

The Northeast OSR TRANSCRIPT

National Convention, Chicago, Illinois, November 11-13, 1988

Northeast OSR: Upcoming Events by Beth Malko, U. Conn. Northeast OSR Chair

Dear OSR Reps,

Hi! It was great to see you in Chicago. To the new reps-welcome, I hope you had a good experience and are excited about working hard! Tom has told me I need to keep this short so here goes:

1. I'm the rep to the Northeast Group on Medical Education's Steering Committee. I met with them on Sunday in Chicago. They will be having their spring meeting in Providence on April 3-5th. They are going to break into about 6 groups and have continuing workshops where each group tries to design the ideal curriculum for the portion of medical education they are dealing with (i.e. one group will address Basic Science., one ICM, one ethics, etc. Dr. Stephen Smith, Brown, will be the program chair. Please contact me or Yeva Johnson (Brown) if you're interested in attending. I think student input could go so far in each of these issues.

2. Spring meeting. Let me just re-mention where we'll need help:

a. Thursday afternoon workshops: 2 or 3 run by NE OSR about 35-40 minutes long. Many of you offered and I have a list of names and I'll be calling you soon to get definite commitments. If you offered please think out in detail what you'd do and how you'd do it so we can firm things up when I call you.

b. Saturday night "Projects at my School": NE and South will present 3 ten minute talks each detailing something excellent done at your school. Again many of you volunteered and I'll be calling you for firm commitments. Remember also that those people who present will be asked to submit a short document to Wendy in February for distribution at the meeting. Also at the

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Northeast OSR members after the last meeting

OSR Main Plenary - Society, and Ethics, Public Health and Science : Focus on Health Policy by Thomas Lee, Cornell

With Kim Dunn, OSR Chairperson, presiding, the plenary began with, Dr. Alfred Gelhorn, chairman of the commission on Graduate Medical Education of New York State. Much of Dr. Gelhorn's discussion centered on many of the changes that have occurred in medicine, issues that must be addressed at some point. Of all the factors of medicine to be affected, it is the house officer that has taken much of the impact of this changing environment. With the advent of DRG's and other financial constraints, patients who were admitted tended to be sicker and also spent less time in the hospital. Academic hospitals were becoming more like ICU's. These and other factors have made the already demanding job of the house officer that much more difficult. In addition to having more responsibility and control taken away, house officers are less able to see the complete pathology of the patient's disease. In an attempt to confront the growing problems in medicine, Dr. Gelhorn has targeted several key issues, a primary concern being the working environment of the house officer. It was felt that the past 80 hour work week of 36 hours on - 36 hours off put too much stress on the HO resulting in such things as a high divorce

and suicide rate. The committee on graduate medical education of New York state came up with several proposals. The first was to revise the work schedual to 24 on - 24 off with HO's having supervision by an attending on call at all times. Additionally, it was felt that graduate medical education was very fragmented in that it was not integrated with no main office being responsible for overseeing post-graduate education. One resolution, Dr. Gelhorn proposed, would be to have a consortium composed of faculty from both the medical schools and affiliated hospitals charged with the responsibility of governing post-graduate education. Other issues needing attention are physician reimbursements with less emphasis on procedures and more on the cognitive process. Additionally, to attract more physicians into primary care there needs to be a corresponding increase in future reimbursements. In the midst of all these changes, Dr. Gelhorn stressed how important it was to always remember the principle philosophy of medicine and healing, that of providing care and compassion to your fellow man.

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Letter from the Editor:

By the time most of you receive this newsletter, you will all probably be going through one of the more busy times of the year. Many of you are probably finishing up exams while others may be just starting. Those who are fortunate enough not to have either are busy getting ready to go home and take care of holiday shopping or catching up on some neglected school work. If there is anything that I have found true about med school it is that we are always busy. Whether it is trying to stay on top of the workload or struggling to wake up for an early rotation, we often find ourselves running fast just stay in place. As a result we rarely get the chance to stop and reflect on what is going on around us.

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Demographics of Health Care and Education: Are We Investing in a Brighter Future?

by Karin Berger Cornell OSR

Dr. David E. Hayes-Bautista (Ph.D.), a professor at UCLA School of Medicine, dynamically addressed the health care needs of the elderly who are poorly served by our health care system. Dr. Hayes-Bautista began by looking at the changes which have occurred in the United States' population, mainly that as a society we are growing older and that the Latino population is rapidly growing at an estimated 6.6% per year (all figures represent statistics in the state of California). By exploring the issues of mortality, migration, and fertility, he argued that although the two concepts of an older society and rapidly growing Latino population are not usually linked, they are actually related. This concept underlies his entire argument and proposed "remedy" for the health care of the elderly.

Dr. Hayes-Bautista presented many interesting statistics in order to convey the changing structure of this country. In 1860, before industrialization, there were high fertility and mortality rates. With increasing urbanization and industrialization, however, mortality and fertility started to decline except for the "blur" of the baby boom. By 2030, he predicts that we will be an old society in which one out of four Americans will be older than 65 years of age.

Accepting this trend of an eventually old society, Dr. Hayes-Bautista explored the issue of how the younger societies relate to the older generation. Since we have been witnessing an increase in nursing home placement, it seems that the

children cannot continue to take care of their parents. There has also been a sharp rise in the expenditure for the elderly, and by 2030, the federal outlays for the elderly as a percentage of the total federal budget is projected to be 65% compared with 13% of the year 1960. Where will this money come from? The magnitude of money necessary is phenomenal.

At this point, Dr. Hayes-Bautista posed a number of questions including: "Americans are living longer but who will foot the bill?", "How much do we value the elderly?", and "As a society, how do we relate to one another...to other generations?". He then proceeded to address the second variable; the growing Latino population. "What we are experiencing is a pediatric society, the immigrant average age being 17, right near a geriatric society," he stated. He pointed out that since Latino fertility is high, the different generations of people living in the United States are being inhabited by different ethnic groups.

Since it seems that the younger generations are being monopolized by the Latino population whereas the older population is mainly composed of the Anglo population, the concept of the productive, working generation taking care of the dependent youth and elderly will cross cultural lines. Well, considering the fact that the productive generation will comprise less of the population than the elderly, who will

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Computers: Tools for Medical Education in the 1990's

by Eric Kraut, Georgetown OSR

Speaker: Michael McCoy, M.D.
Assistant Dean, instructional computing
UCLA School of Medicine

Various topics were brought up during this meeting concerning computers and medicine:

I. Will computers dehumanize medicine?

Dr. McCoy says no. Computers will humanize medicine more because they will give doctors more time to do what they do best, that is empathize and relate to the patient, while the computer

will take care of a lot of scut work. The computer can do all of the dehumanizing chores that separates the physician from his patient such as searching through literature. The physician can thus be more efficient.

II. Advances in technology.

Dr. McCoy quoted Gordon Moore - "More electronics are manufactured each year than existed in the world at the beginning of that year." The technology is growing so fast it is hard to buy a computer and not have it outdated the next

year.

III. Computer role in Decision Analysis.

Computers can be extremely useful in teaching doctors to use information that is available to them. Physicians are continually faced with the task of making correct, critical decisions based on the information available to them. In the past, physicians were expected to use their memory to correlate information in the literature with information about their patients to reach diagnostic and therapeutic conclusions. With the

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Clinical Teaching at Bedside: Improving House Officer Teaching Skills

by Karen Murray, Johns Hopkins OSR

During the discussion group Saturday afternoon, November 12, entitled "Clinical Teaching at Bedside", topics concerning clinical teaching by attendings and house staff and how their teaching skills could be improved, were covered.

Moderated by Cynthia Carlson, OSR rep University of Washington, Dr. Jan Hirshman, associate professor of internal medicine at the Seattle VA hospital, opened the discussion by describing his own teaching methods during rounds. He has the intern present the patient's history just outside the room or at the bedside and then proceeds into the room where he himself performs the physical exam, highlighting the positive findings. The group as a whole then goes to a conference room where they hear lab and study findings and then discuss the case. He relates that he began doing the physical himself upon entering the room instead of having related verbally when students and house officers expressed concern that they lacked adequate instruction in performing the physical.

One of the students attending the session volunteered that in addition to the above mentioned, the attendings at her school were in practice of selecting a medical student house officer at rounds to do selected portions of the exam in front of the group and then describing the findings which the attending would then comment on. She feels this is an

excellent way of teaching and involving the groups.

Dr. Jay Ramsey, Associate Professor of Internal Medicine at University of Washington, questioned the group as to the importance of bedside teaching. Only 50% of the group said they actually see patients with their attendings during rounds and less than 25% were even observed doing an H+P by a house officer or attending. Everyone agreed that such teaching would be beneficial.

The questions of what to do to encourage better teaching on the part of attendings was then raised. Sam Steel from Georgetown School of Medicine volunteered that each year, the students award the "Golden Apple Award" to the teacher they vote was the best that year. Someone else suggested that simply verbal praise was very effective in encouraging better teaching. The possibility of having teaching programs for the attendings for developing their teaching skills overall thought to be an excellent idea that few institutions employ. University of Washington School of Medicine is just this year getting such a program underway. Overall then the group agreed that bedside teaching is a highly valuable experience and that more must be done to improve the teaching abilities of our attendings.

Plenary (continued p.1)

Dr. Roger Jellifee, Professor of medicine at University of Southern California, was the second speaker of the plenary and commented on how the science of medicine has reached the level where we should now be able to be more accurate and quantitative in our medical treatments. Instead of giving a dosage based on just the criteria of child/adult, physicians have the means to control and optimize the therapy to that individual patient. Instead of taking blood measurements of a drug the next day, the physician can take more frequent measurements and create a time course. Technology now allows physicians to carefully monitor their patients and can provide detailed information. With this new information, not only can the diagnosis and treatment be more accurate, but it will also allow physicians to use decision analysis techniques enabling a more objective approach to the diagnosis. Dr. Jellifee's views were summarized in an analogy he gave of the Wright brothers, "What made their achievement great was not that they were the first to fly but that they were the first to fly with control."

Dr. George Pickett, MD MPH, Professor, University of Michigan School of Public Health, followed Dr. Jellifee's talk by focusing on how few potential patients actually end up seeing a physician. Since it is up to the patient to contact doctor when he or she is ill, there are many opportunities for patients to "sift" themselves out of the process of making an appointment. Some may end up taking home remedies for an illness, others may see a chiropractor or osteopath, and still others may elect to do nothing at all. In the end only one in three potential patients actually reach a physician. Once a patient has seen a doctor, an effort must still be made to ensure that the patient comes in for follow up physicals. Dr. Pickett noted dentists as models for enforcing return check ups. There is no reason physicians cannot do the same.

Dr. Roger Bulger, President, Association of Academic Health Centers, ended the plenary by stating that while medicine prides itself on

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Jeralyn Bernier, past Northeast OSR Chairperson, attending her last OSR meeting

International Health: Inspiration and Information

by Ellen Hight, Boston Univ.

This exciting workshop started out with a slide presentation by Gabriel Smilkstein M.D. He focused on the development of preventative and primary health care systems in the developing world with fascinating slides from his ventures into such countries as Africa and Thailand. His compassion and dedication for working in these countries was demonstrated by his genuine enthusiasm for his projects and his emphasis on respect for the local community medicine.

Following his presentation was a panel discussion with OSR representatives Carol DeCosta, Ashleigh Head, and Cindy Knudsen, all of whom had exciting stories to tell about their experiences abroad as well as ways to fund these adventures. Following is an outline of "how to set up a project abroad" presented by Carol DeCosta who travelled to Haiti on a Smithkline Beckman Scholarship.

I. Choose a topic of concern to you and formulate a hypothesis

II. Identify a location where this question can be best answered or where information can be obtained

III. Contact possible sponsors for the project

A. funding (e.g. Smithkline Beckman): use several funding sources if possible

B. obtain supervision while in foreign country both here and in the country of interest

IV. Write a proposal including methods and materials

V. Begin Early

You can contact Carol at (716) 839-2907 or (716) 462-5609

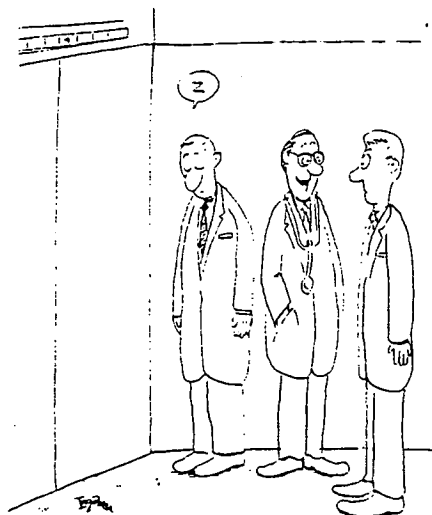
In terms of funding, other creative ideas presented by Cindy and Ashleigh include asking student government or Dean of Students, workathons, or T-shirt sales.

Obtaining contacts abroad can be problematic especially in schools which do not have an established International Health Program. Suggestions for overcoming this include sending a letter to all faculty members in your school who have

worked abroad asking about their contacts and establishing a file with this info; going through schools that already have established International Health Programs such as Yale, Boston University, or Georgetown; and AMSA has a publication on International Health Electives for Medical Students which can be obtained through your AMSA chapters.

Plenary (continued p. 3)

being scientific, a significant part of the success in treatment may not be due to the medication itself but rather to the faith the patient has in the doctor. While such a placebo affect should be used to the physician's advantage, it underscores how little the medical community really understands about the actual affects of the treatments given and that more basic research still needs to be done in all areas of medicine. On a more philosophical note, Dr. Bulger finished his talk by discussing the beliefs of Dr. William F. Noyes, a physician at the turn of the century. Dr Noyes described a covenant each doctor has with his fellow man and in that covenant, the physician is compared to the good samaritan who offers help to those in need. As times have changed, so too has medicine and with the advent of third party payment, the philanthropy described in that covenant has diminished. Dr. Bulger, like Dr. Gelhorn, asked physicians to reaffirm their commitment to society.



You're not a real doctor until you can fall asleep standing up.

Computers (continued p. 2)

progress that has been made in computer technology, we can do more than back up our decisions by saying that "in our experience...." The storage, retrieval, and management of information is necessary to aid medical decision making. The use of computers to aid in decision making is increasing at a rate of 13% per year, and the scientific data base is doubling every 5.5 years according to Thomas Piemme, JAMA 1988.

IV. Educational computing.

With this rapid increase in the wealth of medical information, much of a student's time is taken up by rote memorization of facts. Therefore, medical schools need to start teaching people how to think instead of teaching them just facts to memorize. The Panel on the General Professional education of the Physician of the AAMC recommended changes in its 1984 report: 1) Medical faculties must limit the amount of factual material that students are expected to memorize; 2) Medical faculties should adopt methods to identify students who have the ability to learn independently provide opportunities for their further development of this skill; 3) Medical faculties should consider major reductions in passive learning and require students to be active, independent learners and problem solvers; 4) Medical schools should lead in the application of information science and computer technology and promote their effective use. Dr. McCoy stated that students should learn a functional level of computing just as they have with pharmacology. Since computer assisted learning allows the student discretion of content, time, place and pace of instruction, it is essential that we teach computers in medicine.

Some schools use computer based exams. In computer based exams, the student is asked a question of known difficulty. If the question is answered correctly, a more difficult question is asked. If the question is answered incorrectly, a less difficult question is asked. An asymptote of performance is established. If the performance of a

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Upcoming Events: Spring Meeting *Continued p. 1)*

meeting everyone will be asked to write a BRIEF summary of a project at their school. This will be copied during the meeting and distributed to each rep at the Sat. night meeting so make sure you've thought about it in advance.

c. The Post Spring Meeting Newsletter: The way I understand this is that everybody more or less feels that a conference is an unworkable project but we would like to produce something we could pass around at our schools. So everybody mentioned a topic that they were interested in and Sarah wrote it down. What we'd like to do is have everybody bring to the meeting some information, a great article or list of references or a short statement, on that topic. These will be collated and made part of the following newsletter, a sort of resource document that each member could place in the Dean's office or photocopy and distribute at their school. So please bring something with you for the newsletter.

3. Newsletter: Kudos to Tom for doing so much of the work on this! He's planning another newsletter maybe jointly with the South for February. Please send him something—a progress report on something you began after the meeting, a cartoon, a poem, a description of a great project at your school, or a SHORT great article—but please, this can be so great when everyone contributes.

4. Positions: Congrats to our NE reps for their efforts for Ad Board positions. I thought you were all the best; we'll try again next year! But remember there are all those other positions listed on the blue paper in your folders—apply yourselves and get other students at your school to apply. At the spring meeting we'll be electing a new Chair-Elect, a newsletter editor (I hope Tom runs again) and a new rep to the GME. So I hope we'll have lots of candidates.

5. HELP: Call me anytime at (203) 272-8172 with ideas, suggestions or questions. Please.

Well Tom's gonna get me as it is, this is way too long.

See you in Alabama,
Beth Malko, UConn

M.D. Activity in the Health Policy Arena

by Peggy Duggan, Boston Univ.

During this workshop Bernard J. Turnock, M.D. and James Stout, M.D. discussed their experiences in Health Policy through the Robert Wood Johnson Foundation Fellowship Program for Physicians interested in full time involvement in policy discussed on the national level. This fellowship program involves an 8 week training program and an 8 month work experience either on the Congressional or Executive level.

Dr. Turnock also discussed with us the need for physician involvement at this level. There are presently only 8 physicians who work full time for congress meaning that the bulk of health care policy is decided without the expertise of the physicians who administer health care. We were encouraged to consider policy involvement as either a part or full time commitment.

Drs. Stout and Turnock also suggested some alterations so that one could be a full time clinician yet be a part of the policy decisions. They both suggested involvement in the AMA and state Medical Association as a way to impact on policy. Both emphasized the importance of working through established societies and they pointed out that by our involvement in these societies we can not only effect health care policy but also we can effect the issues and opinions these societies stand for.

By the end of the workshop it was clear how important physician involvement in policy making is. Physicians working in the community and probably the best source of information regarding the direction medical care should take in order to provide best care for the patients we serve.

The Future Evaluation of Medical Students

by Thomas Lee, Cornell

One issue that was raised was the increasing role the national boards part 1 were having not just in the application to residency programs but also in determining the actual format of basic science curriculums in medical school. Students complained that many of their courses were emphasizing detailed specifics and not the larger concepts on the basis that the National Boards would have similar questions. More significantly, though, the Boards were becoming an inhibiting factor in establishing innovative curriculums at some schools. Attending the meeting was Dr. L. Volle, President of the National Board of Medical Examiners (NBME). Dr. Volle agreed with the

students in that too much emphasis was being placed on the Boards part 1, but he argued that it was wrong to place the blame entirely on the exam. the NBME designed the boards for a very specific purpose, to evaluate the factual information acquired in the basic sciences. He argued that in trying to keep the exam completely objective, constraints would be placed on the format and nature of the exam. This aspect of the exam, however, need not be used by a school itself and it should not dictate how the course is structured. He felt that the course directors should not let the exam become and end in itself and that they should place more confidence in their curriculums.

Letter from the Editor (p.2)

One reason I have enjoyed OSR so much is that it has given me just that, a chance to think about important issues that affect us but which we rarely have time to think about. With the spring meeting ahead, you may want to start coming up with ideas and topics for discussion or workshops. Send anything you might be thinking of to Beth; she can never have too much help. Before I end this, I would

like to thank all those who wrote articles, and I hope this newsletter meets your standards. Please send in any comments or suggestions on ways to improve the newsletter. Thank you

**Beth needs your
ideas. Giver her a
Call today!**

Computers (continued p. 4)

student is marginal in a subject, the computer can dwell on the topic until it is well established that the candidate is above or below the pass/fail threshold. This type of examination can also be used prescriptively to provide references for remedial reading.

V. Knowledge representations and databases.

Hypertext is a program that allows you to read about a subject on the computer and cross reference it without leaving your chair and searching around a library. It is not very efficient to look up every word you don't understand in Harrison's, but with hypertext you can jump from the pathology of jaundice to the biochemistry of bilirubin formation by just the touch of the button. Since the computer has the material cross-referenced you can jump to any related topic without having to ever turn a page or get another book. All the information is in one integrated source.

VI. Advertisements

1) The Upjohn Co. has a good line of simulation software. These are available **FREE** and may be run on any IBM-PC compatible machine. To obtain these simulations, write to: Educational Services, The Upjohn Company, 7000 Portage Rd., Unit #9435-88-0, Kalamazoo, MI 49001. Ask for Psychal (psychiatry), Mical (microbiology), or Endocal (endocrinology).

2) ETLINE is an online computer conference whose purpose is to electronically link together medical professionals who are developers and

users of medical information software.

This provides information about the availability and quality of medical information software, and it is **FREE**. It is funded by the National Library of Medicine. Contact ETLINE c/o Michael Ackerman, PhD, The Learning Center for Interactive Technology, Lister Hill Center for Biomedical Communications, National Library of Medicine, Bethesda, MD 20894.

3) Colleague Student Program-Colleague, a computer database service, allows students to search the databases of the core medical library at a cost of \$5 for a password at a rate of \$17/hour. Call BRS Information Technologies at 1-800-468-0908.

4) Free on-line genetics textbook: an on-line version of Victor McKusick's "Mendelian Inheritance in Man" with the latest information in it. Contact John A. Johnston at the William H. Welch Medical Library, Johns Hopkins Medical Institutions, 1900 E. Monument St. Baltimore, MD 21205. (301) 955-7058. [Editor's Note: if you are ever in New York City and would like a demonstration of a hypertext database, I would be happy to give a demonstration of Cornell's PathMac system. It currently has all of our biochemistry, physiology, and pathology transcripts on line with corresponding pictures stored on laserdisc or in digital files. The system is in the process of being converted to a hypertext database with some parts already complete. If you are interested please feel free to contact me.]

Demographics (continued p. 2)

take care of the elderly?

Dr. Hayes-Bautista believes that the growing Latino population is *not the problem but the answer*; the baby boom is the problem. He thinks that since the Latino population is quickly becoming a part of the labor force, if the discrepancies in the income that they receive are eliminated, we could see a 75% rise in total generated income in years to come. In other words, the Latino population can have the capacity to support the Anglo elderly and foot the 65% needed if their incomes are increased. Dr. Hayes-Bautista argued that a labor force that is well educated has good potential and therefore we should be concerned with education of the Latino labor force who could be supporting the elderly in the near future. Dr. Hayes-Bautista concluded by driving the point that since the Latino population is estimated to be increasing by 6.6% per year and the baby boomers are getting older, either the Anglo labor force must be extremely productive to support the elderly or we must rely on the Latino labor force and invest in the health and education of the Latino population. He argued that our futures lie in the Latino and minority hands and "what goes around comes around: If the yuppies do not want to pay for the education of Latino children because they do not have children of their own and would rather buy a BMW, then why should the older Latino children of years to come want to pay 65% for the Anglo elderly?"

