starting complicates the lives of the affected students beyond necessity.

The earlier that classes fill and students know if and where they are going to school, the better for the schools and the students.

SOME STEPS TOWARD SOLVING THESE:

-Schools need to offer their acceptances early and in numbers at least equal to the number of class spots by a spring date (May 1?)

-Schools need to keep the national acceptance listing updated promptly after any actions taken, especially on students holding multiple acceptances.

-Because of the priority of financial aid offers in students' decision processes, schools should get financial aid applications processed as soon after acceptance as possible.

-Students should be restricted to holding only one or two class spots after about May 1, with subsequent acceptances requiring prompt notification of the schools as to which spot or spots will be retained. By using class spot deposit forfeiture as a penalty, compliance by students could be enhanced

-Waiver procedures for the rules about deposits need to be in place and accessible to financially disadvantaged students.

ADMISSIONS
OSR facilitator: Clayton Ballentine

DECLINING APPLICANT POOLS

Medical schools are going to have to start recruiting to keep getting good students.

Good financial counseling as early as possible in the process will aid recruitment. As will sending students back to their undergrad alma maters to talk to students and pre-med advisors there.

Also class sizes may need to be reduced as the baby boom fades to baby bust since inflated class sizes may lead to increased attrition rates.

CURRICULUM
OSR Facilitator: Slayton "Claxton" Ballentine
CURRICULUM CHANGES

Wide variation exists in the way schools approach and utilize the National Board Exams.

The way students are prepared for NBME I, ranges from a total curricular focus in the M-2 4th quarter on board review and study time to a full load of course work right up to the exam date. Given the general weight accorded to board scores, however inappropriate, by residency program directors for applicant ranking, some schools' students are at a considerable disadvantage. Board review courses are generally well received by students for the effects of reducing anxiety, bettering scores, refreshing knowledge and pointing out areas where concentrated studying is necessary.

On a broader focus, there is a widely held belief by students that appearance on national boards and not clinical relevance is dictating M-1 & M-2 curriculum. "You won't need to know this in the clinics, but it may be on boards" is the frequent rationale for inclusion of trivia in lectures. This calls into questions the content of the exam themselves and some mechanism for assessing practical medical relevance appears needed.

Any easing of this lecture burden will allow more emphasis on traditionally under taught material such as nutrition, preventive medicine and problem-based learning.

Students should have a voice in the curriculum design through official representation on whatever curriculum committees exist.

Also the AAMC may be able to provide valuable assistance in improving the curriculum by gathering information on the innovative programs and providing that data to those people charged with curricular oversight at all schools.

OSR Facilitator - Clayton Ballentine

CAREER COUNSELING

Currently, peer counseling and hearsay are the usual sources of information available to students looking at career choices. This lack of solid organized information causes a great deal of anxiety to students.

Greater emphasis should be placed on career counseling. More benefit seems to be gained by structuring small group or individual advising sessions. Since contact with role models in a given specialty continues to be the most important factor in selection of a specialty, priority should be given to programs that get students into small group or individual advising sessions with clinicians. Students should be allowed to choose their advisors or be assisted in choosing via information booklets and questionnaires as is done at Bowman Gray. The role of preclinical instructors serving as career counselors was called into question unless clinical faculty are also an integral part of the process.

The new dates for the residency matching program have helped open the narrow time frame for specialty selection. This will help reverse the effects of the Millis report and will make it easier for students to sample potential specialties, to broaden their medical knowledge, and to take offsite "audition" electives. In order to curtail the tendency for abuse of audition electives perhaps a limit should be placed on the number of offsite electives in a given specialty. This may handicap students from schools which impose limits considering the highly competitive nature of some specialty programs.

For those students who have a hard time deciding, internal medicine seems to be the choice to "buy time" because it may be the easiest training from which to step into another specialty.

INFORMATION DIRECTORY DATA

Name: Joseph L. Joyave
School: University of South Carolina
Information to Share: Basic Science Honor Code; Medical Practice & Society Course; Stress Committee info; Physical Diagnosis and Behavioral Science Courses in 2nd year; Clinical Correlations in 1st and 2nd year; Faculty-Student Liaison Committee; Changes in the 4th year curr.
Information Wanted: Sophomore orientation into Hospitals; Practice Management type courses; Honor Code/Ethical Code (!!); Hep. B/Vaccine Programs; National Board Preparation/Instruction; Medical Student Interaction with Undergraduate Government; Problem-based Learning.

Name: David Watson
School: University of Arkansas
Information to Share: 1) Noncognitive evaluation of students (ethical conduct; 2) AIMS; 3) Good availability of information for residency selection; 4) Free Hep B vaccine; and 5) Improved Student Health Insurance

Name: Dave Ehle
School: University of Florida
Information to Share: 1) Housing network to host medical school applicants; 2) Prying money out of student government; and 3) Orientation to the ward given by 3rd year students.
Information Wanted: 1) Still need ways to convince our administration that the Hep B vaccine should be provided free -- currently pay \$150 for the shots; 2) Stress reduction mechanisms that actually work; and 3) Programs to educate med students about business practices, setting up an office, etc.

Name: Bill Pietra
School: University of South Florida
Information to Share: 1) Computerized "elective" match (similar to National Res. Match Program); 2) Changes in 1st year/2nd year curriculum; 3) Receiving Hep B Vaccine for med students via clinical research; 4) Recent battle with animal rights activists at our school; and 5) honor code/professional conduct statement used at our school.
Information Wanted: 1) Computer Programs and networks; 2) Curriculum/transitionists, whether changes in extrenships are being made; 3) Use of National Boards to rank students vs. pass/fail; 4) Residency/match - survival manuals; 5) Insurance programs, liability problems; and 6) OSR rep's role in contacting their congressmen.

Name: Kathleen Huff
School: University of South Florida
Information to Share: 1) Fight with animal rights activists for use of pound animals for medical research; and 2) Student run note service of M-1/2.

Name: Danny Shapiro
School: Emory
Information to Share: 1) Hep B vaccine paid for by administration; 2) Ethics course in 2nd year, Ethics conference in 1/86; and 3) 'Theresa' and 'Colleague' computer programs as used at Grady.
Information Wanted: 1) Organization of 3rd year medicine rotations; and 2) AIMS.

Name: Ann Reynolds
School: MCG
Information to Share: Information on how to get medical liability exemption for students.
Information Wanted: 1) how to get insured for out of state rotations; and 2) How to solve problems between students and faculty that arise over class attendance.

Name: Shelly Birdseye
School: Mercer University School of Medicine
Information to Share: AMSA project with medical and nursing students working at the health department doing screening exams and family planning for approximately 20 students bussed to the health department from local middle schools.
Information Wanted: A policy about maternity leave for medical students. Is there is reduced call for nursing mothers?

Name: Cathy Corbitt
School: Morehouse School of Medicine
Information to Share: National Board Review.
Information Wanted: 1) AIMS; and 2) Use of computer software.

Name: Michael Rush
School: University of Kentucky Medical Center
Information to Share: 1) ___ monkey course; 2) Behavior Code; and 3) Insurance (Liability) for off-site rotation.
Information Wanted: 1) Curriculum during the 1st and 2nd years which provide clinical/potential exposure; 2) Computer-based or problem-oriented instruction; 3) Formal courses in ethics; 4) Community service program; and 5) Sexuality Courses.

Name: Tom Causey
School: Louisiana State University, Shreveport, Louisiana
Information to Share: 1) One week of orientation for freshmen that includes dinner with a faculty member; and 2) Reramping the curriculum.
Information Wanted: 1) Nutrition courses; 2) Programs done by medical students for local junior high/high school students; and 3) Debt management courses.

Name: Ray Germany
School: LSU Medical Center, Shreveport, Louisiana
Information to Share: 1) Honor Code; 2) Computer assisted instruction; and 3) Support group for stress management.
Information Wanted: 1) How to get free Hepatitis Vaccine; 2) Student insurance options; 3) Family Day information; 4) 'Theresa' Software information; and 5) Ward Handbook.

Name: David Kostick
School: Tulane
Information to Share: 1) Student-run Honor Board; 2) The 2nd year class has arranged to review charts for major drug company to help pay for class functions including our graduation; 3) A benefit for charity hospital, "An Evening for the Children." We raised gifts and toys and \$10,000(!); 4) A city-wide drug abuse awareness day talking to local Jr. and Sr. high school students; 5) "need projects," such as food drives for local food shelves and blood drives; and 6) The Student Executive Committee formed a financial sub-committee to investigate the problems of the financial state of students.

Name: Steve Krems
School: Tulane
Information Wanted: 1) AIMS program; 2) Info on revamping physical diagnosis course; 3) Computer info -- software and networks; 4) Free Hepatitis vaccine; 5) Problem based learning info; and 6) Handbook on clinical years.

Name: Billy Rice
School: Bowman Gray
Information to Share: 1) AIMS Council; and 2) STEP Program (Students Teaching Early Prevention).

Name: Lalen Koochek
School: University of North Carolina, Chapel Hill, North Carolina
Information to Share: Impairment Committee which is a combination of Faculty and Students.
Information Wanted: Ideas about how to tackle the problem of substance abuse before adverse effects on students' academic and behavior.

Name: Bill Obremskey
School: Duke University
Information to Share: 1) 7th grade sex education program; 2) student/faculty variety show; 3) Undergraduate Pre-med symposium; 4) Student Carnival fundraiser; 5) Public Health Clinic; and 6) Ethics through Literature course.
Information Wanted: 1) Professional Conduct Code; 2) AIMS; and 3) Computers.

Name: Penny McDonald
School: East Carolina University
Information to Share: 1) Primary Care Conference (interviewing techniques) in 1st and 2nd years; and 2) Medical Ethics Course in 1st and 2nd years.
Information Wanted: 1) Clinical exposure for 1st and 2nd years; and 2) National Boards preparation.

Name: Eva O'Neal
School: East Carolina University, North Carolina
Information Wanted: More National and Regional News.

Name: Wendell Novoa Colberg
School: University of Puerto Rico, School of Medicine
Information Wanted: 1) Free Hepatitis B vaccine; 2) Establishment and ruling of the Honor Code at different schools; and 3) Reviewing programs for the boards.

Name: Hugh L. Preas II
School: East Tennessee State University
Information to Share: Organization of a Medical Fraternity.
Information Wanted: Honor Code/Code of Ethics.

Name: Andy Spooner
School: University of Tennessee
Information to Share: Class Attendance Forum with Students and Faculty.

Name: Joe Prudhomme
School: Baylor College of Medicine
Information to Share: 1) 1st year retreat (the weekend before classes begin); 2) Day with a Doctor Program (a one-day clinical experience for basic science students); 3) Introduction to clinics workshop; 4) Grey Matter - a publication for new clinical students to carry in their pockets; and 5) Residency Planning Workshop and Manual.
Information Wanted: 1) Courses in Medical Economics; 2) "Chart Review for Drug Companies"; 3) Copies of Honor Codes.

Name: Tom Pajewski
School: University of Texas in Houston
Information to Share: Mechanic of setting up elective courses -- preventive medicine and nutrition).
Information Wanted: 1) Evaluation of courses (basic sciences and clinical); 2) Programs and data base relating to medical students/medical education; and 3) AIMS/Peer counselling.

Name: Bob Resnek
School: Eastern Virginia
Information to Share: 1) Programs established for teaching 7-9th grade students in the area of smoking, drugs, alcohol, STD's, and AIDS; and 2) Summer and Winter Retreats to discuss current topics in medicine (all students, faculty, administration invited).
Information Wanted: 1) Honor Code; and 2) Review courses for National Board exam, Part I.

Name: Linn Mangano
School: West Virginia University
Information to Share: 1) Recent LCME site visit (12/86); and 2) Pass/Fail System.
Information Wanted: 1) Problem based learning workshops for instructors; and 2) Computerization of curriculum.

FOR

THE SOUTHERN COUNCIL OF DEANS

Opryland Hotel - September 21, 1985

"Transitionitis"

Preparing for the transition into internship and residency training has been labeled the "pre-residency syndrome" by Gus Swanson in his terse but thoughtful editorial in the Journal of Medical Education for March, 1985. Therein, he calls upon specialty boards and residency review committees to mend their ways and provide relief for the Fourth Year medical student in this country. While awaiting any initiative on their part, the DEANS in this country can take steps to help alleviate some of the problems program directors have created. Towards that end, this presentation is made.

"Transitionosis" as the more specific diagnostic label was considered, and the condition does have some of the characteristics of metastatic malignancy. The term "transitionitis," however, seems more appropriate since this is epidemic in proportion and acute in nature but both curable and preventable. The DEANS' therapeutic intervention is urgently indicated. Some problems are presented followed by possible solutions.

What we have lost from the Fourth Year educational experience:

By virtue of the residency-seeking process as it now operates, no longer is it feasible for Fourth Year medical students to use:

- ◆ their third summer in medical school for research;
- ◆ their third summer and early fall academic units for clinical experiences (clerkships) to help decide among fields of potential interest;
- ◆ their Fourth Year for general professional education, emphasizing areas other than their intended field of specialization;
- ◆ their Fourth Year in imaginative and innovative ways to broaden their education and enhance the liberal and humanistic side of their education.

What we have instead in the Fourth Year:

Not only have we lost the above, but no longer can Fourth Year students approach the transition into residency training in an orderly, deliberate and thoughtful manner. Instead, what we have is a group of students:

- ◆ who have to spend half of their Fourth Year in a high state of anxiety and frustration;
- ◆ who have to spend time in visiting clerkships as a prerequisite even to be considered for a particular residency program with the attendant costs in terms of time applying, arranging temporary housing, paying registrations fees and/or tuition, and the dollar expense of all of it;

- ◆ who have to spend a great deal of time and money in filling out applications, trying to schedule interviews, traveling to interviews, being interviewed, and paying for all of it;
- ◆ who have to compromise their own educational experience or risk not making the transition, which makes them indignant, dispirited and resigned.

The underlying problem:

- ◆ The real problem is the program director whose conduct is self-centered and self-serving, who disregards his role as chairman of a department or division in the medical school and his obligations to medical students, and who seems to have forgotten he, too, was once a medical student seeking a residency.

As one of our junior faculty members in OB/GYN put it,
 "Our first priority is to get a good house staff rather than helping students get into the programs of their choice."

Specific problems:

- ◆ Programs which are not even in the Match.

Such programs feel they are not bound by any constraints; they may not be the best programs; they are often the earliest to offer the student a position; and they are the most likely to pressure the student into premature commitment.

- ◆ Programs which are partially in the Match, offering perhaps half of their PGY-1 (or PGY-whatever) positions through the Match and keeping the other positions in their back pocket for under-the-table negotiations.
- ◆ Programs which are in the Match but do not abide by the spirit and intent of the Match.
- ◆ Programs which have banded together creating separate matching programs. The "Colenbrander matches" are the best examples:

Ophthalmology (the original)
 Otolaryngology

Neurology
 Neurological Surgery

Dermatology and Colon & Rectal Surgery, although "Colenbrander" for a while, are now back with NRMP.

The newest match but not "Colenbrander" is the First Annual (1985) AUA Residency Matching Program for Urology (For PGY-3 positions available July, 1988).

- ✓ There is new this year the "Central Application Service for Ophthalmology" from Colenbrander. The student must send to Colenbrander a completed Colenbrander "home-made" application form, the Dean's Letter, transcript, letters of recommendation and address list. All material is then photocopied and reduced for distribution. There is, of course, a fee (\$35 for the first five addresses and \$35 for each additional five) for the service.

At least one program (West Virginia) initially announced it would accept applications only if they had been processed through Colenbrander. That program has since recanted. Apparently this is a "pilot program."

While I understand such a service represents a "convenience" for students (and therefore must be a good thing) and perhaps the idea even sprung from students, I object to it for the following reasons:

- 1) The University transcript is not longer "official" if it is duplicated and does not bear the seal of the University;
- 2) The Dean's Letter is null and void if it does bear the signature of the Dean or his designee;
- 3) There is considerable doubt in my mind whether Colenbrander has the resources to guarantee authenticity of submitted material in the manner of AMCAS, for example, where constant vigil uncovers fraud and deception.
- 4) There is doubt in my mind whether Colenbrander has the staff capable of duplicating and distributing such material in a timely manner.
- 5) The service imposes yet an earlier deadline to meet.

This year, I advised my students not to participate; Dr. Colenbrander himself phoned to learn my objections; and he said that the folders of Vanderbilt students would have to contain a letter explaining our students' non-participation.

It is interesting that Colenbrander's "Service" is trying to accomplish the reduction of duplication of effort at the same time we have been unsuccessful in gaining widespread acceptance of the AAMC's APPLICATION FOR RESIDENCY, which our students refer to as the "universal application form."

- ◆ Programs which require the student to serve in a visiting clerkship before even being considered for a residency.
- ◆ Programs which have "pre-application" in order to get an application form.
- ◆ Programs which interview on only two days in the entire fall.
- ◆ Programs which interview on only one day of the week.

Our Department of Surgery is a good example, seeing applicants only on Saturday mornings. I understand that surgeons may be operating the other five days, and maybe it is a good thing to put a ceiling on the student since there are only so many Saturdays in the fall. But, it makes scheduling difficult for students.

- ◆ Programs which establish unreasonably early deadlines for application.

I can see no justification whatever for a deadline of August 15th when interviews are scheduled after the 1st of November.

- ◆ Programs which, although no early deadlines are announced, nevertheless have a cut-off at the first, say, 100 applications for their 2 positions and will not consider any applicants after that, regardless of their qualifications.

The process of applying for internships:

- ◆ The student writes off for descriptive material and application forms;
- ◆ The application folder must be "complete" with application, Dean's Letter, transcript, all recommendations and whatever, before it is submitted to "the committee" for review (this usually takes 2 weeks);
- ◆ The "invitation to interview" is extended either in writing or by phone, and the student must then schedule the interview date, interdigitating it with any other interviews already scheduled;
- ◆ In order to qualify for reduced airfare rates, the ticket must be bought at least 30 days ahead (adding another 4 weeks to the early deadline);
- ◆ On unlimited mileage tickets, the airline often requires the passenger to return to some focal point. For example, the student flying from Seattle to San Diego may have to fly to Denver first and then transfer. It is enormously time consuming.
- ◆ The student applying to PGY-1 and PGY-2 programs (most of the Surgical subspecialties, many Radiology programs, Emergency Medicine and others) simultaneously must invest at least twice the time and effort and money and two separate rounds of applications and interviews.

Vanderbilt's Dean's Letters:

Like approximately half of the medical schools in the country, Vanderbilt's Dean's Letters are written by a single individual. He enjoys the task but earlier and earlier deadlines place undue stress on the process. Another growing problem is the total number of applications being mailed out. Last year for 100 students, we sent out 1,850 Letters and transcripts. This year, we entered into a gentleman's agreement that a reasonable number of applications for the student applying to PGY-1 programs would be 15, and for the student applying to both PGY-1 and PGY-2 programs, a reasonable total would be 25. More than that, and we charge the student for each transcript. To show you how effective that agreement has been, we have one student this year applying for Orthopedics who has, to date, requested 94 copies of his Dean's Letter and transcript.

MATCH RELIEF, INC.:

"Created by medical students for medical students" is MRI, an entrepreneurial invention introduced this summer which, for a fee of \$88, will perform some of the steps involved in NRMP application. We provide most of those for our students at no cost, such as addressing envelopes. It is designed to relieve "THE MATCH HEADACHE," but none of our students, to my knowledge, has used it.

Some possible solutions:

To combat the entropy threatening the entire transition process, DEANS should agree that there are problems, that the problems can and should be resolved, and that the problems shall be resolved by collective, concerted action on their parts.

Each DEAN should inquire of the program directors within his own institution as to their policies with respect to the transition process, realizing the solutions will not come from them individually or from their specialty associations without external force.

- ◆ Have LCME accreditation of medical schools include full participation of all its affiliated residency programs in the NRMP;
- ◆ Insist that specialty associations, if they must have separate matches, do so through the auspices of the NRMP;
- ◆ Encourage specialty associations and specialty boards to reconsider the whole training process and the undesirability of such early commitment on the medical students' part to specialty careers. Delaying selection of candidates for PGY-2 and PGY-3 positions until, at least, midway in the internship year would result in surer selection and fewer wipe-outs along the line.
- ◆ Encourage NRMP to continue reconsidering the entire process and to seek innovative solutions for implementation with the full support of the DEANS.
- ◆ Insist on the elimination of individual application forms in favor of the GRADUATE MEDICAL EDUCATION APPLICATION FOR RESIDENCY provided by the NRMP and developed by the AAMC.
- ◆ Refuse to release Dean's Letters and official university transcripts to any other than bona fide residency training programs.
- ◆ Honor the recommendation of the AAMC's Task Force on Graduate Medical Education in 1981 that no Dean's Letters and transcripts are to be released prior to October 1st, and this should include the Armed Services as well.
- ◆ Consider recommending that program directors accept residency applications only from students in medical schools approved by the LCME.
- ◆ Consider limiting the Fourth Year medical student to two clerkships in the area he intends to specialize, only one of which may be a "visiting clerkship."
- ◆ Insist that programs remove even the suggestion that a "visiting clerkship" might be pre-requisite to consideration for residency.
- ◆ Refuse to accept any "visiting students" except those from LCME approved medical schools.
- ◆ Cut back on class size.

Philip W. Felts, M.D.
Assistant Dean, Student Affairs
Vanderbilt University School of Medicine

New Jersey }
Maryland } K

MEDICAL CARE FOR THE INDIGENT

At their meeting of September, 1986, the Midwest deans developed the attached statement on medical care for the indigent for consideration by the CUD Administrative Board.

The AAMC's recent statements on this issue can be summarized briefly. At its September, 1983 meeting, the CUTH Administrative Board reached a consensus that the two major policy issues requiring attention and increased emphasis were the financing of both charity care and graduate medical education under price-oriented payment systems. In September, 1984, Dr. Haynes Rice presented an AAMC statement (see attached) on "Uncompensated Care and the Teaching Hospital," to the National Council on Health Planning and Development, DHHS (the same statement was presented later that month by Dr. Robert Heyssel to the U.S. Senate Subcommittee on Health, Committee on Finance). In the statement, the AAMC expressed concern about the effect of the uneven distribution of uncompensated care across hospitals in a price-conscious competitive environment. In July, 1985, Dr. James Bentley testified before the Senate Subcommittee on Health, Committee on Finance, regarding Medicare's prospective payment system. The AAMC argued that the higher costs to hospitals of indigent Medicare patients was an appropriate expense for the Medicare Trust Fund.

The AHA and AMA have been active on the issue of indigent care. The AHA has proposed both long and short-term initiatives to the financing of indigent care, involving both the public and private sectors (see attached executive summary of report). The AMA's Council on Medical Service has prepared several reports, including one on the characteristics of the uninsured and underinsured populations (see attached). In the last year, the AMA has used these data to develop proposals targeted at various subgroups of these populations, which center on the development by states of risk pools. A concise summary of these recommendations is currently being prepared by AMA staff.

The position paper adopted by the Midwest deans contains a number of admonitions for the AAMC which the Board should consider:

- There is adequate money available within the current system for the proper care of the indigent if the services were properly organized and emphasized preventive care.
- It is important for the AAMC to make a public commitment to the care of the indigent both to contribute to the national dialogue on the subject and to clarify public perceptions as to the non-self-serving character of our interest.
- An important role for the Association is to develop not only a commitment to a provision of quality care, but a mechanism by which the quality of care can be assessed and evaluated.

Recommendation: That the Board consider the position paper formulated by the Midwest Deans and discuss the appropriate role and position of the AAMC with respect to the issues raised.

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HEALTH CARE FOR THE MEDICALLY INDIGENT
POSITION PAPER
MIDWEST/GREAT PLAINS DEANS

At its meeting in September, 1986, members of the Midwest/Great Plains Section of the Council of Deans and invited representatives from the AAMC and its governance structure addressed the issue of the role academic institutions might play in improving the health care provided to the medically indigent. During the first half day of the meeting, deans from four separate areas of the country described unique approaches that have been tried in their communities to address the problem. The second half day was spent discussing the following:

- a. What issues concerning quality and access should be addressed by academic institutions?
- b. How should academic medical centers integrate missions in education and research into a system of health care for the medically indigent?
- c. What are options for financing a better level of health care for the medically indigent; is capitation the best approach?
- d. What are the political ramifications of academic institutions taking a more active role in addressing the problem of improving the delivery of health care to the medically indigent?

The discussion of these questions led to several points of agreement. For example, the term medically indigent should include not only the traditional public aid recipients but also those who are uninsured or underinsured. A high proportion of the approximately 40 million people in these categories are employed but either cannot participate in group insurance programs or cannot afford the premiums. There also was general agreement that there are few acceptable measurements of the quality of health care. An early requirement is to work with other entities in organized medicine to define quality and defend it in all components of the delivery system.

A multitude of problems relating to financing health care to the medically indigent were discussed. Suggestions for funding this care include expanding government programs such as Medicare/Medicaid, dismantling Medicaid and reorganizing reimbursement for nursing home care, etc., developing a risk pool for commercial insurance companies to be reimbursed by government for care rendered, pursuing a federal or state capitation system. The issue is complex, but many feel there is enough money in the system, if it is utilized to emphasize health education and prevention of illness rather than crisis intervention.

The political implications of a more proactive role of academic medical institutions in focusing attention on this issue are extensive. It is imperative to clarify and communicate our motives, help increase the power base of and advocacy for the medically indigent, and work with other organizations such as the AMA. The latter could be facilitated by working with state associations and supporting the activities of the Section on Medical Schools in the AMA.

The following represents a statement of positions the Midwest/Great Plains Deans suggest for adoption by the Administrative Board of the Council of Deans:

1. A diverse population of patients from all socio-economic, cultural and ethnic groups in our society is an important element in the educational experience of today's medical students and house staff, and should be cultivated by academic medical centers.
2. Academic medical centers must include within their research missions not only the typical clinical and epidemiological study of medical problems among economically disadvantaged populations, but must be leaders in developing, modeling and evaluating innovative approaches to delivering and financing medical care for the poor and medically indigent.
3. The system of medical care in which our students and residents learn must increasingly reflect the system in which they will practice medicine. Thus, appropriate ambulatory care programs must be incorporated into those educational experiences. That same system of care must be provided in our academic medical centers for the poor and medically indigent.
4. Academic medical centers and their leaders must be strong advocates for methods of financing health care for the poor and medically indigent that will ensure viability of this linkage between our academic mission and our commitment to providing care in a modern, relevant system of care.

By taking a stance on the issue of health care for the medically indigent, the AAMC may serve as a catalyst for beneficial change and can begin the process of improving its image with those who think it traditionally only takes positions that are self-serving.

10/25/86

University of Colorado Health Sciences Center



University Hospitals
School of Medicine
School of Nursing
School of Dentistry

4200 East Ninth Avenue
Denver, Colorado 80262

October 7, 1986

TO: Members of the Administrative Board of the
Organization of Student Representatives
FROM: Henry K. Silver, M.D.
Associate Dean for Admissions
SUBJECT: Medical Student Abuse

Dear Members of the Board:

I am writing to you as members of the Administrative Board of the Organization of Student Representatives of the AAMC to obtain your assistance in helping us carry out a survey of the frequency and significance of medical student abuse in various schools in the United States and Canada. After reading this letter and the accompanying reprint which describe the background and plans for our study, I hope that you will agree that although medical student abuse is a problem of unknown magnitude it is one that could be a very significant cause of concern to students and one that could interfere with their education. We feel that medical student abuse deserves more attention that it has received in the past, and we hope you will be willing to consider this letter at your board meeting on Friday afternoon, October 24, 1986 and the refer it for discussion to the business meeting of the OSR on Sunday afternoon, October 26, 1986.

Medical students with whom we have discussed the problem of abuse have been almost unanimous in stating that they feel that it is a problem of potentially great significance and that medical students themselves should take an active part in studying it, determining its importance, and in working with others to develop procedures for its prevention and management. We believe that student representatives from a number of schools will appreciate the importance of what we want to do and so will be willing to arrange for a survey to be carried out at their schools. I also hope that they will want to participate in future planning to develop procedures and protocols to deal with various aspects of the problem.

Since we have found that the survey of abuse of students is best carried out by the students themselves and that their input is crucial at all stages of planning and implementation, we are contacting you and other members of the OSR Board to ask you to participate in implementing a survey of students at a number of medical schools so that we can obtain a clearer picture of the importance of medical student abuse.

You may know that in 1982 in a Commentary in the Journal of the American Medical Association I speculated about the possible reasons that many medical students changed, over a period of weeks or months after admission to medical school, from eager, alert, enthusiastic, and excited men and women to cynical, dejected, depressed, and frustrated persons. I wondered whether some of the changes we saw in medical students might be due to abuse and suggested that the changes were the result of avoidable, unnecessary, and harmful abuse, a malady that had long been known to exist but has either not received adequate

recognition or been largely ignored. I wondered what would happen if the subject of abuse was brought to the attention of the faculty. Would the faculty want to learn more about the reasons for the changes that occurred in these students?

After the Commentary was published, I received a large number of letters from physicians in practice who indicated that they had been abused in medical school and that it had affected them and their education a great deal; its effects had continued to affect them even after they entered practice.

Although it was easy to speculate about the extent and severity of medical student abuse, I couldn't be sure that it was a significant problem. Was it a major and widespread one or did it involve only a few students and very few faculty members and members of the housestaff? Was the abuse some students experience severe enough to have a marked impact on their education, their future lives, and the care they will provide their patients? And, most importantly, what could and should be done about it?

In order to obtain additional information to answer the speculations raised in the Commentary, I arranged for a colleague to join me in surveying a sampling of students at the University of Colorado School of Medicine. I also wrote to a number of associate and assistant deans who were involved with student affairs in medical schools across the United States to obtain their impressions of the incidence and severity of medical school abuse at their schools. In addition, students in all four classes of the medical school in Colorado were invited to meet with us to discuss whether they had been abused and talk about any other aspect of the subject of interest to them. Approximately one-tenth (fifty students) of the medical school student body agreed to talk to us. About half of these students reported they had, to a variable degree, been abused and humiliated by faculty members, residents, or others. In contrast, of the 18 responses we received from representative associate and assistant deans, 16 of them denied the existence of abuse of medical students at their schools.

In a second Commentary in the JAMA (see enclosed reprint) we reviewed the comments of the respondents, speculated further about medical student abuse, and offered our preliminary interpretation and recommendations regarding its prevention and its management after it occurred. We stated, "Verbal abuse, humiliation, and the undermining of a student's self-esteem are not only harmful to students and destructive to medical education - they are untenable. Abuse of medical students has the potential of being one of the most stressful and demoralizing features of medical education and as such it should not be condoned. Attempts should be made to discover it and to eliminate it whenever it is found. The goals should be the prevention of abuse, the protection of students, and the interruption of what seems to have become a generational legacy." We are asking for your assistance so that all of us working together can meet these goals.

Because the findings reported in the commentaries were derived mainly from an unsolicited group of physicians and from an essentially self-selected group of medical students, we feel that it is necessary to carry out studies

of frequency, significance, and other characteristics of abuse as perceived and reported by students. If abuse is found to be a significant problem, we need to develop (or improve) codes of conduct for those who have significant contact with medical students; develop an improved method of reporting abuse; determine the steps necessary to prevent medical student abuse from occurring; define methods of dealing with those who are determined to have inflicted significant abuse; study the effect of abuse on various groups of students and on different aspects of their education; and determine how to alleviate the effects of abuse on the students who have been abused.

The following are some of the specific studies and procedures that will be carried out:

- oo Students enrolled in a number of schools of medicine will be surveyed by questionnaire to determine the frequency, severity, place of occurrence, person who inflicted the abuse, long- and short-term effects, and other characteristics of medical student abuse.
- oo A Task Force and an Advisory Committee of students, faculty representatives, and appropriate consultants will assess and evaluate the results of the surveys at the participating schools and assist in improving guidelines, protocols, codes of conduct and procedures to deal with the prevention and management of medical student abuse.
- oo Plans will be developed to study the effect of abuse on the education of medical students and on the quality of their academic experience.

The project herein described will be the first in which medical student abuse will be studied in depth. We estimate that there are a large number of students each year who are significantly influenced by the abuse they experience in medical school. Increased knowledge about various aspects of medical student abuse will permit us to develop the means of preventing abuse and of delineating methods of assisting those who have been abused.

I had planned to be available to the Administrative Board on October 24th in New Orleans and for the Business Meeting on October 26th. However, on being told that there would be very limited time to present my proposal at either of these meetings, it seemed more reasonable to write this letter to you and leave it up to the Administrative Board to consider this and then decide how to have it presented at the Business Meeting.

Please call me collect at (303) 394-7361 before you go to New Orleans if you have any questions about my proposal or if you wish to discuss how it might be implemented.

Sincerely,



Henry K. Silver, M.D.
Professor of Pediatrics
Associate Dean for Admissions