AAMC Update

Association of American Medical Colleges | Spring 1988
Albert Einstein College of Medicine | Volume Four

Editor's Note:

I hope you enjoy this issue of the **AAMC Update**. Special thanks to Bradley Mackler, AECOM C'88, for his help as my co-representative to the Organization of Student Representatives of the Association of American Medical Colleges.

Please mail the attached letters to our congressman ... they are pre-addressed: just tear out, fold in thirds, staple shut, attach a stamp, and mail. I hope we can influence these congressmen to support new legislation to restore tax deductibility of student loan interest.

Seth M. Rubin
Class of 1989

Truthtelling and Ethical Considerations in Preparing Dean's Letters

Jean Cook, MD
Dean of Student Affairs

I participated in two program sessions at the Spring Meeting of the Northeast Group on Student Affairs (NEGSA) in Montreal this April. One of the sessions was titled, "Counseling and Graduate Medical Education: Truthtelling and Ethical Considerations in Preparing Dean's Letters."

The author of a letter published in the April 22/29 issue of **JAMA** complains that most American medical schools provide residency selection committees with a "pollyannaish dean's letter, which finds complimentary things to say about all students and seldom provides class ranking."

Almost all of us in the NEGSA dean's letter session were student affairs officers responsible for writing dean's letters. Of course we find "complimentary things to say about all students" ... at least all students who are expected to qualify for the M.D. degree.

Residency program directors should not expect the dean's letter to be a prose version of the transcript and nothing more. Rather, it is a document which attempts to "sell" the student on the basis of his or her strong qualities. Significant weaknesses must be included as well; not to do so would be deceptive. We must also bear in mind that residency selection committees, at least in the very competitive specialties, use even slightly negative information in the dean's letter as a basis for denying an interview.

One member of the panel described a situation in which a student had been granted two leaves of absence for emotional reasons. In her fourth year, when the dean's letter was written, the student was performing very well and seemed to have resolved her earlier problems. The dean's letter summarized the situation by stating that the student "was twice granted a leave of absence for reasons of personal growth." With this statement the student was granted a good many interviews. Had the letter read that she required "two leaves of absence for emotional reasons and irresponsible behavior" this student certainly would not have needed a large travel budget for interviews! The dean's letter writer assumed that questions about the leaves of absence would be raised at the interview.

Another panelist described Paula, a student who completed her senior year rotation in the Department of Medicine with an evaluation which described her performance as inadequate for her level of training, and stated that she showed little initiative, independence, industry, or interest in ward work. She was required to repeat the rotation at another site, and this time her evaluation described her as "a very bright young woman ... excellent fund of knowledge ... soft-spoken and gentle ... relates well to peers and house staff." Should the earlier evaluation be mentioned at all in the dean's letter?

Tom is a third-year medical student, married with a child. Shortly after he finished his Ob/Gyn rotation the Dean of Students received a call from the clerkship coordinator who stated that Tom had been sexually harassing the nursing staff and was also too "familiar" with a number of his patients. When the Dean of Students called Tom in to talk about the allegations, Tow was very distressed, and said he found it difficult to differentiate between the physical contact appropriate in friendships and that which is appropriate in professional relationships. Tom was required to undergo counseling

before completing requirements to graduate. Would it be unfair to Tom if the alleged harassment and the prescribed counseling were mentioned in the dean's letter? On the other hand, would it be unfair to program directors, or just plain dishonest, not to mention it?

Commentary on the April 1988 Meeting of the Northeast Group on Medical Education in Montreal, Canada

Dr. Albert S. Kuperman
Associate Dean for Educational Affairs

This was one of the more enjoyable and informative meetings on medical education that I have attended. The medical school faculty of McGill University, our host institution, did an outstanding job of organizing and planning, and the social events provided samples of the cuisine for which Montreal is justly famous. The meeting site was adjacent to the pleasant and architecturally interesting McGill campus, but pity the medical students who must conquer a steep hill on a windy, snowy day in order to attend classes. I enjoyed strolling along a boulevard named for Docteuer William Penfield, the great McGill neurosurgeon and investigator whose classic 1954 treatise on epilepsy still occupies an honored place in my bookcase.

I was also thrilled to browse in the Sir William Osler Library. Osler graduated from McGill in 1872 and served on its Faculty of Medicine for a decade before going on to a brilliant career at the University of Pennsylvania and Johns Hopkins medical schools and, finally, at Oxford. Bibliomaniac that he was, Osler believed passionately in the importance of books, especially for the young. His book collection at McGill is eloquent testimony to the eclecticism and humanism of this great physician and teacher whose written and spoken words have touched many generations of medical students. Unfortunately, most medical students today may read thousands of pages, many containing facts and opinions of questionable value, but never read one word of William Osler. Just one quotation, please, from his 1906 oration on "The Growth of Truth:"

> Sooner or later - insensibly, unconsciously - the iron yoke of conformity is upon our necks; and in our minds, as in our bodies, the force of habit becomes irresistible. From our teachers and associates, from our reading, from the social atmosphere about us we catch the beliefs of our day, and they become ingrained - part of our nature. For most of us this happens in the haphazard process we call education, and it goes on just as long as we retain any mental receptivity.

The plenary session of the meeting dealt with a subject that Osler would probably approve of, the evaluation of students' clinical competence. Indeed, this seems to be the medical education theme of the 1980's. Although medical schools have long tolerated varying degrees of imperfection with the evaluation process, the past several years have been witness to a rising tide of concern. The reasons for this are multiple, complex and interactive. They related to recent transformations in the health care system; changes in reimbursement and regulatory mechanisms; the prominent role of interns and residents as teachers and evaluators; the changing nature of the patient population served by our teaching hospitals; increasing non-educational commitments of our clinical faculty, including chiefs of service; the continuing rise of specialization and specialty training; the lack of adequate

recognition/reward systems for good teaching; insufficient fiscal support for the educational functions of clinical departments.

Even as this is being written, societal and economic forces that drive the health care system continue unabated, and attitudinal and structural deficiencies in medical schools that contribute to problems with medical education are not likely to be corrected soon. Meanwhile, we should not allow too many more cohorts of 16,000 students to complete their undergraduate medical education without making fundamental improvements in the evaluation system and process. The sense of urgency is based not only on the faculty's legitimate responsibility to certify clinical competence; defects in evaluation also limit the efficacy of the total clinical education experience.

Quoting from the 1984 AAMC sponsored GPEP Report, "Physicians for the Twenty-First Century:"

Medical faculties should develop procedures and adopt explicit criteria for the systematic evaluation of students' clinical performance. These evaluations will provide a cumulative record of students' achievements as they progress through clerkships. Faculty members should share timely evaluations with students; they should reinforce the strengths of their performance, identify any deficiencies, and plan strategies with them for needed improvement.

Quoting from the 1986 report by AECOM's task force on Clinical Education for the Twenty-First Century:

Each clerkship should develop evaluative methods and instruments that will more accurately assess students' achievement of the defined learning objectives and make the department's expectations for students across clerkship sites more consistent than current evaluation systems permit. Such methods might include observed patient workups, objective structured clinical examinations (OSCE's), problem solving exercises, and traditional written and oral examinations of cognitive knowledge.

Since publication of the above mentioned reports, AECOM has taken significant steps to improve the clinical evaluation system and process. Starting March 1988, clinical teaching faculty began to use a new form for evaluating clinical performance. This form contains 33 behavioral descriptors for assessment of knowledge, skill and interpersonal/professional characteristics; it also has a five-point scale, with precise descriptors, for evaluation of total performance. With appropriate faculty training and experience, this new instrument should facilitate the ability of faculty to evaluate both the cognitive and non-cognitive domains of learning, and it should also provide more effective feedback to students about their performance. Along with the new form, we have established a process that enhances communication between clinical teaching faculty, site leaders, teaching coordinators and the Associate Dean for Students, thus permitting earlier identification of problem students and the development of remediation programs for such students. Additionally, we have called for more precise presentations of learning goals and expectations; improved supervision of patient examination, communication and clinical decision making skills; and more frequent use of high quality written examinations.

All of the above evaluation approaches were discussed at the Montreal meeting. There was also extensive discussion of the *objective structured clinical examination* (OSCE). In this relatively new method of assessment, components of competence such as history taking, physical examination techniques, interpretation of laboratory data and patient management skills are tested in a range of subject areas. Each component of competence is tested at one or more stations round which students rotate. In a typical examination, students spend five minutes at each of 20 such stations.

Users of the OSCE are often wildly enthusiastic about its effectiveness. During the past year, it has been used with a group of fourth year medical students at a consortium of New England schools. At AECOM we have transformed the OSCE into GOSCE *(group objective structured clinical examination)*; the emphasis is on learning and self-evaluation rather than testing. So far, we have limited this approach to the course in physical diagnosis where it has been

reviewed very favorably by students. For the learning and evaluation of communication skills, we continue to depend heavily on videotaped interviews of patient simulators.

Dr. Robert Volle, the new President of the National Board of Medical Examiners (NBME), gave an update on the computer based testing (CBX) project. This is another method for evaluating clinical competence, especially in the realm of clinical reasoning and decision making. I looks like CBX will be postponed for use in the Part III NBME examination for several more years, giving medical faculties and students time to obtain extensive experience with this new evaluation method. We hope to soon begin using CBX software supplied by the NBME, in conjunction with interactive videodisc-computer hardware, during the medicine clerkship at BMHC in order to determine the value of this approach in both learning and evaluation processes.

From the above, I think you can see that AECOM is keeping abreast of new evaluation strategies and is even an innovator in some respects. For this I am grateful to many faculty, students and the Office of Educational Research and Evaluation staff who devote much of their creative energy and thought to this subject. Despite the periodic "healthquakes" that shake our clinical teaching facilities here in the Bronx, the faculty remains alert to new challenges and opportunities. Whenever I return from a meeting on medical education attended by colleagues from other institutions, I return to AECOM with complete confidence in our ability to move ahead in all aspects of the education process.

Resident Supervision and Working Hours

Bradley Mackler
Class of 1988

New York State has taken the lead in studying the present working conditions of housestaff and how these conditions may be improved. These issues have received national attention. Other states are actively studying their housestaff training programs and are waiting to see what reforms are enacted in New York. The American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) have drafted proposals for improving residency training. Newspapers, magazines, and television have produced editorials and documentaries on the state of post-graduate medical education.

All of this attention to problems with residency training was galvanized by the unfortunate case of Libby Zion, the 18 year old daughter of Sidney Zion, and attorney and writer for the *New York Times*, who died in March 1984 at New York Hospital (see *New England Journal of Medicine* 318:771, 1988). A grand jury report was issued which made a series of recommendations for modifications in the manner patient care is delivered in teaching hospitals. Subsequently, Dr. David Axelrod, commissioner of the New York State Department of Health, appointed Dr. Bertrand Bell of AECOM to chair the Ad Hoc Advisory Committee on Emergency Services. They came up with one set of recommendations for the emergency room which would limit attendings and housestaff to 12-hour shifts and require that busy emergency rooms be staffed at all times with an attending physician certified in Emergency Medicine, Medicine, Family Practice, or Surgery. These recommendations met with little opposition with most busy emergency rooms.

Conversely, the committee's recommendations for in-patient supervision and hours met with stiff resistance. This lead to a modification of their original recommendations. Many of the opponents to the original recommendations also changed their views. For instance, Drs. Bell and Petersdorf, president of the AAMC, bitterly debated the original housestaff training recommendations during a live television broadcast. Dr. Petersdorf, however, recently issued a memo in March 1988 which supports the New York State recommended guidelines. Thus, there is now a general consensus within the medical profession that post-graduate medical education needs reform, and there is now widespread support for the kinds of recommendations set forth by New York State.

The New York State recommendations on housestaff training are:
1) Residents may work a maximum of 80 hours per week averaged over a four week period.
2) Residents may work a maximum of 24 consecutive hours and then must have at least an eight hour break.
3) For all residents, each week there must be a 24 hour period away from the hospital.
4) A physician of at least the level of a PGY-4 (a physician with greater than three years of training following medical school) must be present at all times.

These modified recommendations will allow flexibility in arranging monthly schedules. The 24 hour cap on consecutive hours makes sense because most residents and medical students agree that working from 7am to 7am is difficult but tolerable. Continuing the working period for an additional 12 hours from 7am to 7pm on the post-call day is extremely difficult, tired residents working inefficiently and with a short temper.

The eight hour break will ensure that the resident has some time to sleep before resuming work. Finally, the 24 hour period each week away from the hospital was recommended to avoid burn-out and ensure that the new set of guidelines did not lead to more chronic fatigue and less time outside of the hospital than the straight every third or fourth call schedule. The *Committee of Interns and Residents of New York State* especially pushed for the 24 hours away from the hospital per week recommendation because they viewed working shorter shifts each day without a day off to be as bad if not worse than the present system.

These recommendations will now be used by Dr. Axelrod to formulate new regulations for graduate medical education (GME) in New York State starting in July 1989. However, several questions remain on how these rules will be implemented. Most notably is where will the funds come from to pay for the additional manpower needed to fill in for the residents who will work shorter shifts? New York State pays approximately $1.3 billion for GME and the new recommendations would cost approximately $200 million more. Also, who will fill in for residents? More residents would be a simple solution, but with a projected surplus of physicians, fewer medical school applicants, and fewer doctors pursuing careers in internal medicine and pediatrics, this might not be a good solution.

This brings up an important point ... namely, is the resident a student or an employee? Most program directors believe that residency should ideally be balanced between service and education. However, in some programs, the balance has shifted too far toward service and away from education. The implementation of these recommendations should provide an excellent opportunity for individual program directors and organizations that accredit them to examine each program's balance for residents between service and education. Some programs may decide to close and others to make changes to improve their programs. The next few years will be exciting for GME and I am optimistic that all the attention GME is receiving will lead to improved programs.

Dukakis' Health Insurance Plan*

Seth M. Rubin
Class of 1989

Governor Michael Dukakis, the certain Democratic candidate for President, recently signed into law in Massachusetts a state-managed, privately-funded health insurance plan for every state resident. By 1992, all uninsured Massachusetts residents will be able to purchase health insurance from the state at rates subsidized by private business contributions; customers for the insurance plan will be primarily the unemployed, the uninsured employed, and college students. People insured through private insurance carriers will likely remain with the private carriers. Indeed, Mr. Dukakis hopes to pursue a national health insurance plan if elected to the presidency.

Under the new Massachusetts law, companies pay a set fee of up to $1680 per employee to a state-managed insurance pool; these funds are used to subsidize the cost of the insurance plan an individual purchases from the state. Companies which choose to provide health insurance for their employees through private carriers need pay a smaller fee per employee. Exemptions will exist, however, for small businesses with fewer than six employees. In addition, the Massachusetts plan offers financial assistance to small firms who are financially jolted by the new plan.

Mr. Dukakis' plan is indicative of the Governor's view that the federal government should be a catalyst for social reform. Furthermore, the Massachusetts plan acknowledges the reality that in a budget-conscious legislature, a government-funded program is a certain flop. A plan funded by non-government sources is the only feasible option, and even so will face a difficult challenge in Washington if Michael Dukakis is the next President. The government's cumbersome bureaucracy, with a poor track record for efficiency, may make the costs of a national health insurance plan outstrip the benefits.

Business leaders doubtless will lobby vigorously to defeat a national health insurance plan. The additional costs to companies will inspire management to reduce the number of employees. According to business leaders, the cost of a national health plan will be unemployment, increased production costs, hence increased prices, and decreased productivity. In addition, many fear that the government, once controlling a large share of the health insurance market, will someday mandate the types of insurance an employer must provide, narrowing the options an employer currently enjoys.

There are many Americans who have inadequate access to health care, most often due to poor economic status. The current Medicaid system has many flaws, and often poor patients do not receive optimal care. It is impressive that Governor Dukakis recognizes the importance that all people have access to satisfactory care. However, one must be cautious to summon the inefficient federal government to the rescue. Michael Dukakis' health insurance plan for Massachusetts was passed in a state legislature enjoying an 80% Democratic majority. The prospects for such legislation on the Federal level are dubious.

*Based largely on an article which recently appeared in the *Wall Street Journal*. Davidson, Joe: "Dukakis's Health Insurance Plan Would Face Bigger Fight on Hill Than It Did in Massachusetts," **The Wall Street Journal**, May 12, 1988.

The Honorable Daniel P. Moynihan
The United States Senate
464 Russell Senate Office Building
Washington, DC 20510

Dear Senator Moynihan,

As a medical student, I would like to express the crucial need for a bill that would restore deductibility of interest paid on educational loans. Among these is H.R. 592 sponsored by Representative Richard Schulze (R-PA). The Association of American Medical Colleges (AAMC) has formally endorsed this legislation and is actively seeking its passage during the 100th Congress.

A few of the important reasons this legislation should pass include:
- Many young graduates face severe financial hardship.
- It is unfair to phase-out deductibility of loans to students who had predicated their borrowing on the terms of prior law.
- Deductibility should be supported because it helps minimize loan default rates and encourages participation in higher education by individuals from lower-income families who may not otherwise be able to afford higher education.

I would appreciate your support of this legislation. Thank you.

Sincerely yours,

Albert Einstein College of Medicine
of Yeshiva University

From: _____

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The Honorable Daniel P. Moynihan
The United States Senate
464 Russell Senate Office Building
Washington, DC 20510

The Honorable Alfonse M. D'Amato
The United States Senate
520 Harat Senate Office Building
Washington, DC 20510

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The Honorable Alfonse M. D'Amato
The United States Senate
520 Harat Senate Office Building
Washington, DC 20510

The Honorable Charles Rangel
The United States House of Representatives
2330 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Rangel,

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The Honorable Charles Rangel
The United States House of Representatives
2330 Rayburn House Office Building
Washington, DC 20515

The Honorable William Green
The United States House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

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