ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES

aamc

Volume XI
Number 1
Fall 1987

progress notes

Medical Education News from the
Organization of Student Representatives

perspective from the chair

The OSR Administrative Board has, as one of its major responsibilities, the provision of the medical students' perspective to the issues that come before the AAMC Executive Council and its Administrative Boards. The 12 member board, each of whom has been elected by the OSR membership at large, contributes the results of their discussions to the deliberations of the Council of Deans Administrative Board and the AAMC Executive Council. The purpose of this Perspective article is to summarize for you the discussions of one important and current issue that came before the OSR Administrative Board during its September meeting.

The discussions were the result of a set of recommendations of the State of New York regarding proposed limitations on housestaff working hours and closer supervision of housestaff by attendings. In order to provide a framework for the Administrative Board's discussion, a brief summary of the New York State recommendations is provided.

The Recommendations from New York State:

An Ad Hoc Advisory Committee on Emergency Services, consisting of physicians and representatives from major hospitals in New York State, was recently formed by the New York State Commissioner of Health, David Axelrod, M.D. This committee was formed in response to a New York Grand Jury investigation of the circumstances surrounding the death of a young woman in a New York City teaching hospital.

Continued on page 5

Inside this issue . . .

Preventive Medicine: What It Is and What The Medical Student Can Do to Learn More About It

Dennis J. Barbour, J.D., Executive Director
Association of Teachers of Preventive Medicine

I have been asked to comment on "preventive medicine in medical education." The fact that I am the Executive Director of the Association of Teachers of Preventive Medicine notwithstanding, the reader should know that the following observations are not necessarily the views of the organization which employs me. In fact, my views probably do not even represent the prevailing consensus within the field of preventive medicine (to the extent that consensus exists). The following are merely personal views borne of thirteen years' experience representing organizations and interest in the fields of public health and preventive medicine. Truth in labeling compels me to announce at the outset that my opinions may be injurious to your biases.

Preventive medicine has an image problem; this state of affairs has existed since well before the early part of this century when the Flexner report on medical education pointed out deficiencies in medical student training in prevention. (1) Unfortunately, in terms of the content of medical education, not a great deal has changed since that time. What has apparently changed, particularly in recent years, is medical students' and patients' perceptions of the importance of clinical preventive medicine. In recent years, therefore, many individuals within the field of prevention have been grappling with the issue of how to capitalize on this opening. One approach has been to identify or develop models for integrating prevention into medical education and practice. (2)(3)(4)(5)(6) Some of these initiatives have been generated by medical students. As might be expected, these efforts have been a struggle. Proponents of change have not only had to deal with the constrictive realities of present day health care economics but with certain unpleasant realities of the field of preventive medicine itself.

This brings us to the quandary of definitions. Preventive medicine has long suffered an identity crisis, borne largely by its own failure to clearly define its role and mission. Some attempts, however, have been made. (7) Defined most broadly, preventive medicine encompasses a range of activities from public health policy to clinical interventions such as physician counseling on smoking cessation. Departments of Preventive Medicine (the generic title) within U.S. medical schools reflect this broad diversity, or, as some say, chaos. A recent study by the ATPM identified 128 such units. Although this figure is impressive, it

Continued on page 2

project forum

A Medical Student Clinic for the Homeless

At the OSR national conference in Washington in 1985, I heard students from a New York City medical school talk about a storefront walk-in clinic for street people. It was operated by medical students and housestaff. I wondered at the time how this idea might be applied in Hartford. Last spring, in my fourth year, I was required to do a project for our Primary Care Clerkship that (1) identified a community problem, (2) assessed its scope, and (3) provided some solution. I had time to look more closely at applying the New York idea to a much smaller, but no less needy, population of homeless people.

I began by calling the State of Connecticut Governor's Office. (They were much relieved to learn that I was not looking for funding.) I learned that there had been a pilot project sponsored by the Hartford County Medical Society (HCMS) in which doctors had volunteered their time to staff a one-room clinic in Hartford's South Park Inn Shelter. In calling the HCMS, I learned that the current head of the society had been involved in the pilot project and was also the Assistant Dean for Clinical Affairs at U. Conn. He loaned me the participating physicians' patient reports as well as their evaluations of the program. They were unanimous in two areas: (1) the clinic was very much needed and (2) the work could be performed by someone trained at the nurse practitioner level. This was encouraging, for it provided both a statement of need and evidence that a fourth year medical student, with proper support, would not be under-qualified for the majority of problems seen in the clinic.

I drafted a proposal, having had two years to think about the clinic's design, and presented it to the directors of the HCMS and the South Park Inn Shelter, winning their whole-hearted support for the idea. The plan called for a one-room clinic to be operated by U. Conn. medical students two evenings each week. Staffing would consist of an intake person, two patient care teams, and a physician preceptor. The intake person could be a fourth year student. Each team would briefly present their patients and proposed treatment plan to the physician volunteer. The clinic would be operated by an elected board of student directors and a group of faculty advisors. I investigated issues of malpractice, operating costs, supply of physician volunteers, and burden on the participating medical students, and none appeared to be prohibitory.

I presented the idea to the student body at the end of last year. The response was gratifying, with more than 45 students attending the first organizational meeting. My class donated $300 of the class gift money to the start up of the clinic. Over this past summer, a group of six fourth-year students have provided leadership in drafting bylaws, finalizing malpractice coverage, getting donations, making the clinic space operable, and enlisting physician volunteers. The opening is scheduled for this fall.

The clinic may serve as a means of cultivating and refining the idealism with which so many of us entered medical school. Medical school can be a self-oriented four years, where free time is a scarce commodity. The clinic is designed to provide a service to the community while asking for a plausible commitment from its medical student and physician staff. Hopefully, they will all feel a sense of fulfillment from serving others in need. □

Thomas Sherman, M.D.

Continued from page 1

is deceptive; most of these departments have very limited faculty resources and are allotted a meager number of hours in the curriculum. They are responsible for the teaching of a wide range of topics, from the sciences of epidemiology and biostatistics to such subjects as legal and ethical aspects of health care delivery. The names of these departments alone reflect this variety, ranging from "Department of Preventive Medicine" to "Department of Socio-Medical Sciences." Although 92 percent of the 102 departments involved in the ATPM study teach required didactic courses, 36 percent responded that their institutions have other departments as well that teach subjects traditionally taught by departments of preventive medicine. (8) ("Traditionally taught by departments of preventive medicine" having been chosen by ATPM as one means of attempting to impose some degree of definitional uniformity to units whose role is oftentimes quite unclear and uneven.) In short, the canard about Saturday morning being the prime time for preventive medicine teaching is unfortunately not far from reality.

An understanding of this background, however, is an essential ingredient for an appreciation of not only the role that preventive medicine now plays in undergraduate medical education, but what role it can and should assume.

Briefly stated, *epidemiology* is the study of the incidence and prevalence of disease in population groups. Epidemiology (with biostatistics) is a "core" science of public health. With apologies for simplicity that may offend some, epidemiology is akin to the software package for our local, state, and national community-based, prevention hardware; i.e., departments of public health. For reasons I state below, a thorough understanding of epidemiology should also be a part of clinical medical practice.

Compared with the curative medical sciences, epidemiology may sound like it possesses the texture of unbuttered toast. To

Continued on page 3

progress notes

Published by the

Association of American Medical Colleges
for the Organization of Student Representatives

One Dupont Circle
Washington, D.C. 20036

Wendy Pechacek, Editor

Continued from page 2
be maximally effective, a practicing clinician should be cognizant not only of the incidence of disease within his/her community, but how that incidence may relate to his/her patient practice. The medical specialist in the field, the physician/epidemiologist, is often the individual who is responsible for gathering and interpreting this data. Nonetheless, an understanding of and appreciation for the science of epidemiology and the role of the epidemiologist, is essential to quality medical care, particularly when medical care seeks to prevent, as well as cure, disease.

Although there are many who would disagree *public health* (or "community health") and *preventive medicine,* although used interchangeably, are quite different areas of science and practice. Unfortunately, they are labels that have been inappropriately applied from time to time by the discipline itself, leading to confusion on the part of those outside of the field.

Public health is a body of knowledge and sciences that is utilized in the development and delivery of health care to population groups. These groups range from the nation as a whole to subgroups within communities. Public health services can be curative or preventive in nature. Regretably, the body of public health knowledge also includes areas not traditionally associated with health professions training such as health care finance, administration, and management.

Depending upon one's perspective, *preventive medicine* can be defined as:

A. A subset of public health;
B. The umbrella within which public health resides;
C. A subset of medicine;
D. The umbrella of health care within which traditional, curative medicine resides.

To most medical students as well as educators, definition D is undoubtedly the most appalling. Definitions A and C, however, are the most descriptive of preventive medicine in the 1980's, and for the foreseeable future. That is, *preventive medicine* is a unique, emergent clinical discipline that bridges the traditional sciences of public health and curative medicine. In order to be maximally effective, preventive medicine must include an understanding of the public health sciences that relate to causation of disease within populations. At the same time, preventive medicine must have a clinical relevance that allows the practitioner to translate what is known about disease prevention within groups to the care of individual patients within his/her practice. The sciences of preventive medicine are the tools that provide the practicing physician with these clinical capabilities.

The obvious next question is: what are these "sciences", and how can medical students acquire the requisite knowledge and skills to practice preventive medicine in practice? For the answers to these questions, we must look to individual medical schools and students that are engaged in innovative approaches to the teaching of disease prevention and health promotion. Examples of these approaches are not plentiful but do exist.(9)(10) Unfortunately, the modern medical model does not contain a component that can be clearly identified as preventive medicine as defined above; hence, the paradigm of medical education is similarly lacking in a formulaic approach to teaching of the subject.

As stated in the introduction, there is a burgeoning interest on the part of medical students and patients in clinical preventive care. Although the environment is changing, most medical educators do not share this enthusiasm. This clash represents both a challenge and an opportunity to medical students and patients alike.

Some years ago, during a discussion with an eminent medical educator, I was advised to use caution in advancing organizational policies that demanded a change in medical school curriculum to increase emphasis on prevention. The reason given was that, in time, medical students themselves would demand such changes, and, at that time, an evolutionary process would occur. As I have witnessed the changes in the attitudes of medical students in the past few years, I have reason to confirm that prediction and to be encouraged by the possibilities that lie ahead. Together with health care consumers who are increasingly vocal in their demands, medical students now stand as a determinant force for change within medical education. What is the prescription for greater clarity and curriculum change? Engage yourself in this evolutionary process. Talk to faculty in departments of preventive medicine and the primary care fields, and ask the hard questions. Organize with other students with like interests. And, for your own benefit and that of your future patients, attend those preventive prime time sessions and challenge your instructors, strong or weak. The future of medical care and prevention is, after all, in your hands.

References

1. Flexner A. Medical education in the United States and Canada. New York: Carnegie Foundation, 1910. Reprinted, Washington, D.C.: Science and Health Publications, 1960. 26; App 1,A; App 1,B.
2. Jonas S. Implementing the recommendations of the GPEP report pertaining to preventive medicine. Washington, D.C.: Association of Teachers of Preventive Medicine, 1986.
3. An inventory of knowledge and skills relating to disease prevention and health promotion. Perspect Prev 1987; 1(2);14.
4. Segall AJ. et al. Health maintenance in clinical practice: instructional system. 19 volumes. Boston, Mass: Center for Educational Development in Health, Boston University, 1983.
5. Interrelationships between preventive/community medicine and family medicine. Kansas City, Mo.: Society of Teachers of Family Medicine, 1983.
6. Interrelationships of general internal medicine and preventive/community medicine. Washington, D.C.: Association of Teachers of Preventive Medicine, 1985.
7. Stokes J. Noren J, Shindell S. Definitions of terms and concepts applicable to clinical preventive medicine. J Community Health 1982; 8:33-41.
8. Directory and profile of academic units in preventive medicine. Washington, D.C.: Association of Teachers of Preventive Medicine, 1986.
9. Survey of excellence in teaching preventive medicine (unpublished). Washington, D.C.: Organization of Student Representatives of the Association of American Medical Colleges and the Association of Teachers of Preventive Medicine, 1987.
10. Report on departments of preventive medicine. Perspect Prev 1987; 1(3);41. □

aamc focus

The AAMC focus column, as originally perceived, would give students information and background on the variety of resources available at the AAMC. The Administrative Board felt that students would be interested in knowing more about the career path leading to chief executive officer of a national health association. Here's one example . . .

Robert G. Petersdorf, AAMC President

Dr. Petersdorf began his career as an instructor in the Department of Medicine at Yale University School of Medicine, where he received his M.D. He was an intern and assistant resident at University Service, Grace-New Haven Community Hospital, where he practiced as an internist specializing in infectious disease.

Dr. Petersdorf subsequently joined the faculty of Johns Hopkins University School of Medicine as an assistant professor in the Department of Medicine. In 1960, he moved to the University of Washington School of Medicine where he was appointed associate professor in the Department of Medicine. He became a full professor in 1962, and chairman of the department two years later. He served as chairman for 15 years.

From 1979 to 1981, he was president of Brigham and Women's Hospital in Boston and also held the appointment of professor at Harvard Medical School's Department of Medicine.

Prior to joining the AAMC, Dr. Petersdorf was vice chancellor for health sciences and dean of the medical school at the University of California Medical Center, San Diego, from 1981 to 1986.

Dr. Petersdorf has been President of the American College of Physicians, the Association of American Physicians, the Association of Professors of Medicine, Chairman of the Board of Governors of the American Board of Internal Medicine, and of the Assembly of the Association of American Medical Colleges. He is a member and has served on the Council of the Institute of Medicine of the National Academy of Sciences. He has served on advisory committees for the Center for Disease Control, Health Care Financing Administration, Food and Drug Administration, and the National Institute of Health.

He has been an editor of *Harrison's Principles of Internal Medicine* since 1968, and has served on the editorial boards of a number of journals. He has published over 300 papers in professional and scientific journals. His chief areas of research interest have been the pathogenesis, epidemiology, diagnosis and treatment of bacterial infections, including urinary tract infections, meningitis, bacterial endocarditis and gram negative bacteremia, along with an in-depth study of fever. He has been a frequent commentator on the organization and management of academic medical centers, graduate medical education and health manpower issues.

Last month, Dr. Petersdorf celebrated his one year anniversary as president of the association. During that time his efforts have focused on: implementing a physician manpower study; increasing the minority applicant pool; and promoting improved biomedical research, student financial aid, and adequate teaching hospitals. To help address these issues, the AAMC staff has been reorganized into five categorical divisions: Biomedical Research, Academic Affairs, Institutional Planning and Development, Clinical Services, and Communications.

Future columns will address each of these divisions and the people and programs they comprise. □

Federal update

Student Loan Interest Deductibility

The following pieces of legislation are identical, in that they would restore the full tax deductibility of interest on educational loans: H.R. 592 (Schulze, R-Pa), H.R. 603 (Tauke, R-Ia), H.R. 979 (Gaydos, D-Pa), H.R. 2262 (Fascell, D-Fl) and S. 628 (Grassley, R-Ia). Although the timetable and legislative vehicles are both uncertain, restoration of the deductibility of student loan interest is a possible candidate for action during the 100th Congress. The Association has written to the sponsor of each bill to express its support for this initiative. All parties interested in this issue should contact members of Congress to request that they support these measures.

IRS Guidance on Taxation of Scholarships and Fellowships

On April 27, the IRS published Notice 87-31, outlining new rules on the tax treatment of scholarships and fellowships. Under the provisions of last year's Tax Reform Act, certain portions of these funds received by students are now to be included in taxable income.

There has been considerable speculation and concern as to how the new rules would be interpreted and enforced by the Treasury Department. Notice 87-31 spells out some of the new rules, including a clarification that regulations will be promulgated generally relieving institutions of the obligation to file information returns with the IRS, or withhold income or employment taxes. Only in cases where the aid is devoted to meeting costs other than "qualified tuition and related expenses" would institutions be required to report the amount of aid provided and make tax withholdings. The notice also makes clear that recipients of the aid themselves will be responsible for determining whether all or part of the aid is taxable income.

Additionally, the Notice clarifies the effective date of the new tax requirements; as long as students were notified on or before August 16, 1986, that they would receive a definite amount of scholarship aid, the award will not be subject to the new tax. The IRS said that even if the funds are used over several years, they will remain excludable from gross income if initially awarded before the effective date. The new Notice is intended to provide guidance, but does not have the effect of formal regulations.

Continued on page 5

Continued from page 4

National Health Service Corps Reauthorization

The House approved September 9 H.R. 1327 authorizing the continuation of the National Health Service Corps (NHSC) programs for fiscal years 1988-90. This legislation will breathe new life into the NHSC and enable the Corps to continue to support approximately 3,000 providers.

The legislation reauthorizes the NHSC scholarship program and establishes a new recruitment mechanism through a loan repayment program. Health professionals who agree to become Corps providers and serve in designated health manpower shortage areas will be eligible for Federal loan repayments of up to $20,000 for each year of service. The advantage of the loan repayment program is that it allows students to make service commitments at a later point in their training period when they can make more realistic assessments of their future plans and goals.

Before casting the final 387-9 vote, the House amended the bill to permit the HHS Secretary to allow individuals who have defaulted on scholarship payback requirements a second opportunity to participate in the Corps and relieve their financial liability; to provide grants for states to establish programs similar to the loan repayment program; and to require that collection agencies be used to recover delinquent debts. The annual authorization for H.R. 1327 is $65 million. □

Continued from page 1

A *brief* summary of the recommendations from the Grand Jury and from the Ad Hoc Committee will follow.

Staffing of Emergency Rooms

There should be at least one emergency service attending physician on duty all of the time—for hospitals whose services exceed 15,000 unscheduled visits annually. For hospitals serving smaller populations, the attending physician should be available within 20 minutes.

Supervision of Housestaff

Interns and junior residents should be supervised contemporaneously and in-person by attending physicians or housestaff who have completed at least 3 years of residency.

Housestaff Working Hours

- Housestaff and attendings who have direct patient care responsibilities should work no more than 12 consecutive hours per shift in the Emergency Room, separated by no less than 8 hours of non-working time.
- Housestaff and attendings who have direct patient care responsibilities (in areas other than the emergency room) should work no more than 16 consecutive hours per shift, separated by no less than 8 hours of non-working time.
- "In no case shall an individual person who has worked the maximum consecutive hours in one hospital, work in a different hospital in a consecutive fashion."

Physical Restraining of Patients

The thrust of this recommendation is that physical restraints should only be used in circumstances when all other ways of protecting the patient from injury to himself or to others has been exhausted. The use of restraints must be authorized by a fully licensed physician, monitored closely by a registered professional nurse and limited to a specific time period.

Contraindicated Drugs

"The State Department of Health should conduct a study to determine the feasibility of requiring level one hospitals to implement a computerized system to check for contraindicated drugs."

Summary of OSR Administrative Board Discussion:

Many have focused their concern with these recommendations only on the provisions to limit housestaff working hours. While Administrative Board members felt that "hours of work" was a very important topic, they felt the core issues in improving patient care and graduate medical education relate to matters of education, supervision, and ancillary support. The Administrative Board discussion focused on the following areas:

Supervision of Housestaff and Medical Students

The Administrative Board discussed the importance of retaining and improving the current system of graded responsibility of housestaff. The Board felt that outlining specific roles and responsibilities of each team member is crucial. Excellent training occurs when there is supervised responsibility of housestaff with increasing levels of freedom as housestaff gain experience and competence.

Administrative Board members expressed the view that attendings need not be present in-person for each clinical decision. In addition to the drawbacks in developing responsibility in residents, this would degrade patient care—not only would there be exhausted residents, there would also be exhausted attendings!! On the other hand, students and house officers will gain much insight and perspective into patient care from more bedside clinical teaching by experienced attendings.

Housestaff Hours

- Fatigue

  The members of the Board who are currently in residency training reported that the reality of the residency experience across the various specialties is that at the end of the "on-call" period, usually lasting at least 36 hours, residents are truly exhausted. They therefore feel that the effects of fatigue on clinical judgment and thus patient care need thorough investigation.

  Some members described situations where students and residents have found that the state of exhaustion may lead to a conflict of interest in patient care. That is, when a resident is exhausted and a patient presents, there may be a tendency to minimize the patient's symptoms in an effort to decrease the resident's workload. Proper supervision and more frequent relief from other house officers were suggested as ways to combat this conflict of interest.

- "The Hours"

  The Board did not feel there was anything magical about the 16 or 12 hour shift—just as there is nothing magical about the 36 hour shift. Members suggested that perhaps each discipline should decide the number of working hours that optimizes patient care as well as education of their residents. For example, in Obstetrics it may be important for a resident to be present for 24 consecutive hours to learn how to correctly manage labor and delivery. Members discussed their perceptions that students and residents are asking for a decrease in the total number of hours in direct patient care per week, as opposed to one stringent set of guidelines for all disciplines. Continued on page 6

Continued from page 5

- Natural Course of Illness

  Some of those opposed to changing housestaff hours have said that doing so will compromise the resident's opportunity to learn the natural course of an acute disease process. Administrative Board members felt that following the natural history of a disease by one resident through a 20-40 hour period may yield some educational gain. However, they discussed the following potential benefits of residents providing patient care through shorter time frames:

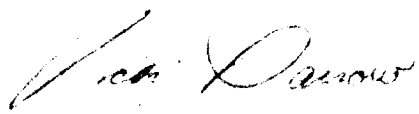
  - Better develop in residents essential communication skills used to organize the pertinent information when relating the course of illness in signing over patients.
  - Improve patient care by bringing new ideas to the management of the patient.
  - Double or triple the number of residents who would be exposed to the acute progression of the illness.
  - Foster the attitude that the team approach to patient care is in the best interest of the patient.

In summary, OSR Administrative Board members hold the conviction that residents are willing providers of clinical service to hospitals and that they are not an implicit financial liability.

However, in the Board's view, residents do need better supervision early in their training, decreased administrative workloads, and improved patient care, nursing and ancillary services. Some of these changes will involve increased initial financial outlays by hospitals. However, the resultant improvement in quality of education and care, decreased length of stay and increased clinical efficiency, should provide a net financial gain. This should be concurrent with providing residents more time for educational needs by the decrease of working hours. It is not the quantity of time, but the quality that is at issue.

To facilitate medical student input and to communicate the discussions of the OSR Administrative Board, the AAMC has asked me to serve on a committee along with medical school deans, teaching hospital administrators and faculty. This committee is designated to make recommendations concerning the AAMC response to the New York State recommendations on housestaff. This is one example of the way in which OSR interfaces with the AAMC—representing the student point of view on a crucial issue in medical education.

I hope this report and the entire "Progress Notes" has helped to bring you up to date on some current issues in medical education facing medical students. □



Vicki Darrow, M.D.
OSR Chair

the bulletin board

Graduates to be Surveyed on Content of Questions Asked During Residency Interviews

In response to concerns raised by the OSR Administrative Board and the Consortium of Medical Student Associations about potentially discriminatory questions which were asked during residency interviews, the AAMC will be adding a new question to the 1988 Graduation Questionnaire. Graduates will be asked, "How many programs to which you applied asked you for information during the interviews regarding your: age, race, religion, present or future marital status, form of contraception, sexual preference, stability of interpersonal relationships, intention to have children, or spouse's profession or employment status?" Students will be asked to comment on the specific nature of the questions asked, the context in which they were asked, and the position of the person who asked the question.

Results of this question can be tabulated by type of specialty, sex or race of respondent in order to elucidate patterns. Data will be used to educate students and program directors about the frequency of such potentially discriminatory practices in hopes of reducing their occurrence.

Secretary's Award for Innovations in Health Promotion and Disease Prevention

The Department of Health and Human Services, Bureau of Health Professions, has announced the sixth annual competition for the Secretary's Award for Innovations in Health Promotion and Disease Prevention. Winners of last year's competition were; first prize to Lorna Smith, a senior nursing student at the University of Texas Health Science Center, School of Nursing, San Antonio, for a proposal to teach parents in a shelter for the homeless about the treatment of mild diarrhea and secondary dehydration of infants and small children; second prize to Lila Stanger, a health administration student at Idaho State University, School of Allied Health, Pocatello, for her program, "Shots for Tots," to provide easier access to immunization for groups of children through a mobile unit; and third prize to Susan Crockett, a doctoral student in public health at the University of Minnesota, School of Public Health, Minneapolis, for her proposal to maximize health promotion behavior changes in children through parental education and support. Eighteen additional proposals were awarded an honorable mention. Cash prizes range from $250 to $3000.

In mid-October, deans' and student affairs' offices will receive

Continued on page 7

Please forward a copy of any programs, newsletters or resource materials developed at your school to Wendy Pechacek, Staff Associate, AAMC, One Dupont Circle, Suite 200, Washington, D.C. 20036. The OSR office will act as a clearinghouse of information on projects at the schools. If you would like to start up a new program and would like some ideas, you can also contact Wendy for assistance at (202) 828-0570.

Continued from page 6
additional information to be distributed to students. Contact Wendy Pechacek at the AAMC for additional information. The deadline for submission of student papers to the dean or designated faculty member at their school will be January 15, 1988.

Committee Openings for Students, 1987-88

At the conclusion of the annual meeting in November, the OSR Administrative Board will consider applications for openings on the following committees:

- Group on Student Affairs (GSA) Committee on Student Financial Assistance
- GSA Committee on Student Affairs
- GSA Committee on Admissions
- Flexner Award Committee
- Liaison Committee on Medical Education
- National Resident Matching Program Board of Directors
- Association of Teachers of Preventive Medicine Board of Directors

A full description of the responsibilities for each position is available in the OSR Business Meeting Agenda for 1987. *Applications must be received by Wendy Pechacek at the AAMC by November 5* (March 30 for LCME) in order to receive full consideration by the Board. Students need not be members of OSR to apply to these positions.

Executive Council Approves Consideration of Organization of Resident Representatives

At its meeting September 10, the AAMC Executive Council received the report of the Ad Hoc Committee on Housestaff Participation and directed that its recommendations be considered by each of the three full Councils at their Spring meetings in 1988. The Committee was charged to consider and make recommendations concerning the role that residents should have in the Association.

The Committee recommended that an Organization of Resident Representatives (ORR), modeled after the Organization of Student Representatives, be formed to represent residents within the AAMC. The ORR would be a formal mechanism for consistent, continuing communication between the Association and residents in the identification of issues and the formulation of policy. The Committee anticipated that subjects of shared concern would include, among others, issues related to the student role, the teaching role, the patient care role, the research role, and the social and public health role of residents. Bearing in mind the mission of the AAMC, the focus would be on education and scholarship rather than economics or working conditions. The report will be discussed by the full membership of each Council before final Executive Council and possible Assembly action in 1988.

AMSA Announces International Health Fellowship Program

The AMSA International Health Fellowship Program, supported by USA for Africa and the Pew Memorial Trust, will be accepting applications this fall for opportunities beginning next year. There will be eighteen two-year clerkships available for fourth year students and residents who want to go to Africa and set up health clinics. Call AMSA at 1-800-336-0158 for applications this fall.

Examination of Maternity Leave in COTH Hospitals Completed:

The 1986 COTH Survey of Housestaff Stipends, Benefits, and Funding asked responding hospitals whether they have a written policy regarding maternity leave for residents, and if so, what is the permitted duration, what category of leave is credited, and what entity monitors compliance with educational responsibilities. Those hospitals that answered affirmatively were asked to submit a copy of their written policy. Of the 369 hospitals participating in the survey, 342 responded to this question. One hundred ninety-five of the respondents (57 percent) indicated they do have a specific policy, and approximately 30 institutions submitted a copy of that policy.

Fifty-seven percent of the hospitals responding to the question regarding duration of maternity leave indicated that no leave is granted prior to delivery. Sixty-two percent of the respondents indicated that they allow from six to eight weeks leave after delivery; 26 percent allow less than six weeks, and 12 percent allow more than eight weeks. A few granted as much as 24 weeks. □

Annual Meeting Reminders

November 6-9, 1987
Washington, D.C.

- OSR members are encouraged to plan to stay in Washington from Friday, November 6 through Monday, November 9. On Monday morning there is an AAMC Plenary addressing issues including: "The Rising Physician Supply: Some Implications", "Supply and Demand: Lessons from Dental Medicine?", and "On the Perennial Problem of America's Physician Shortage." In addition, there will be a Women in Medicine Career Development Program, and a Group on Student Affairs Plenary on the increasing costs of medical education. Tuesday morning, November 10, the Honorable Edward M. Kennedy will speak. There will be a joint Group on Medical Education/GSA Plenary on the NBME Part III as well. Please consult your annual meeting program for details of these sessions as well as those of the OSR program.
- Elections: Anyone who is considering running for a national OSR office (chair-elect or representative-at-large), should come to the annual meeting prepared with:
  - a copy of their current curriculum vitae/resume;
  - the ability to stay at the meeting through Sunday evening when a meeting of old and new Administrative Boards is held;
  - and the ability to be a fully functioning member of the Administrative Board. That is, able to attend *all* of the meetings of the Board. Dates for these meetings in 1988 are listed in the back of the OSR annual meeting program.

letters to the editor

To the Editor:

Joanne Fruth's article entitled, "Success or Failure: Silent Questionings About Medical School," provided great insight into the complexity of emotions and behaviors that exist in medical students and the medical school system that creates these emotions and behaviors.

As was well pointed out, personal characteristics that make good medical students are not always conducive to establishing a stable emotional life outside of medicine, and it is such characteristics that are often deemed most worthy by medical schools. We have all seen or maybe have been the medical student who can be at the top of the class academically but begins to struggle or even fails in his/her interpersonal relations with patients, friends, and even family because of maladjustments created by the medical system.

So where can the medical student seek help? Unfortunately the system is not well equipped to deal with the stresses it can create. Counseling programs do not always exist within the medical school and when they do, they are not always well supported. It is the rare medical school that has developed support groups such as AIMS (Aid for the Impaired Medical Student) to help students work through their problems. At my medical school it was never expressed that if counseling with a medical health professional was needed, such services existed through the medical school.

There are no quick and easy solutions to ridding medical students of the maladaptive behaviors that are created by the current medical system. However, it is articles like Joanne Fruth's that allow readers to recognize that they are not alone in having feelings of uncertainty, fear of failure, and unhappiness that lead to maladaptive behaviors, and this is an excellent beginning to the search for solutions to this difficult problem.

Clayton W. Kersting, M.D.
Seattle, WA

To the Editor:

The Spring 1987 issue of *OSR Report* contained two interesting and related articles. Indeed, the development of moral, ethical, and societal perspectives via teaching programs in human values not only represents a healthy diversification of the medical curriculum, but may also help students overcome some of the "silent questionings about medical school."

As a non-science major from a small liberal arts college, however, I believe that the "residual trauma" from the undergraduate pre-med curriculum was understressed in the article by Joanne Fruth. The four years of stress and competition inherent in many pre-medical curriculums undoubtedly plays an important role in impairment before admission to medical school. Alternatives to the traditional premedical curriculum should therefore be considered, and options allowing for diversification of the undergraduate experience should be presented to premedical students. This approach may be effective prevention for the problem of debilitating maladjustment. □

John LoMonaco, MS I
University of Texas-Houston

About Progress Notes

The former *OSR Report* has been redesigned in the past few months by the OSR Administrative Board. The purpose of the new format is to provide a consistent, readable newsletter that will inform medical students of resources and current information on medical education. Regular columns will be:

- a feature article on a current topic of interest with an accompanying bibliography for those interested in further reading;
- Perspective from the Chair—an article by the current OSR chair reporting on national activities in medical education;
- Project Forum—outlining a student-initiated program at one of the schools, how it was designed and how it works;
- AAMC Focus—featuring different staff members or functional sections at the association and what they can offer as resources;
- Federal Update—on current activities on the Hill and who to contact about them;
- Bulletin Board—resources and information of interest to medical students including committee openings, educational opportunities, results of studies;
- Letters to the Editor.

Student input is especially welcome for the project forum, bulletin board, and letters to the editor columns. Please send comments to: Wendy Pechacek, Editor, *Progress Notes*, AAMC, One Dupont Circle, Suite 200, Washington, D.C. 20036. □

ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES

aamc

Volume XII
Number 1
Spring 1988

progress notes

Medical Education News from the
Organization of Student Representatives

perspective from the chair

Dear Colleagues,

Greetings! I hope that each of you is having a productive year and learning how to treat and—although it is somewhat difficult given the current medical educational system—prevent disease. This difficulty is documented in the 1987 AAMC Graduation Questionnaire where of the 11,500 graduating students from U.S. medical schools who responded (70.1%) 60.4% felt that their education was inadequate in preventive care, 51.9% inadequate in public health, and 65.7% in nutrition. In this issue, there are several pieces that pertain to preventive medicine and public health. Mike Parkinson, a Preventive Medicine Resident at Johns Hopkins, has written a thoughtful letter to the editor about preventive medicine and its function in society. Kevin Flanigan, (Rush) has contributed a short note detailing his involvement as the student representative to the AAMC Task Force on AIDS. There is an announcement from the J.M. Foundation about scholarships for medical students to attend a conference on alcoholism and its prevention. Jennifer Hoock, (Duke) has written an excellent summary of a different model of medical education, Problem-Based Learning, which is increasingly popular in the U.S. and other countries. It has, in fact, been adopted by the World Health Organization as an appropriate model of medical education. As one of its benefits over the traditional curriculum is the flexibility for prevention to take a much more prominent position in the curriculum.

Our feature article is a thoughtful piece by Dr. Vicki Darrow, OB/GYN Resident at UC-Irvine and Andy Spooner, (University of Tennessee), about the abuse of language with patients. The use of derogatory terms is a symptom of a disease that we as medical students acquire while in medical school—hardening of the heart causally associated with, among other causes, sleep deprivation, stress, and the example that is set by some of our teachers—residents and faculty.

In the AAMC Focus column, Dr. Cynthia Tudor, AAMC staff, explains the many different questionnaires that we, as medical students, complete for the AAMC and how they are used to improve medical education. Also enclosed is an article from Dr. Joanne Fruth, Family Practice Resident at Swedish Hospital in Seattle, about her involvement with the AAMC Transition Committee.

Continued on page 5

Doctor Talk

I had settled into bed in the uninviting call room for about 45 minutes, I guess. I knew my intern was going to call me at any minute, so I made a point of not sleeping too soundly. Nevertheless, I was startled when the phone rang.

"Come on down," sang my intern, trying to sound good-natured. "Another gome from the home awaits your inspection." As I rolled out of bed I thought about how much I was enjoying my internal medicine rotation.

As it turned out, the new patient was not as he was originally billed.

"A dirtball. I pity you, man. You get all the lousy hits," my intern advised. "The guy's been drinking for about 40 years nonstop and now he has abdominal pain. . . ."

I had to interrupt. "I thought you said he was a gome."

"Yeah well, so he's a dirtball." My intern looked tired. She didn't like lip from her "studs." "What's the difference—you still gotta work him up. I got two others parked and waiting. You got any problems, you call me, OK?"

I picked up the chart and saw that the surgery resident had already seen the patient and had written, illegibly, "do not believe surgical intervention necessary at this time."

What the surgeon probably said at the time was something like "this player is definitely flea material." He didn't write that in the chart, though; that would have been unprofessional.

Our Bilingual Profession

Medicine, like any other profession, has its own language. In order to deal with the unique demands medicine places upon us, we easily learn to use this language in medical school. Medical language can at times be flippant, callous, and vague, but it can also save us time and ease the psychic strain of the difficult situations medicine presents to us. The problem with our jargon, though, is that sometimes it impedes patient care and medical education. This commentary examines the nature of this second language and raises some questions that medical students may need to answer in order to become comfortable in communicating with their colleagues and patients. Research in this area is scant, and we do not presume to know what's best for each medical professional.

It is easy to blame the stresses of medical training for the development of "Medicalspeak"—the specialized jargon doctors use among themselves and often use when talking to their patients. But perhaps it is medicine's self esteem that is causing

Continued on page 2

Continued from page 1

the problem. We have a lower opinion of ourselves these days, and this low esteem is reflected in our language. There is less dignity in doctoring, and as a result, interest in medicine among colleges graduates is declining. The example at the beginning of this article is the best known: we deride our patients almost without thinking, yet our patients are the most valuable part of our medical educational experience!

There is certainly no room in our curriculum for coursework in medical language, but perhaps this commentary will prompt some medical students to question the nature of the language they use in medicine and decide for themselves how to better communicate with their colleagues and patients as they mature in our profession.

Medicalspeak: the Dark Side

Let's look at the characteristics of medicine as our second language:

■ *It is evasive.* Some words we use on the wards are specifically designed to obscure meaning[1]. For instance, the phrase "neuro exam was within normal limits," often means we think the neurological exam was normal, but we're not sure. The same thing goes for the word *essentially*. When we say the SMAC was "essentially" normal, we're hedging our bets a bit, in case we didn't notice a slightly high transaminase or two. And the double-whammy: "essentially within normal limits." Who knows what that *really* means? And I wonder if our patients would be insulted to know that their exam was "unremarkable" or amused to know their abdomen was, thank goodness, "benign"? As medical students, when we use this language we learn to be tentative—we learn that is easier to disguise our uncertainty than to state the facts plainly.

How soon we forget that the one person most deserving of a clear, honest explanation of his or her problem is the patient![2]

■ *It tries to be different from plain English at all costs.* Who had heard of a "sauntometer" [centimeter] before medical school? And what is a "treemore" [tremor]? Uniquely medical pronunciations, along with all of our uniquely medical abbreviations and terms, help to separate our chatter from the realm of ordinary people.[3,4] But weren't we all more or less ordinary before we started this medical game? Why can't we talk the way we did before we started medical school? Why do we cling to phrases such as "prior to admission" when "before admission" is the easier and plainer way to say it? Perhaps we need to compile special dictionaries to translate medical language into English, as some have done.[4,5]

■ *It is often derogatory.* The most distressing feature of medical language is its derogatory tone in reference to patients. We don't write these kinds of words in the chart or in our journals, but even the most distinguished attending will speak of "hits" as if it meant "patients," or refer to the veteran with COPD as "the chronic lunger."

This callousness has its roots in battlefield humor.[6] When we face illness and death, we can make light of it and reduce our fear of it. We can also build up a psychic callus to protect ourselves from uncomfortable emotions, like pity for a sick, demented nursing home patient. An excuse often used by people who decide not to go into Pediatrics is that "I cannot stand to see sick children"; but why is it any more comfortable to see sick adults? We work hard to replace uncomfortable emotions with pleasant ones, even if it costs us our humanity.

■ *It abbreviates to a fault.* We love our abbreviations. Abbreviations are a necessary part of any language. But when we put PERRLA (Pupils Equal, Round, and Reactive to Light and Accommodation) on a chart of a patient who is too young to accommodate, or when we put TBLC (Term Birth, Live Child) in the past history of a two-year old, aren't we again admitting how little we are thinking about what we're doing? How often does "WNL" (within normal limits) mean "we never looked"?

■ *It is unnecessarily complex.* We abbreviate to make things simple, but then we work hard to add complexity. The word *symptomatology* is a good example of a complex term where a simple one would do. "Prior to" as a substitute for "before." "Acuity" takes the place of an old standard, "severity."

On the Other Hand: The Bright Side of Medicalspeak

Our professional jargon arose not from malice, but from a need to communicate in a certain way. What does medical language accomplish for us?

■ *It is efficient.* Saying "the patient got a septic workup" is a lot faster and easier to understand than a description of what *really* happened. In this sense, our professional language is like the talk used in restaurants to relay a customer's order to the short order cook. We don't have a lot of time or energy to waste on the wards, so it's easy to see how abbreviated forms and colloquialisms have taken up permanent residence in our vocabulary.

■ *It helps us cope.* A little black humor goes a long way toward alleviating our fears of failure, our overwhelming concern for our patients, and the emotional instability that accompanies our long hours of stressful work. As long as we see this humor for what it is, this shouldn't affect our concern for our patients.

■ *It helps us control our legitimate anger.* As humans, doctors are entitled to some anger when confronted with an abusive parent, a drug-abusing pregnant patient, or a victim of senseless violence. By employing a terminology that might seem abusive to outsiders, we use a verbal punching bag to release our anger in a harmless way. This mechanism can backfire, though, if this sort of talk leaves the confines of the residents' lounge and is used at the bedside or in the examination room.

■ *It provides a sense of camaraderie.* When the times get tough, sometimes it feels good to talk to someone who knows what one is going through. Sharing a special language intensifies the sense of togetherness that can give one badly needed confidence in times of stress or uncertainty.

Continued on page 3

progress notes

Published by the

Association of American Medical Colleges
for the Organization of Student Representatives

One Dupont Circle
Washington, D.C. 20036

Wendy Pechacek, Editor

project *forum*

Problem-Based Education from a Student's Perspective

I arrived at medical school, as many of us did, with a well-developed appetite for intellectual pursuit and interests that were as broad as any undergraduate education could offer. Though I had heard about the horrors of medical training, I don't think I understood it would happen to me. Idealistically, I expected an intimate "graduate" environment with small classes, individualized instruction, close relationships with my mentors and a learning system in which students actively worked together to gain an understanding of medical science concepts in an applied context. The curriculum I encountered had no such components, and as an act of self-preservation I became involved in educational reform.

Through my activities with A.M.S.A. (the American Medical Student Association) I learned that over the last 20 years, several institutions across the USA and Canada have gathered their resources and devised "experimental" curricula which incorporated an innovative educational method, "problem-based learning" (PBL). PBL is an active, student-directed system of education which is generally conducted in a small group tutorial setting. PBL is not an entirely new concept, having some roots in the "case-method" used in business and law schools. It is referred to in the educational literature as "adult" or "task-oriented" learning, focusing on its quality of assured relevance and current applicability. Its efficacy is supported by cognitive psychologists' conclusions that learning is most efficient if it is tied to information already possessed by the student (learning by elaboration rather than memorization), and learned in the context in which it will eventually be applied.

By design, PBL is an answer to the *Report of The Panel on the General Professional Education of the Physician and College Preparation for Medicine* (G.P.E.P.). The report defined general curricular revisions important in the establishment of an educational system that would be, 1) responsive to the "interdependence of the development both of the whole person and the specialized professional", and 2) able to "anticipate the circumstances that are beginning to alter the practice of medicine" while striving to prepare medical students to confront them in the future. It states that medical students must be taught to evaluate and care for patients in an efficient, effective and humane manner, and to be self-directed learners. The report reminds medical educators that they "can't teach . . . everything", but they are responsible for providing an environment where students can learn the knowledge, attitudes and skills necessary for the practice of medicine, including the ability to continue their own educational process for life. It recommends revision of teaching methods in undergraduate medical programs, primarily in the pre-clinical years, by a) *setting attainable educational objectives* [for faculty and students]; b) *increasing unscheduled time* [to allow for independent study]; c) *reducing lecture time* [replacing it with small group meetings]; d) *increasing activities that promote independent learning and the development of problem-solving skills*; and e) *using appropriate evaluation methods* [derived from the established objectives and incorporating the use of problem-solving and self-directed study skills]. The PBL method meets these criteria.

It is the combination of components in the theoretical base of PBL which sets it apart from other methods incorporating the use of clinical cases and/or problem-solving in medical education. The first of these components is the *use of the "ill-structured problem"* (Herbert Simon). This is the situation occurring most frequently in real life where 1) all the information necessary is not available at the outset of the problem, 2) as more information becomes available, the nature of the problem may change completely, 3) there is no one "right way" to solve the problem, and 4) one is never sure the problem is solved. Problems like these are best approached in a hypothetical-deductive manner otherwise known as clinical reasoning (problem-based learning). The second component of the PBL method, the *incorporation of the system of clinical reasoning used by physicians and researchers* includes a) information gathering, b) hypothesis generation, c) research and investigation, d) hypothesis revision and problem-synthesis. Third, is an emphasis on *student-directed learning*. As students discuss the case problem in tutorial, they are actively involved in identifying the

Continued on page 4

Continued from page 2

So What?

Occasionally a concerned medical scholar will point out the shortcomings of our medical language. One author has described "Medspeak," and has detailed its adverse effects on professional behavior: "the consequences of Medspeak—that is, the consequences of pedantry, cryptic brevity, and the use of verbal smoke screens—are funny, so long as communication is not the purpose of spoken medical language . . . the purposes of Medspeak are not communicative but manipulative. . . ."[1] This author maintains that we use this language to protect ourselves from scrutiny by peers and superiors, from lab results we cannot understand, from patients' nagging questions, and from our own insecurity. The article goes on to claim that "English is our second language". Another critic gathers all the worst elements of our medical language and assembles a grotesque case presentation that sounds all too familiar to anyone who has spent time on the wards.[7] These articles tend to be amusing and have obviously had no impact on the abuses of English we pass off as professional language. So what? As long as we make ourselves clear, what does it matter what words we use?

It matters because we stand to sacrifice our professional dignity if we, as medical students, do not consider our words more carefully.

Andy Spooner, MSIV
University of Tennessee, Memphis
Vicki Darrow, M.D.
R1, OB/GYN
University of California, Irvine

References:

1. Christy, NP. English is our second language. New England Journal of Medicine 1979; 300(17):979-981.
2. Barondess, JA. On the importance of ideals. The Pharos 1985; Spring: 2-4.
3. Bleed, D. Medicalspeak. The New Physician 1986; 35(6):20-21.
4. Scott, N & Weiner, MF. "Patientspeak": an exercise in communication. J. Medical Education 1984; 59(11):890-893.
5. Cleveland, WW. Physician's handy guide to medspeak. J. Pediatrics 1987; 111(1):78-79.
6. Peschel, BE & Peschel, ER. Aberrant medical humor: case histories, literary histories. The Pharos 1985; Winter:17-22.
7. Cleveland, WW & Cyanamon, H. A fascinoma. J Pediatrics 1984; 105(4):669-672. □

Continued from page 3

questions they need to pursue before understanding the scientific basis of the patient problem, its social science context, and eventually the diagnostic and patient care options.

Following from this, the fourth unique component in this system is the development of *skills in self-education.* These include the ability to self-evaluate (know what you don't know) and self-teach with development of the understanding that education is a lifelong process. One must constantly work to integrate new knowledge and skills into one's practice of medicine (clinical or research) in order to remain a competent physician.

The fifth component is the *use of a clinical case* as the basis for basic science education. This structures the students' learning in a clinical context, resulting in increased relevance and motivation for study.

The final and most unique feature, at least in my experience of preclinical medical education, is that *students have fun learning.* They pursue issues into the evening and over the weekend with friends and fellow classmates, seeking not just "the answer", but true understanding of the question and its implications. Various combinations of the above components are included in other methods of instruction used in medical education today, but only in PBL do they all come together to form a whole which is greater than its parts.

The unique structure of PBL results in a very different learning atmosphere. Students are responsible for their own schedule (outside of tutorial meetings). They develop their own study groups and are encouraged to work cooperatively rather than compete for grades/class rank. "I don't know" is a commonly used phrase indicating a self-assessed lack of knowledge rather than an admission of imperfection or lack of application to one's studies. Students learn from a variety of resources, choosing those they find individually to be most effective with an emphasis on information management, not memorization and recall. Ongoing evaluation is part of the learning process and occurs regularly with a focus on "formative" assessment and constructive feedback. To succeed, students must eventually meet both program and personal objectives as evaluated by themselves, their peers and their tutors. Students interact closely and frequently with the faculty who are involved with students in several capacities—tutor, resource person, or advisor.

When a tutorial group meets, they receive the presenting complaint of an actual patient. Students take various roles in the process that follows—one will serve as reader, another will be the recorder at the blackboard, and a third will man the dictionary as questions about terms arise. These roles alternate with each session, and the tutor oversees the process, preventing the students from getting bogged down in minutia. Students work together to develop a "Problem List", identifying the problem(s) with possible explanations (Generating Hypotheses) for each identified concern. The focus is on the underlying mechanisms, not the differential diagnosis. At this point the tutor will often encourage the students to decide which hypotheses are most likely and discuss their understanding of them (Rank Hypotheses and Test Hypotheses using current knowledge). The group then begins to identify "Learning Issues"—topics for study before the next meeting. Core issues are studied by all group members, but minor topics are assigned to individuals who will report on them at the next meeting. At this point, the tutor might make an effort to encourage the participation of a quieter student by giving him/her a specific "leadership" role for the next session. Following assignment of study topics, the groups hold a brief evaluation of the session with members offering praise and constructive criticism of the groups' functioning for the day. At this point students may seek feedback from their peers and tutor on their role in the group process and knowledge brought to discussion of the problem. They are encouraged to offer their own assessment first. Throughout the meeting, the emphasis is on the students to "do the work". Their control of the learning environment generates excitement and leads to a sense of ownership over the understanding gained.

McMaster University in Canada started the first problem-based curriculum in undergraduate medical education with its inception in 1969. As their program matured, others adopted varying degrees of the original concept. These include longstanding tracks at the University of New Mexico School of Medicine and Michigan State University School of Medicine, more recently developed programs at Rush Medical College, Mercer University School of Medicine, Harvard Medical School, and Bowman Gray School of Medicine of Wake Forest University. In addition several schools including Southern Illinois University, Tufts University School of Medicine, Case Western Reserve University School of Medicine, and Georgetown School of Medicine are running problem-based units or components within their traditional basic science curricula. There is a great deal to be learned from studying these programs both individually and collectively.

Last year, I conducted a series of site visits, to survey and compare the curricula at several of these institutions. My purpose was to examine both the *method,* its strengths and weaknesses, and the *value system* which forms the philosophical basis for this type of education, with implications at both the organizational and instructional levels. The specific aims of this study were to 1) describe the characteristics of five existing PBL programs operating in medical schools as a method of preclinical education; 2) determine the self-identified goals and essential components of these programs; 3) report the strengths and weaknesses of existing PBL programs as described by students, faculty and administrators; and 4) develop a personal analysis of these programs (in terms of their origination, implementation and success) based on the information and impressions I gained.

My visits were for 3-5 days each to the University of New Mexico, McMaster, Harvard, Tufts, and Case Western. Though I'm still in the process of formally compiling the results, I am convinced that the problem-based method is sound, and would like to see it implemented at schools across the nation in at least some portion of the curriculum. However, I realized as I traveled that the problems with medical education are much more far reaching than questions of methodology. There is the issue of priorities, allocation of resources and commitment to undergraduate education which must be addressed before questions of method and educational philosophy can really be determined. The truly far reaching accomplishment of programs like McMaster, New Mexico and the others is that they have decided that medical education is important and deserves a commitment to excellence equivalent to patient care and biomedical research. □

Jennifer Hoock, MSIII
Duke University Medical School

aamc focus

The AAMC processes and analyzes information from over 48,000 questionnaires administered to prospective or actual medical students on an annual basis. The three student questionnaires include: the Pre-medical Questionnaire, administered as part of the MCAT registration process; the Matriculating Student Questionnaire, administered to first-year medical students; and the Graduation Questionnaire, administered to final year medical students.

The Pre-medical Questionnaire (PMQ), which has been administered to MCAT registrants since 1977, was designed to elicit baseline information from students who may or may not apply (or be accepted) to medical school. In an effort to collect information similarly across all three student questionnaires, the PMQ was revised in 1987. For example, the new PMQ includes attitudinal items concerning the changing perceptions of medicine. These include, "Medicine will be as financially rewarding in the future as in the past." and "Physicians' legal liabilities and their high cost of malpractice insurance are not major problems." The new PMQ also includes expanded sections on financial aid needs and future specialty choices.

The Matriculating Student Questionnaire (MSQ) was first administered in 1987 to medical school new entrants. It provides a second source of information about students before they have been exposed to the medical school curricula. Similar to the PMQ, students are asked their perceptions of medicine. For example, preliminary results showed that 86% of the 1987 first year students thought that medicine will be as financially rewarding in the future as in the past and only 4% thought physicians' legal liabilities and high malpractice insurance costs are not major problems. In addition, questions are included on the type of physicians students want to be, as well as their first year specialty choices. As processing is completed, medical schools are provided with an aggregate summary of their students responses to the MSQ.

The third questionnaire administered to students is the Graduation Questionnaire (GQ). This questionnaire has been administered since 1978 and provides data on specialty choices and research plans of graduates, as well as their evaluation of the adequacy of medical school instruction. This year, in response to student and specialty board inquiries, respectively, the GQ included items on questions asked of students during the residency interview and on factors affecting the choice of a specialty. Like the MSQ, schools are provided with an aggregate summary of their students' responses to the GQ, as well as an anonymous student evaluation of the strengths and weaknesses of the medical school.

The three questionnaires are monitored closely so that different information is elicited from students at each time period. However, items are also included so that changes in student choices can be assessed. For example, by examining a student's specialty choice on the PMQ, MSQ, and GQ, changes in specialty choice from before medical school to the first and the fourth year of medical school can be identified. While changes in student's choices, attitudes, etc. are studied, the student's anonymity and confidentiality of responses are protected.

In summary, the PMQ, MSQ, and GQ provide invaluable data to each medical school, as well as to the AAMC and national policymakers. Suggestions concerning additional questions to be included or research areas to be identified are always welcome. □

Cynthia Tudor, Ph.D.
Director, Student Studies
Section for Student and Educational Programs

Continued from page 1

Finally, I want to focus your attention on an issue which will prove to be one of the most significant for our professional lives—access to health care.

I want to start it off with a question that is often directed to medical students:

"Whose service are you on?"

A teaching service for providing care to the poor is a concept used in many medical school hospitals. At present there are 35-43 million Americans uninsured or underinsured compared to 25 million in 1977. Increasingly, these are the patients on whom we learn. With the cost-conscious reimbursement system currently in vogue, there is no longer the luxury of subsidizing indigent care through monies from insured patients. Unfortunately the problem will soon be exacerbated due to increasing pressures in several areas. First, if one looks at birth rates comparing low to higher SES groups, it is evident that the poor, as a proportion of the population is increasing. Second, poor people have a higher incidence of disease. Therefore, the segments of the population for which there has traditionally been a higher burden of disease is increasing. Third, the very real economic problems this country faces are not trivial and require urgent redress.

The issues surrounding access to health care are numerous, ranging from ethical and moral to economic and political. Together they occupy a seemingly overwhelming challenge to our societal values, institutions, and in some respects, current structure for redress. The immense scope of the problem has contributed to an attitude of helplessness textured by such comments as "the need for a broad societal address." Increasingly, recognition of the enormity of the problem has served as a convenient scapegoat for inactivity without first discerning what each individual and institution could contribute singly and, through unity of effort, collectively.

Studies have shown that there is an improvement in health with access. Examples include the findings that access to hypertension medication and attendant medical care decrease morbidity and mortality, immunizations for children prevent many childhood diseases, and some decrease in low birth-weight infants and perinatal mortality are seen with prenatal programs.

Evidence indicates marked improvements in access for minorities and lower SES groups since the introduction of Medicare and Medicaid. However, there are still gaps with existing programs and gains of the past are threatened by spending cuts.

Aside from the moral imperative for addressing this issue, there is a financial one as well. For example, 1977 expenditures on cardiovascular disease were over $25 billion. If the lower 25% of the SES distribution experienced equivalent disease rates to the median SES group, there would have been 250,000 fewer cases and a resultant savings of $3.3 billion. Similar calculations could be done for many diseases.

That it is society's issue is true but as we will be the future leaders in the delivery of medical care, it is also very much our problem. As future physicians we can choose to ignore the

Continued on page 6

Continued from page 5

problem. Although this is not a very constructive solution, we can, like the ostrich, bury our heads in the sand. At present, doctor-bashing seems to be an increasingly popular societal game. Why would we want to improve the target? If we do not contribute effectively, the problem will be solved by laws and I don't think they do an optimal job. Therefore I raise as a springboard for discussion the following:

1. Should there by a mandatory period of service for graduating physicians after residency?

   The education costs are probably higher than what we pay. Is this a rationale for serving? I have heard a range of opinions on this. Everything from "Yes, I should serve two years in an underserved area because I feel I owe it to society for providing the infrastructure for an excellent medical education" to "No, I repay my debt by spending 8-12 years in free service while I'm in training." Should there be mandatory service?

2. Pro-bona for licensure

   Lawyers in California have as part of their eligibility for licensure a period of annual service to those unable to pay. Is that a viable option for the medical care profession?

3. National Health Insurance—Is this a panacea?

4. Research into quality of care

   Is there a minimum of care acceptable for those who are unable to pay? Why or why not? If there is, what is it?

I have often felt like an ostrich when my head is in some book studying something the significance of which is determined by the preference of a given professor at that time. However, in your copius free time there are some ways that you can become informed on the issues and, where possible, contribute to the dialogue. There are a number of groups that are active in this area—American Public Health Association Medical Care Section, AMA-MSS, AMSA, local and state medical societies and public health groups. Additionally, talk among your classmates. Arrange to have noontime speakers who are informed on the issues. If you see discrepancies between paying and non-paying patients in your teaching hospitals, question the practice of your attendings, residents, and hospital.

Now, as students, we are on teaching services providing care to the poor as we learn the practice of medicine. Who will we serve in the future when our formal training is completed?

Look forward to hearing from you.

Cheers,

Kim Dunn

References:

1. Amler, RW & Dull, HB. (Eds.) Closing the gap: the burden of unnecessary illness. Oxford Press, 1987.
2. Anderson, RM, Giachello, AL & Aday, LA. Access of hispanics to health care and cuts in services: a state-of-the-art overview. Public Health Reports 1986; 101(3):238-252.
3. Davis, K, Gold, M & Makuc, D. Access to health care for the poor: does the gap remain? Ann. Rev. Public Health 1981; 2:159-182.
4. Final evaluation of the obstetrical access pilot project. Sacramento, California: California DHS, Maternal and Child Health Branch, 1984.
5. Greenberg, D. Uncompensated care: how should the charitable mission of hospitals be financed? Senior thesis, Princeton University, 1987.
6. Hafferty, FW. Physician supply as a socially constructed reality. J. Health and Social Behavior, 1986; (27):358-369.
7. McCarthy, CM. Financing indigent care: short- and long-term strategies. JAMA, 1988; 259(1).
8. Minden, S. A review of the literature regarding evaluation of programs for multi-disciplinary prenatal care. Sacramento, California: California DHS, Maternal and Child Health Branch, 1983.

the bulletin board

Report from the Transition Forum

The November 1 uniform release date for Deans' Letters last fall caught many people involved in the resident selection process by surprise. The new policy caused inconvenience and even hardship for program directors, residency staff, and students trying to coordinate application deadlines, interviewing, and resident selection. Whose idea was this change? What is the rationale behind the new policy? What changes will result for medical students and residency programs?

The uniform release date is the first of many major changes that will affect the senior year of medical school. That's the recommendation of the Association of American Medical Colleges' (AAMC) ad hoc Committee on Graduate Medical Education and Transition from Medical School to Residency. The committee examined the effect of the selection process for residency positions on medical students' education and generated the following concerns:

1) Medical students are pressured into making decisions about specialty choices without adequate time, guidance or basis for decision-making.
2) Faculties are asked to provide evaluations of students' academic achievement and clinical performance before faculties have had a sufficient opportunity to assess fully the students' abilities.
3) Students who are asked by program directors to take "audition electives" or who elect to take multiple clerkships in their chosen specialties to improve their changes for desired residency appointments jeopardize their *general* professional education.

The ad hoc committee made a number of recommendations which were published as an "Agenda for Action" by the Executive Council to the AAMC on January 22, 1987. One of these recommendations adopted by the Council of Deans was that the uniform release date for Deans' Letters be November 1, 1987. This release date was meant to pave the way for implementing a new time frame for resident selection across the country. This change is possible given the new capability of the National Resident Matching Program (NRMP) to compress the time between submissions of rank order lists to Match Day. The turn-around time was five weeks in 1988 and may be as little as two weeks in 1989. The goal in delaying the application process is to allow students more time for making career decisions and to provide more opportunity for medical school deans and faculties to access each student's clinical abilities. The success in incorporating the new time schedule for the 1987-88 season has been variable among residency programs across the country.

Continued on page 7

Continued from page 6

It is unfortunate that many programs did not have enough time to respond last year to the decision of the Council of Deans. Now is the time, however, for every residency program to decide whether to make a commitment to the recommendations of the AAMC and adjust their selection process for 1988-89 appropriately.

Other recommendations spelled out by the AAMC include improving the Universal Application Form, improving the quality of Deans' Letters, ensuring appropriate use of National Board of Medical Examiners test scores, and restraining excessive audition and single specialty electives. Details on the progress of these recommendations are available from the Division of Academic Affairs, AAMC, One Dupont Circle, N.W., Suite 200, Washington, D.C. 20036.

Joanne M. Fruth, M.D.
R1, Family Practice
Swedish Hospital, Seattle
and representative to the AAMC Forum on the Transition from Medical School to Residency.

1987 AMA Impaired Health Professional Conference Update

I represented the AAMC at the American Medical Association (AMA) 8th National Conference on Impaired Health Professionals on October 8-11, 1987 in Chicago, Illinois. The program included excellent presentations on the following topics: education, prevention, recognition, and early treatment of impairment among medical students, residents, physicians, and other health professionals; techniques for the design and implementation of assistance programs; strategies for psychiatric impairments other than chemical impairment; intervention training; suicide prevention; coping skills training; survival techniques for the stressed professional; and the "politics" of impairment.

I highly recommend the conference to anyone who has experienced, or wishes to gain knowledge and understanding of the prevention, identification, and treatment of impairments which affect health professionals. The conference sessions were packed with useful information. The conference may be particularly useful to students, faculty, and deans who are involved in the development implementation, or ongoing operation of medical student assistance programs and those who frequently deal with impaired medical students, residents, or physicians.

During this year as the Central Region OSR Chairperson, I hope to work with AMA Impaired Health Professional Conference Program Planning Committee members to increase medical student awareness of and participation in the 1988 AMA Impaired Health Professionals Conference. In addition, I will be working with Wendy Pechacek, OSR Staff Director, to develop a data base containing current information about existing and developing medical student assistance programs. In this way, the OSR hopes to facilitate cooperation and exchange of ideas among students, faculty and deans who are involved in the development of such programs. We will be requesting information from the OSR representatives and Deans of Student Affairs of each medical school. If you can provide information about the student assistance programs at your school, please forward them to Wendy Pechacek, AAMC, One Dupont Circle, N.W., Suite 200, Washington, DC 20036. □

Julie K. Drier, MSIII
University of Minnesota-Minneapolis
OSR Central Region Chair

News from the Committee on AIDS and the Academic Medical Center

AIDS has had a great impact on all aspects of medicine, including medical education. The academic medical center plays a unique role in the fight against this disease, both providing the specialized medical care needed by AIDS patients and educating the next generation of physicians—who will have to meet the challenges AIDS presents. Because of the scope of these challenges, the Executive Council of the AAMC established the Committee on AIDS and the Academic Medical Center "to recommend policy positions and possible programmatic initiatives for the Association concerning this issue of increasing importance." The Committee is chaired by Dr. Jay Sanford, President and Dean of the Uniformed Services University of the Health Sciences. Committee members represent all of the constituent groups of the AAMC

At its first meeting, the Committee divided into two Subcommittees to address two areas which could best be considered separately. The first Subcommittee, chaired by Dr. Festus Adebonojo of Meharry Medical College, will address institutional policies towards applicants, medical students, residents, and faculty, including screening, admissions, and management of those HIV-positive.

The second Subcommittee, chaired by Dr. Richard Behrman of Case Western Reserve University School of Medicine, will address issues of medical student education. I serve on this Subcommittee; issues we are presently discussing include:

- Students' fears of acquiring HIV
- Curricular issues (prevention and public health, medical ethics, etc.)
- Student and faculty attitudes toward AIDS patients
- Impact of AIDS on the general professional education of medical students

At its February 25 meeting the Executive Council of the AAMC adopted the subcommittee's Statement on Professional Responsibility in Treating AIDS Patients, which helps to define the responsibilities of students, residents, faculty, and administrations of medical centers. This statement complements statements made by various professional organizations and, of special interest to students, help to clarify the individual student's responsibilities and rights in treating AIDS patients.

As the student representative to the Committee, I am working to represent students by accurately voicing their concerns. Anyone with questions or comments is welcome, and encouraged, to write me at the address below. □

Kevin Flanigan
MSI
Rush Medical College
600 S. Paulina
Chicago, IL 60612

AMA Medical Student Section

The AMA-MSS has available by request the *Resource Manual*, a guide to state/local section development, leadership, membership, programming, communications and policy development and resources. Also available is a videotape introduction to the AMA-MSS 7:22 in length.

The 10th Annual Meeting of the MSS Assembly will be June 24-26, 1988, in Chicago, Illinois. The theme will be "Ethics and Economics: The Physician's Tightrope." For more information contact the AMA Department of Medical Student Services (312) 645-4746. □

133 Medical Student Scholarships Available For Alcohol and Drug Abuse Training in 1988

J. M. Foundation President Jeremiah Milbank, Jr., has announced the availability of 133 J. M. Foundation Medical Student Scholarships in Alcohol and Other Drug Dependencies for 1988. The education/training scholarships cover tuition, room and board, and a travel/expense stipend at fourteen 1-week to 3-week institutes and summer schools of alcohol studies held across the country.

The purpose of the program is to provide medical students with a comprehensive understanding of alcoholism and other drug dependencies; enhance knowledge and basic skills on the identification, intervention and treatment of alcohol and other drug dependent people; and encourage a positive attitude toward patients with alcohol and drug problems.

Since its founding in 1924, the J. M. Foundation has given priority attention to medical education, biomedical research, and rehabilitation medicine. The new initiative in alcoholism is directed at model projects that test new approaches in prevention, education, or early intervention with problem drinkers. Four broad areas of particular interest have been identified: children of alcoholics, voluntary organizations, public policy, and medical education and training.

Since a limited number of scholarships are available, interested students should contact the appropriate coordinator of respective schools. Call Wendy Pechacek at 202/828-0570 to determine the school nearest you. □

letters to the editor

To the Editor:

Dennis Barbour's article in the most recent issue of *Progress Notes*, "Prevention Medicine: What It Is and What the Medical Student Can Do to Learn More About It," fulfills its former, but unfortunately, not its latter promise. It represents an excellent, terse summary of the definitional and linguistic problems encountered by the medical student who seeks to learn the principles and practice of this growing field. However, I fear that it may leave the student with yet another expression of what may appear to the uninitiated to be "professional chaos" which might actually deter him/her from identifying specific career choices in the field of prevention.

Furthermore, absent from the article is any mention of preventive medicine as a board-certifiable medical specialty, among other things, a definite training option for the aspiring "physician/epidemiologist." The specialty is 40 years old with 70 programs nationwide training nearly 500 residents.

"Hard questions" of primary care/preventive/family/community medicine faculty all too often do not produce any "hard answers" about specific residency training options for the aspiring prevention-oriented physician. I have received numerous inquiries from students around the country looking for just this guidance. After attending a session titled "Prevention in the Clinical Specialities" at the most recent AAMC convention and again having this concern expressed to me by several students, I thought I might share my perspective on more specific ways to collect information about and choose a specific residency track in the broad field of prevention.

Traditionally, the primary care specialties (internal medicine, pediatrics and family practice) have focused on the individual patient. They still do. Likewise, the specialty of preventive medicine has considered the population or community as the "patient." It still does.

For the student who wants to focus exclusively on the individual patient with a preventive emphasis, the primary care specialties with their increased awareness of primary prevention and risk factor reduction remain the route of choice. For the future public health officer, occupational medicine director or aerospace medicine physician who will be collecting and analyzing data on, programming budgets for and administering health care resources to a population, the preventive medicine residency is decidedly the way to go.

While primary care practitioners may have a "community perspective," their training primarily does not. Similarly, while a recent American College of Preventive Medicine survey demonstrated that 70% of preventive medicine specialists engage in some clinical care, their residency clearly does not emphasize this aspect of their practice.

What about the student who wishes to become, and perhaps in the process define, a "clinical preventive medicine specialist"? First, he/she should realize that "trailblazers" rarely have safe, predictable or prescribed routes to follow. Furthermore, it is possible to follow many different routes to the same end, and yes, even the same route to different ends.

There are currently in existence preventive medicine residencies which offer and emphasize rotations in preventive cardiology, exercise physiology and behavioral modification. These are internal medicine and famliy practice programs offering similar rotations as elective opportunities or fellowships. There are a few preventive medicine residencies which only accept residents who have already completed a primary care training program. Each option, I maintain, offers a different emphasis which will suit the needs and goals of a given student planning for a future role in the multifaceted field of clinical prevention.

Unfortunately, the legacy of the historical rift between curative and preventive medicine necessitates that, at least for the present, students must often look outside their medical school for detailed (as opposed to conceptual) information. Speak to practitioners in the community whose practices you admire regarding their previous training; to your local or state public health director; to the MD responsible for occupational health or health promotion programs in a major company or HMO. Arrange an elective with one of these individuals or at one of these sites. Ask the Dean why there aren't more resources to address your career needs. Encourage role models you discover to formally affiliate with your medical school. Write the specialty organizations concerned with the field. Read the AMA Green Book of Residencies well before you apply. Write specific programs and/or residents for a description of their curricula. Visit a school of public health to see what perspectives and skills it may offer you, whether within or outside of a formal residency program.

Finally, I strongly applaud Mr. Barbour's charge to students to engage in the evolutionary process of medical and residency education. Insist on obtaining all the information available to and necessary to make your residency decision. Most importantly, provide feedback to other students and medical faculty as to why and how you made your decision so that the entire medical community can benefit from your "pioneering" efforts! □

Michael Parkinson, MD, MPH
President
Association of Preventive Medicine Residents

ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES

aamc

Volume XII
Number 2
Fall 1988

progress notes

Medical Education News from the
Organization of Student Representatives

perspective from the chair

Greetings. I hope that your new school year is off to a good start.

In this issue of *Progress Notes* are a variety of articles which I hope you will find of interest. Among them is an article by Drs. Dan Shapiro and Nadine Becker, a married couple in Obstetrics and Gynecology residency training at Pennsylvania Hospital in Philadelphia discussing their experiences during residency interviewing. Also, Dr. Jeralyn Bernier, Pediatrics resident at Yale, compares the Swedish health care system with that of the U.S. In Project Forum, Chris Bartels, MSIII, highlights the experience of students at the University of Virginia in improving feedback on their clinical rotations. Another article is by Dr. Michael Rothenberg on creating a healing environment.

Finally, here are some thoughts on public health and your medical education:

As members of the medical profession, we are involved in public health. We may not think of ourselves that way or be adequately trained to operate as public health specialists, but by fiat we have been placed at the pinnacle of the decision-making processes regarding disease and, by association, health. In general, medical education trains us to think of disease as disease of individuals. There is a paucity of training in applying population data to the individual patient. There is also very little training in ascertaining the level of disease and health in populations or how to prevent or preserve them respectively. We are trained in a biomedical model of disease and to function, we believe, well in that milieu. We can rattle off causes of disease in terms of defective gene products, malfunctioning physiology, etc., and we are taught to believe that if we search hard enough we will be rewarded with a cause and will be able to prescribe an appropriate cure. We are given very little instruction in working with a patient to alter behavior patterns, such as smoking or overeating, or trying to understand such phenomenon as the fact that indigence carries an increased risk of morbidity and mortality. In short, we are trained as disease specialists, not health specialists of individuals.

However, expertise of increasing importance for the practice of medicine lie in areas traditionally associated with public health, including health services research, risk assessment, health policy analysis, and health education. Examples of applications of these areas of research to clinical practice, and therefore, for medical education include:

Continued on page 6

Some Thoughts on Creating a Healing Environment

For most medical students and their families, graduating from medical school represents having survived an ordeal. I wish that, instead, it represented the recognition of your having worked successfully with your teachers to create a mutually rewarding learning environment.

In the hope of helping you a little as you start the next phase of your medical careers—and your lives—I'd like to share some of my thoughts about creating a healing environment.

The creation of a healing environment for the patient—internally and externally—ideally should involve the doctor and patient in a cooperative effort during every medical encounter. This process includes several critical factors: competence, compassion, critical evaluation, candor, and cooperation.

The doctor must be *competent* to diagnose and treat disease.

The doctor must be *compassionate*—that is, he or she must, in fact, never forget that it is a *person* who is being treated, not just a disease. This will lead the physician to practice comprehensive care, which I define as the systematic inclusion of psychosocial dynamics and personality development in the practice of medicine, in a family and community context.[1]

The doctor must *critically evaluate* his or her art and science on a regular basis, so that skills and knowledge can continue to grow with experience and time.

Finally, the doctor and the patient must be willing to be *candid* and *cooperative*, which requires a willingness to work in a give-and-take manner to create a trust level sufficient to allow candor and cooperation to occur. As one patient with a chronic illness put it, "It takes a little courage to ask dumb questions. I, for one, don't like to appear stupid, but if you don't know something, trying to fake it doesn't help you . . . It's your health care that's at stake."

Such candor and cooperation is asking a lot of the doctor, but it is *not* asking for omnipotence or omniscience. In my view, omnipotent and omniscient behavior is the major obstacle to the successful creation of a healing environment.

For four years, you have been given the overt or covert message that you should become omnipotent and omniscient. If you say, "I don't know," and then you hear, "You flunk!", you will stop saying, "I don't know." With people of your intelligence, that is a simple matter of one-trial learning. You may even, to put it politely, start "faking" it, as with the patient I just mentioned. This is a foolproof method for bringing real learning to a halt.

Though this school tries to be supportive of its students, few of you have come through the last four years without experiencing a good deal of personal pain and, at times, have felt anything *but* omnipotent and omniscient. Indeed, most of

Continued on page 6

project *forum*

Being Heard in Virginia

What ever happens to those written evaluations hastily completed at the end of a third year clerkship? Who sees them and what is done with them? These were the questions asked by the recently graduated fourth year class at the University of Virginia. A lack of answers prompted a few student leaders to organize about half of their classmates, over sixty in all, to look over the evaluations which were given to them during their third year and then generate a report called the Comprehensive Clerkship Review.

The forty-four page report received kudos from the administration because it offered criticism and praise, as well as suggestions for improvement. More importantly, it represented the view of the whole class and not just that of select individuals. Another strength of the report was the fact that those fourth year students who prepared it were not around to reap the benefits of their work. "Entitlement" is a word often thrown around medical education board rooms to describe student's demands for improving this or that. However, the Comprehensive Clerkship Report was approached with the objective of cooperation between students and faculty to improve medical education and to give praise where it is due. As consumers of medical education, we have certain expectations, but as responsible individuals we are obliged to do our part to improve the product as well.

Under the leadership of the medical student government president, six individuals were chosen as primary reviewers; one for each of the rotations during the third year. Their job was to write each review by gathering information from written clerkship evaluations, group meetings, and interviews. For added objectivity, each primary reviewer intended to enter a field other than that of the clerkship they evaluated. The initial review was then considered by five to ten other consultants, with consensus opinions resulting in the addition or deletion of comments. Finally, the entire report of all six clerkships was evaluated by fifteen student reviewers, again to insure that the facts and opinions expressed were accurate and appropriate. The result was a comprehensive report with over sixty students involved in its preparation.

An "objectives" format was used to evaluate how well the clerkship experience satisfied its objectives. Each review started by stating the objectives for the clerkship, their use, and how they were initially addressed. The ward experience was then evaluated, with comments about the level of responsibility, teaching, and job performances feedback. Lectures, conferences, reading assignments, and examinations were reviewed to evaluate their effectiveness in helping students to assimilate the material. From the above base, suggestions for improvement were made which summarize ideas expressed throughout the review.

Both strong and weak aspects of each clerkship were highlighted in the report. Constructive criticism was the standard, and every attempt was made to give a fair appraisal. The names of the specific individuals were used to highlight both positive and negative ward experiences. It was the hope of the committee that the information would be used to provide feedback to encourage continued excellence in those who have taught well, and to promote change in those who need improvement.

Continued on page 3

Medical Couples

Nadine and I, like 16,000 other fourth-year medical students, gathered with our classmates on March 23rd to learn where we would be in resident training. Our stomachs were churning and our heads pounding and we opened our envelopes hastily. We stared at each other with joy and disbelief . . . we had matched together. We were married three days later as planned, without the forced smiles we would have worn had the match been a disaster.

Our story is becoming quite common. Last year approximately 700 people entered the "couples" match seeking residency positions together. Most were successful to some degree, but for many, match day brought abrupt change to previously stable relationships.

In our search for positions together, Nadine and I learned about the problems medical couples face as they enter their careers. Many of the problems are those faced by all working couples; who does the shopping, pays the bills, cleans house, cooks dinner, etc. Medical couples though have the complications of long hours and being "on-call".

Still, all the problems medical couples encounter are surmountable. Partly, we set lower expectations of our partners. We know implicitly what it feels like to be "post-call". We know and share that impossibly frustrating feeling of planning a night out and having a patient get sick as we have one foot out of the door. We forgive each other quickly for the way we look or act at the end of a hard day. In short, we (hopefully) know exactly what the other is experiencing.

Certainly, many medical couples don't "make it." As much as we understand the other's situation, people in medical relationships often fall prey to competition, professional jealousy, or inflexibility. Nadine and I have defended against these bugaboos fairly well, but they have zapped us on occasion. Our residency search highlights some of the ways we got zapped.

In our hunt for residency spots, we agreed not to discuss the other's performance or personality in our interviews in order to avoid the appearance of competition. With the single exception of the program we got, every program asked questions of us that fostered a competitive spirit. "Is he/she as good as you?" was a common one. One program director even openly showed disdain for me in his talk with Nadine, while another sent me a solicitous letter but sent nothing to my wife. Often we left programs with frayed nerves or wounded egos.

Continued on page 4

Progress Notes

Published by the

Association of American Medical Colleges
for the Organization of Student Representatives

One Dupont Circle
Washington, D.C. 20036

Wendy Pechacek, Editor

Federal update

Department of Education Internship Deferment

The length of the allowed deferment on the repayment of Department of Education loans (GSLs, now called Stafford loans, and Perkins loans) provided in the Higher Education Act for medical residents has been the subject of a great deal of attention in the past two years. Between 1980 and 1986, the deferment allowed by law was two years. In November, 1986, the Department of Education made a regulatory change that effectively reduced the length of the deferment for most residents. Legislation enacted in June, 1987, was expected to restore the 2-year deferment for all residents. Unfortunately, because of the legislation's effective date, the Department of Education was able to interpret this amendment to apply only to new borrowers, making the reduced deferment still applicable to current residents and those serving residencies until 1990.

This spring, several higher education issues began to take shape in legislation, providing a vehicle for another attempt to overturn the Department's regulation. In June, H.R. 4639, a bill making needed changes in the SLS loan program, was passed by the House and sent to the Senate for consideration. There Senators Claiborne Pell (D-RI), Edward M. Kennedy (D-MA), and Robert T. Stafford (R-VT) added a provision which makes the June, 1987 amendment retroactive. The House subsequently approved the Senate amendments and H.R. 4639 was signed into law July 18, 1988, as P.L. 100-369. The legislation assures that all medical residents, regardless of the length of residency required for state licensure, are eligible for a 2-year deferment of their Department of Education loans. As of this writing, the Department is currently developing a "Dear Colleague" letter to explain all the changes made by P.L. 100-369.

Mandatory Health Insurance

During the 100th Congress legislation has been introduced in both Houses of Congress that would require employers to provide health insurance for their employees. The Minimum Benefits for All Workers Act, introduced in the Senate (S. 1265) by Senator Edward Kennedy (D-MA) and in the House (H.R. 2508) by Representative Henry Waxman (D-CA), would amend the Public Health Service Act and the Fair Labor Standards Act of 1938. Employers would be required to provide a minimum package of health insurance coverage to employees working at least 17½ hours per week and their dependents. The plans must cover inpatient and outpatient physician services, diagnostic and screening tests, as well as prenatal and well-baby care.

Both the Senate Labor and Human Resources Committee and the House Energy and Commerce Subcommittee on Health have held hearings on the issue. While representatives of employee unions enthusiastically support the legislation, businesses, particularly smaller companies, are concerned that the legislation would be far too expensive for them to implement successfully. Critics of the bill contend that mandating health benefits will result in increased labor costs, leading to lower wages and benefits, decreased investment, fewer jobs, and increased product cost for consumers. They also predict that the cost of such health plans may drive many small companies out of business.

By and large, hospitals are strong supporters of the Kennedy/Waxman bill. In 1986, hospitals absorbed nearly $7 billion in costs for the care of the uninsured. The AAMC has supported the Minimum Benefits for All Workers Act through letters to its sponsors in both the Senate and the House. Additionally, the AAMC joined a group of 14 other health care organizations in a joint letter to Senator Kennedy supporting minimum health benefits.

Representative Fortney Stark (D-CA) introduced another Mandatory Health Benefits bill in the House on June 29. Mr. Stark's bill is less rigid in its requirements for minimum health benefits. However, Mr. Stark's proposal would insure a greater portion of the 38 million uninsured Americans than would the Kennedy/Waxman bill because it does not provide an exemption for small companies.

Under Mr. Stark's bill, firms would have to provide at least the same benefits as Medicare, minus the outpatient drug benefit. The bill would emphasize catastrophic coverage by allowing deductibles as high as $1,000 for a single person and $1,500 for families. The bill would offer tax credits and deductions for low income employees and self-employed individuals, and encourage the formation of risk pools. Penalties for non-compliance would include a tax on firms that fail to provide insurance for their employees, and fines on firms in states that fail to set up qualified risk pools.

More hearings are likely for both the Kennedy/Waxman bill and the Stark bill. However, no action is expected for the remainder of this Congress.

Continued from page 2

It sounds simple, right? The best answers usually are. However, the ultimate success of the report rested on a few points. First, the report was timely. It was produced in six weeks and presented to a clerkship directors meeting in October. Second, the report was widely disseminated to both students and faculty. However, the reports to all but the clerkship directors had the names of the "bad" faculty omitted to avoid any semblance of blacklisting. After all, it was not the intention of the report to be a hit list with vengeance taken against all those who need improvement. To reiterate, the document was a sincere attempt to work with faculty to change things for the better at the University of Virginia.

The climate was right for such a report when we printed it. The new dean of the medical school had expressed great interest in medical education when he entered that position two years prior. Students were the first group to generate a report of a student-faculty conference held to discuss the impact of the GPEP report at UVA with those faculty interested in improving medical education. Committees, composed of both faculty and students, are looking at "Faculty as Teachers" and "Residents as Teachers", and are in active discussions, with reports expected from these groups this Fall. The "Task Force on Teaching Effectiveness", also with both faculty and student members, has already printed a very revealing report on the perceived versus desired importance of teaching in faculty promotion decisions. Although changes will not occur overnight, students at UVA will be better off for any improvements and for knowing that they did what they could, even though they might not be present to enjoy the results.

Christopher Bartels
MSIII
University of Virginia 1990

John Armstrong, M.D.
University of Virginia 1988

Continued from page 2

Another major hurdle that we and other couples face is sexism. We naively thought this demon was dead. I can only say we were very wrong. We have not yet seen it in our new-found program, but sexist attitudes clouded many of our interviews.

Interviewers frequently asked Nadine if she knew "what she was in for." We were both especially peeved when interviewers asked her what she would do when I was on-call. No one ever asked me what I would do. I even asked one interviewer why he only asked Nadine that question. He was surprised that I cared. Of course, Nadine had to handle (illegal) questions about our plans for children and her long-term commitment to our specialty. Again, no one asked me these questions.

Though sexist attitudes most often clouded Nadine's interviews, I was not immune. One interviewer told me flat out that experience told him men in medical couples were usually inferior candidates. He added that he figured men in my situation "allowed" themselves to be coupled with superior medical women to advance their careers. When I asked him if he had concluded this from reading my file, he told me he hadn't read it yet.

Still, with all the difficulties we faced, we found a handful of programs that saw us as more of a curiosity than a threat. We found that we were successful with these programs because we were explicit about our goals and because we presented ourselves as two individuals who happened to be married.

Ultimately, Nadine and I got what we hoped for. Partly, we were lucky, but part of our good fortune was good planning. Still, even the best planning does not prevent external forces from stressing a medical couple. To residency programs, hospitals, and private practices that are free of impediments to medical couples we say thank you. To those with barriers intact, we say "get with the program." Current estimates suggest that 50% of the new generation of physicians will marry other doctors. The impact of this will undoubtedly be significant for both medical practice and physicians' lifestyles. The greatest impact, though, will likely be on residencies. The pressure to reduce resident working hours is already on. The influx of medical marrieds into residency programs will likely act to increase this pressure.

Major changes in the way residents are trained are still down the road. For the time being medical couples can expect to encounter difficulty with scheduling, vacation planning, and daily life. Hopefully, though, they will no longer have to deal with sexist attitudes and closed minds in their search for compatible residencies.

Daniel B. Shapiro, M.D.
Obstetrics/Gynecology Resident
The Pennsylvania Hospital

Please forward a copy of any programs, newsletters or resource materials developed at your school to Wendy Pechacek, Staff Associate, AAMC, One Dupont Circle, Suite 200, Washington, D.C. 20036. The OSR office will act as a clearinghouse of information on projects at the schools. If you would like to start up a new program and would like some ideas, you can also contact Wendy for assistance at (202) 828-0570.

the *bulletin* board

Medical Student Research Awards

The Emergency Medicine Foundation and the University Association for Emergency Medicine is sponsoring medical student research awards.

The awards are designed to encourage medical students to engage in and be exposed to emergency medicine research. Stipends are awarded for 1-3 months. The stipend for the EMF-UA/EM Medical Student Research Award is $800.00 a month. The stipend, which is awarded to the student's institution, may not be used for faculty salary support, capital expenditures, i.e., purchases for durable goods over $300.00, or institutional overhead. Each proposal will be evaluated according to the following criteria: 1) relevance of the project to the goals of the program, 2) the applicant's academic background, 3) evidence of institutional support, adequate facilities, and institutional commitment to research, and 4) confidence of the preceptor.

Applications must be postmarked no later than November 1, 1988. Notification of funding will be made February 3, 1989. Those wishing to receive an application should contact Michael E. Gallery, Ph.D., Executive Director, Emergency Medicine Foundation, P.O. Box 619911, Dallas, Texas 75261-9911, 214/550-0911.

California Chicano/Latino Medical Student Association

The California Chicano/Latino Medical Student Association (CMSA) was formed just four years ago. Membership includes approximately 200 medical students from 9 California medical schools and several hundred undergraduate students who participate in CMSA sponsored activities. CMSA's main goals are (1) to promote the development of a communication network for Chicano/Latino students; (2) to promote Chicano/Latino medical student interests that will lead to the improvement of health care for underserved communities in California; (3) to facilitate educational programs for the recruitment and support of Chicano/Latino medical applicants; (4) to support the efforts of all other organizations committed to the improvement of health care of Chicano/Latino and underserved communities. Among the activities sponsored by CMSA are the *Newsbulletin* which is published quarterly and contains information and updates on issues concerning health care in underserved communities, an annual conference held each spring, and the Supernetwork Program, which serves as a recruiting effort by linking undergraduates at various target schools to medical students and other resources. The Hispanic Medical Education Training Program (HISMET) is a CMSA co-sponsored program which places students interested in working in medically underserved areas in preceptorships as well as a Family Practice Residency in California. Many of the issues that concern the membership of CMSA have nationwide importance and all questions and comments from students concerned about these issues are welcome.

Contact: Victor Pulido
Project Coordinator
5234 Hanover Way
Ontario, CA 91762

Continued on page 5

Comments on Sweden and Health Care

It is a function of the modern industrialized government to protect and provide for its citizens, particularly those in need. The government provides collectively what cannot be obtained individually. This applies to national defense, justice, and social welfare programs. Nations have widely divergent views of their social welfare responsibilities—education, income support, pensions for the elderly, and health care are all possible inclusions. Whether there is a centrally organized system as in Sweden or England, or a pluralistic one as in the United States, increasingly we are finding support of health care on the national agenda.

Political ideology and historical trends determine the form which is assumed by the health care system. Nations generally 'nationalize' a health care system based on their existing organizational structures. Thus, when Sweden passed its National Health Insurance policy in 1955, the system utilized the already well-developed regional hospital system and its network of public health/district doctors as its core. There is much local and county based authority, as with other Swedish systems, and health care exists within a nest of welfare programs which enhance and support it. For example, one receives 90% income for days missed for personal illness, that of a child, and after the birth of a child. The Parental Leave Act entitled all new Swedish parents to a full year of paid leave to be divided between them. Benefits include automatic job security, generous pensions, disability and unemployment insurance, and five weeks of guaranteed vacation for every Swede. The work ethic, however, is strong in Sweden, with only 2% unemployment and 80% of women working. It seems a rational balance has been reached between productivity and humanity.

The structure of the health care system is as follows. There are twenty-six county councils, including three large municipalities. Each represents an average of three hundred thousand Swedes. Their jurisdiction includes both inpatient and outpatient medical/surgical care in hospitals, primary health care centers and private offices, as well as public dentistry and the care of the mentally ill. The counties, however, must cooperate with the national government which sets the goals and objectives, supervises, and partially funds the health care system with 18% block grants to equalize funding between regions. County councils must also cooperate with the 284 municipalities which are responsible for social welfare, public/environmental health, the education system, and day care. The county is the primary taxation agency of the government, and 80% of its expenditures are for health care—clearly its major priority. Every three years, new political and economic directives are instituted in conjunction with the elections of new council members, reflective of Parliament composition.

The Social Democrats have been in control for more than fifty years, thus creating a strong foundation for equity and accessibility in the health system. Initially, the system provided 'income maintenance' during illness. This later developed into specific health benefits and then progressed to universal distribution. The definition of health care came to be broadly defined in Sweden, and includes prevention and public health activities. As hospitals developed further, they became 'regionalized' to avoid wasteful duplication of services. There was then a re-emphasis on primary care/generalist practices, and there is now a push to develop high technology-based surgical techniques to meet population demands. Thus, we find a system which attempts to provide all things to all people, but of late is having difficulty meeting such an ambitious goal.

Health care is an unusual commodity, one which creates its own demand. New procedures proven in other nations are successful but costly, especially in the "start-up" phases of training and equipment purchases. Combined with this is the limited work week of the Swedish physician as a salaried government employee. The result is long cues for cardiac catheterization, bypass surgery, hip replacement surgery, and cataract surgery. Swedes rightly feel they pay enough to be assured of any and all that they should need. As we see in our own country, the cost of health care is potentially infinite and expands almost exponentially with further investigation. Interestingly, this cost explosion is occurring in an environment where 95% of physicians are salaried and therefore have no financial gain expected from their increased labors. Can a nation as progressive and egalitarian as Sweden afford to ration health care, which is perceived as a natural right? Can it afford not to? This is the present issue in Sweden, one about which almost all citizens have a strong opinion. Perhaps Sweden will prove able to meet these most recent demands, but what of the next generation of procedures? Is complete, equally distributed, state-of-the-art health care a realistic promise to make to a people?

I do feel that Sweden is doing a remarkable job at fulfilling its promise of comprehensive health care to her people. One needs only to note the well-organized and widely distributed, accessible primary health centers, maternal and child health programs, and impressive infant mortality statistics to see that this is so. However, we have reached a point in the progression of health technology where no amount of resources are ever "enough." Already entrepreneurs have sprung up ready to "fill in" for the failings of the Swedish health care system. The government is careful to curb their growth as their "faults" enlarge. A new and honest health care agenda can acknowledge the limitations of modern health care, and the need to perhaps allocate care where it will reap the most benefit. Perhaps only this will preserve one of the finest and most progressive health care systems of the Western world.

Jeralyn Bernier, M.D.
Pediatrics Resident
Yale

Continued from page 4

Student Osteopathic Medical Association (SOMA)

SOMA was founded in 1970 to propagate educational, scientific, and charitable purposes. SOMA chapters are found at each of the fifteen colleges of osteopathic medicine. SOMA represents over seventy percent of osteopathic medical students and interns. Over the years, SOMA has seen rapid growth in membership benefits and programming. As the future of osteopathic medicine, we work to promote the osteopathic ideal.

The objectives of SOMA are: to improve the quality of health care delivery to the American people and the world; to contribute to the welfare and education of osteopathic medical students; to familiarize its members with the purposes and ideals of osteopathic medicine; to establish lines of communication with other health science students and organizations; and to prepare its members to meet the social, moral, and ethical obligations of the osteopathic profession.
Contact the National SOMA office at 215/581-6792 for more information.

Continued on page 7

Continued from page 1

- Health Services Research—From the 1987 AAMC Graduation Questionnaire (GQ), 60.3% of responding graduating medical seniors felt that their education was inadequate in medical care cost control, and 61.1% felt it was inadequate in cost-effective medical practice. If training included comparative analysis of routes to diagnosis and treatment based on an understanding of research in this area, this could be greatly improved.
- Risk Assessment—In working with individual patients to understand their risks of disease, their prognosis, and available treatment options, it is imperative to first understand the associated population statistics and their application to a given patient. One then must be able to explain that information coherently to patients.
- Health Policy Analysis—According to the 1987 GQ, 41.5% of respondents felt insufficiently trained in the changing practice of medicine. At an Invitational Conference held at Baylor College of Medicine in May 1988, there was recognition of the need to expose medical students to *how* health policy is formed, in order to improve the ability of a physician to function as a patient advocate. The proceedings from this conference, when published, will impart some approaches for improving this area in the curriculum.

Although the ideal model of medical education would develop truly public-health trained physicians, this will not happen easily for two principal reasons. First, there is the lack of jointly-trained faculty. In the absence of an associated School of Public Health (SPH), there are few public health-trained physicians on medical school faculty. Even given an association with a SPH, there is no guarantee that there is cross-fertilization. Along with the lack of faculty come two additional problems. First, there are few role models for students. Second, the small numbers leave little doubt that prevention-related activities are low on the agenda of curriculum committees. Committees and faculty with a low public health titre then assume that prevention for medical students need only constitute a few hours in epidemiology and biostatistics, slotted for such prominent times in the schedule as late afternoons.

The second principal reason for difficulty in integrating medical and public health education is that the two take different approaches to a given problem. Consider, for example, the population distribution of cholesterol. The public health approach to this situation would be to intervene on the entire population to decrease the mean, and therefore attempt to improve health broadly. The medical intervention would be to only intervene on those whose cholesterol was above a certain level and thus have increased risk. What we need are people jointly trained in both medical and public health areas who can serve as bridges between the two approaches.

A variety of educational options exist to help students broaden the public health training being received in their medical education. These include undergraduate opportunities for pursuing a Master of Public Health (MPH) jointly during medical school or taking senior electives at the Center for Disease Control (CDC) or through the Public Health Department. Post-graduate opportunities include the CDC's Epidemiology Intelligence Service, the Robert Wood Johnson Clinical Scholars Fellowship, pursuing a MPH post-graduate or concurrent with your residency, or pursuing a residency in Preventive Medicine.

Look forward to hearing from you.

Until then, cheers!

Kim Dunn
Chairperson, OSR

Continued from page 1

you have probably suffered, among other things, from that special brand of hypochondriasis in which third- and fourth-year medical students become convinced that they have every disease being studied or encountered on the wards and in the clinics.

In a few weeks, hard as it may be to believe, you will undergo a metamorphosis: no more hypochondriasis—instead, you will be the "iron men and women of the wards,"[2] able to work 100 hours a week without the slightest dulling of your cognitive brilliance or diminution of your physical stamina or emotional sensitivity. In short, you will be at high risk for the overnight development of what I have called, "The Omnipotence-Omniscience Syndrome."[3] This "syndrome" consists of a magical belief that doctors should always be everywhere at once, should know and understand everything immediately, should maintain total control and authority in all situations, and should cure all patients. Doctors impose these expectations on themselves and their colleagues all the time, with negative consequences for themselves, their families, and their patients.

In an article that appeared in a recent issue of the *American Journal of Psychiatry*,[4] Gabbard and his coworkers reported the results of their attempt to examine "Sources of Conflict in the Medical Marriage." They pointed out that studies dating as far back as Vaillant's[5] in 1972 have demonstrated that almost half of all medical marriages are perceived by the marital partners as unhappy. In many cases, the partners are leading what Thoreau called "lives of quiet desperation." Gabbard and his colleagues reported that, contrary to conventional wisdom, the number of hours spent at work does not relate to marital satisfaction. Rather, the following five areas were the ones identified as the major sources of conflict in the 134 medical marriages that were studied: tension in the home, quality of sexual relations, finances, lack of intimacy, and religious differences. The physicians and their spouses also revealed striking discrepancies in their perceptions of the importance of each of these areas. It should be noted that, similar to Vaillant's sample, the group of doctors and spouses studied by Gabbard appeared to be skewed in the direction of psychological health.

I mention these studies not to frighten you, but to alert you. I urge you to understand that omnipotence and omniscience are the stuff that dreams are made of, not reality. Specifically, I would urge you to seek out support in your personal and professional lives. Find at least one fellow intern with whom you can share feelings such as the terror that you really don't know enough or that, any day, you're liable to damage or even kill one of your patients with the wrong diagnosis or treatment. The majority of residency program directors are aware of the need for better support programs for their residents[6] and will respond positively to your requests for help.

I also urge you to face and *gently* deal with your own humanity, your own frailty, because you will certainly be better physicians for having done that. I know of no doctor who ever lost a patient to another doctor, or who was ever sued by a patient, because that doctor was too human, too compassionate.

In my view, you have been given too few role models of the kind of physician of whom I've been speaking. I wish it had been otherwise. I hope that you can make it otherwise for those who will follow you.

Let me leave you with a prayer by Sir Robert Hutchison, a 19th Century British pediatrician who was eminently competent, compassionate, and critical:

Continued on page 7

Continued from page 6

From inability to let well alone;
from too much zeal for the new and contempt for what is old;
from putting knowledge before wisdom, science before art, and cleverness before common sense;
from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us.

*Reprinted with permission from: *Resident & Staff Physician* November 1987 by Romaine Pierson Publishers, Inc.

References:

1. Rothenberg MB: Comprehensive care in pediatric practice. Clin Pediatr 15:12, 1976.
2. Rintels P: From Hypochondriasis to Denial. Harvard Medical Alumni Bulletin, Winter, 1986-1987.
3. Rothenberg MB, Rothenberg J: The omnipotence-omniscience syndrome: Medical education advances when interns retreat. Resident & Staff Physician 31:6, 1985.
4. Gabbard GO, Menniger RW Coyne L: Sources of conflict in the medical marriage. Am J Psychiatry 144:5, 1987.
5. Vaillant GE, Sobowale NC, McArthur C: Some psychological vulnerabilities of physicians. N Engl J Med 287:372-375, 1972.
6. McGuire TL: Developmental perspectives on the problem of stress in pediatric house staff training. In Stress in Pediatric House Staff Training, Report from The Study Group in Pediatric Education and Ross Laboratories. February, 1986.

Michael B. Rothenberg, M.D.
University of Washington
School of Medicine
Seattle, WA

Continued from page 5

American Medical Association
Medical Students Section (AMA-MSS)

The purpose of the Medical Student Section of the AMA is to provide medical student participation in the activities of the AMA through adherence tc the following principles: to have meaningful input into the decision- and policy-making process of the association; to improve medical education and to further professional excellence; to involve medical students in addressing and solving the problems of health care and health care delivery and to provide a forum for discussion and dissemination of information; to develop medical leadership; to initiate and affect necessary change; to promote high personal and professional ethics and a humanistic approach to the delivery of quality patient care; to promote activity within organized medicine on the local, state and national levels; and to work cooperatively with other student groups to meet these objectives.

The AMA-MSS meets nationally in December and June each year. Students at each medical school select a voting delegate and an alternate to represent them. All student AMA members receive the *Journal of the American Medical Association*, *American Medical News*, *Pulse*, the *AMA Drug Evaluation Guide* and other membership benefits. Contact your MSS chapter representative or the AMA Department of Medical Student Services (312/645-4746) for additional information.

American Medical Student Association (AMSA)

The American Medical Student Association is the largest independent organization for physicians-in-training not associated with any parent association. AMSA is dedicated to representing the concerns and interests of medical students, fighting for better access to health care, and working to reform medical education. During AMSA's 39 year history, AMSA programs have placed thousands of medical students in medically underserved rural and urban areas. AMSA hires a medical student to work full-time for the organization to represent the interest of physicians-in-training on Capitol Hill. Finally, AMSA organizes numerous national and regional conferences which supplement traditional medical curricula by addressing topics which are not covered at most medical schools. Through all of these programs, AMSA develops leadership in medicine by instilling a commitment to public service and by providing opportunities for medical students to take on responsibilities for project development, fundraising, and guiding the national organization.

Contact: Cindy Osman
President
AMSA
1890 Preston White Drive
Reston, VA 22091
703/620-6600

Boricua Health Organization (BHO)

The Boricua Health Organization is a national group of students, providers, and consumers of health care services, who direct our attention to the inadequate health care delivery system present in our Latino communities. We have come together as an organization in search of knowledge and common strength. We seek progressive and equitable institutionalized changes, and advocate for human rights as they apply to health care for our community.

We define ourselves as members of the national minority composed of Latin Americans by birth or descent who live in the United States of America and Puerto Rico, and are bound by a common language, share a similar cultural and historic heritage, and are confronted with similar problems and needs in the areas of health, education, and quality of life. We include as members all those persons of other national or cultural origins who believe and partake in our goals.

BHO is more than just an organization of Latino students. BHO embraces individual aspirations and countless personal sacrifices with the struggles of our community for better housing, education, health care and living standards. BHO engenders responsibility in each of its current 500 members to take on the poverty that plagues both the academic and practical world in delivering health care to our community.

If you wish to become a BHO member, subscribe to the CURANDERO newsletter, or obtain additional information, contact: Maria Padilla
BHO President
P.O. Box 713
Bronx, NY 10461-0713
(212) 892-3387

Continued on page 8

Continued from page 7

Learning and Study Skills Workshop Offered

One of the greatest tragedies of our modern civilization is that you and I can live a trivial life and get away with it.
—Tim Hansel, *You Gotta Keep Dancin'*

Each of us has our own call to success: the Olympian's gold medal; the fireman's saved forest; the diplomat's country in peace, the plumber's unclogged drain; and the medical student's licensure as a practicing physician. Widely apparent is that we all have a different definition and accompanying litmus test of success. As a third year medical student, I can identify most with licensure as a measure of success, an embrace shared by my family, friends, and the faculty and staff at my medical school. For many students, medical school offers an arduous challenge to licensure. For others, the proposition is an even more difficult obstacle based on their limited backgrounds in education or environment. Minority students often fall into this category. The struggling students' plight is affected by its intimate and inverse relationship with retention. "Retention," Miriam Willey tells us in the book *Medical Education: Responses to a Challenge*, "has been, and continues to be the primary purpose for providing academic support to students."

In response to this appeal, the AAMC Section for Minority Affairs, with the sponsorship of the U.S. Department of Health and Human Services Division of Disadvantaged Assistance and the Health Careers Opportunity Program (HCOP), presented *Learning and Study Skills: An Intensive Five-Day Workshop*. The objective, plainly administered and adhered to, was to assist medical school staff and faculty to develop retention programs at individual medical schools, and to enhance programs already established, in order to better retain and graduate minority students. The workshop leaders, Miriam Willey, Ph.D., the Assistant Dean for Medical Education and Director for the Academic Development Program at the University of Maryland School of Medicine, and Barbara Jarecky, M.S., the Learning Skills Specialist in the Health Careers Program at the University of Kentucky-Lexington, provided a message which was simple and direct. Their sessions covered all of the elements of a retention program—student study skill problems, time management, and alternatives for funding academic support services. Sessions geared towards the individual student included such topics as selecting, organizing, and memorizing information, using course objectives, taking notes, and utilizing self assessment/exam-taking techniques.

Having the esoteric privilege of being the only Organization of Student Representatives member, and one of the few students in attendance, I can easily qualify, that from the student's perspective, the workshop offered a gem of information. This kind of help is difficult to discover. By contrast, the usual, abundant forms of assistance are as unpalatable as they are unhelpful. They only offer seeds to ideas that grow into scattered sticks of advice which make no more sense to the majority of us than Chinese calligraphy. Also, from my standpoint as a member on a team consisting of the Affirmative Action Director and the Learning Resource Counselor from the University of Kansas, I can confirm that the staff and faculty have long been interested in this injection of learning skills. We all anticipate reviewing the effects of our workshop attendance on students', especially minority students', call to success and retention. I challenge each of you to actively utilize the resources offered by the AAMC Section for Minority Affairs and to realize your own successes.

Lawrence Tsen
MS-III
University of Kansas

For further information about the availability of this workshop write to: Dario Prieto
Director, Section for Minority Affairs
AAMC
One Dupont Circle, N.W.
Suite 200
Washington, DC 20036

Continental/Eastern Airlines Offer Discounts for Residency Interviews

The AAMC has recently signed an exclusive agreement with Continental/Eastern Airlines to offer discount fares for U.S. senior students interviewing for U.S. residency positions. The specific terms of the agreement include:

- **Convention Fare Discounts:** 50% off coach fare (*no* restrictions, penalties, or advance booking), 50% off first class fares (*no* restrictions, penalties, or advance booking), 5% off lowest applicable fare (*all* rules and restrictions apply).
- **Dates:** Valid for travel from November 1, 1988, through February 28, 1989, except during holiday periods.*
- **Toll-Free Convention Desk 800 Number:** Within the continental U.S., reservations on Eastern and Continental, as well as other airlines, may be booked through this service. When making reservations, please call 800-468-7022 and remember to refer to the **Easy Access Number: EZ 14P59**.

*The discounts will not apply for travel in certain directions during the holidays as follows:

Not valid southbound (northeast to Florida) November 22-24 and December 22-23, 1988, and February 9-11, 1989.

Not valid northbound (Florida to northeast) January 2-3, and February 13, 14, 19, and 20, 1989.

SCHEDULE OF DATES
1988-89

AAMC/OSR Dates:

November 11-17—AAMC Annual Meeting, Chicago, Illinois

April 12-15—Northeast and Southern Region Meeting, Perdido Key, AL

April 15-17—Central Region Meeting, Columbia, MO

April 23-26—Western Region Meeting, Pacific Grove, CA

NRMP Match Dates:

November 1—earliest date for release of dean's letter to program directors

March 1—deadline for receipt of rank order list at NRMP

March 22—Match Day 1989

ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES

aamc

Volume XIII
Number 1
Spring 1989

progress notes

Medical Education News from the
Organization of Student Representatives

perspective from the chair

Clayton Ballantine
U. of Louisville

Hello Everyone!

As far as medical education is concerned, this is a good time for optimism. It is also a time for action. I hope the information in this issue of OSR Progress Notes will stimulate your thinking and your level of activity. This article will touch on some of the recent national developments that bode well for medical education in the long run.

Evaluation is the key issue. How is student performance judged at your school? How are our schools accredited? The criteria, emphasis, and focus of these evaluations determines the kind of physicians we train.

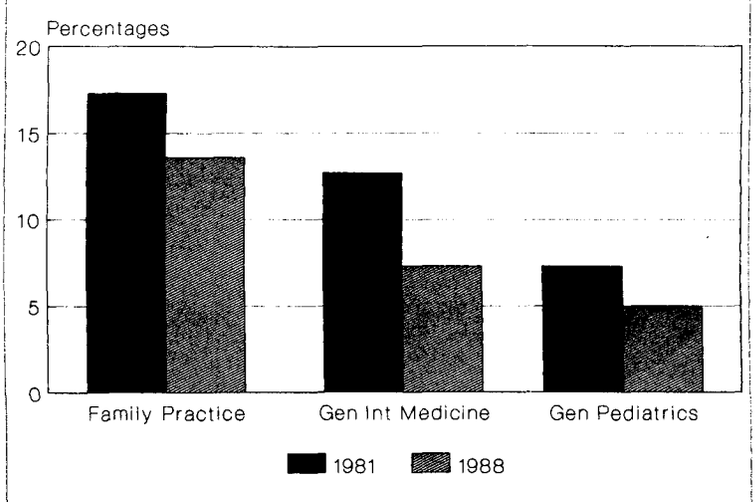
Several of the factors which are responsible for the stability and consistent quality of medical education have also acted to slow improvements and diminish the adaptability of the system to the vastly different scenario of today's health care. Our profession leans toward the heavily traditional. That is reflected in the institutions which oversee and evaluate the enterprise of medical education.

Our profession is also analytical. The realization has come that changes are needed in medical school and residency training if we are to continue to attract the best and brightest students. The mission of medical education also needs to be emphasized—it tends to be overshadowed by the school's research and patient care functions these days. Development of more effective and accurate inclusion of students and their opinion's into accreditation site visits is also on the agenda of the Liaison Committee on Medical Education (LCME).

In addition to these developments, our organization, the Association of American Medical Colleges (AAMC) has announced changes in the Medical College Admissions Test (MCAT) format to alleviate some of the symptoms of the "pre-medical syndrome." The AAMC also recently launched a study of the innovative programs currently in place in medical schools around the country. The plan is to determine how these programs got past the usual inertia and funding hurdles in order to help other schools to implement these improvements.

Obviously, the effects of these changes lie in the future if anywhere. That is the call to action. A lot of pressure for change and working out of solutions at the local level still has to be done. As students, even individually, we have considerably more influence than we realize. I hope you will avoid complaining and instead will assume the responsibility for creating a better educational system. It is your education and your profession. □

Specialty Choice of Graduates for Primary Care



Medical school graduates seeking specialty certification in one of the primary care specialties has dropped during the 1980's. Source: AAMC Graduation Questionnaire.

Inside this issue . . .

aamc focus

AAMC Division for Minority Health, Disease Prevention and Health Promotion

Herbert Nickens, M.D., M.A.
Vice President

Twenty years ago the AAMC made a commitment to equal opportunity in medicine by creating the AAMC Section on Minority Affairs. A year later an AAMC Task Force set as a short-term objective that ". . . U.S. medical schools increase the representation of minorities in the M.D. degree programs from 2.8% to 12% by 1975-76." As we all know that goal has never been reached.

The mission of the new Division of Minority Health, Disease Prevention, and Health Promotion is, in part, to re-invigorate the efforts to meet that original Task Force charge. Our concern is not only to improve the underrepresentation of minorities in undergraduate medical education, but also to address the underrepresentation among the faculty, administration, and management of the academic medical enterprise. There are increasing numbers of qualified minority health professionals now available to fill these positions; the availability of these individuals is tangible evidence of the partial success of the last twenty years of affirmative action.

A second component of the mission of the new Division is disease prevention and health promotion, with a particular emphasis on minority and disadvantaged populations. Two thirds of the deaths in the United States are from cardiovascular disease and cancer. These and other "chronic diseases" are acquired slowly over the life cycle—they also offer great opportunities for primary and secondary prevention. In fact, any rational strategy to reduce the death rates from these diseases requires prevention and behavior change as centerpieces. Moreover, generally speaking, the same minority populations that are underrepresented in medical education also suffer higher death rates from these and other causes. It must be recognized that systematic efforts to change lifestyle and behavior require attention to cultural and social class differences in target populations. Our division will seek to have a salutary influence on the way in which physicians are educated with regard to prevention, and also to find more creative ways in which academic medical centers can have a positive influence on the health of the populations they serve. □

Innovations in Medical Education (IME) Exhibits: A Call for Proposals

The AAMC Group on Medical Education recently sent out a call for proposals for the Fourteenth Annual Session on IME Exhibits at the AAMC Annual Meeting scheduled for October 29-31, 1989, in Washington, D.C. The purpose of the exhibits is to provide a forum for the exchange of ideas and activities in medical education and to encourage communication among colleagues. You are invited to exhibit work still in progress or recently introduced, as well as established projects or components of your medical school curriculum. The deadline for receipt of proposals is JUNE 30, 1989. Contact Wendy Pechacek, OSR Staff Director, 202/828-0682, for additional information. □

OSR REGIONAL MEETINGS

The OSR regional meetings are held each spring. OSR representatives meet to discuss issues of concern at their institutions, and to share ideas for programs, electives, and other opportunities. Agendas for this year's meetings are described below. Contact the regional chair listed, or your school's OSR representative for additional information.

Northeast & Southern Regional Meeting

Beth Malko, U. of Connecticut
203/272-8172
Kathleen Huff, U. of South Florida
813/968-5107

The Northeast and Southern regions are getting together for a combined regional meeting in Perdido Beach Alabama, April 12-16. The theme, "Changes, Challenges, and Attitudes," will be addressed through plenaries on: financing a medical education; women in medicine; and professionalism.

Central Regional Meeting

Joan Lingen, Chicago Medical
312/861-0242

Medical Education in the Year 2000 will be the topic pondered during the combined Central Region meeting in Columbia, Missouri on April 13-16, 1989. The plan for the weekend includes three "Rounds" of simultaneous multiple discussion groups; each composed of a pre-assigned mix of OSR, Group on Student Affairs, and Group on Medical Education participants, and each considering a different medical education scenario about which the group must discuss pros/cons and arrive at a consensus opinion. OSR will focus on the role of medical students in initiating change in medical education.

Western Regional Meeting

Sheila Rege, U. of California, Los Angeles
213/820-5128

The Changing Face of Medicine is the topic of the Western Regional Conference. The conference will be held April 23-26 at Asilomar, California, adjacent to the beautiful Monterey beaches. OSR will have several workshops, including (1) Ambulatory Care-Integration into Medical Education; (2) Non-traditional forms of medical care; (3) Cultural Diversity in the Patient Population; (4) Different Types of Medical Practices; (5) AIDS—what can students do; (6) Ethics; (7) The Declining Applicant Pool. Additionally, your OSR representative will be meeting with your dean to discuss issues of concern at your school. □

progress notes

Published by the

Association of American Medical Colleges
for the Organization of Student Representatives

One Dupont Circle, N.W.
Washington, D.C. 20036

Wendy H. Pechacek, Editor

perspectives on evaluation

What's on the Horizon for Part I and Part II of the National Board Examinations?

Robin D. Powell, M.D.
Vice President, Evaluation Programs
National Board of Medical Examiners

The National Board of Medical Examiners is working to develop improved means for evaluating clinical competence. This report outlines four sets of NBME initiatives and how they may affect NBME examinations in the future.

Part I and Part II Comprehensive Examinations: At present, the subject matter for Part I and Part II is developed according to content outlines prepared in relation to individual disciplines. The content outlines for seven basic science disciplines form the "blueprint" for Part I. The content outlines for six clinical science disciplines form the blueprint for Part II. One of the central recommendations of a Study Committee to Review Part I and Part II was that the examinations be designed as integrated, comprehensive certifying examinations and that multidimensional content specifications, to include new content domains, be prepared for each comprehensive part.

One of the most frequent constructive criticisms of Part I and Part II is that the examinations rely too much on questions that test memory or recall. Many observers have urged more emphasis on questions that require comprehension, reasoning, and problem solving.

Work to develop new Part I and Part II Comprehensive Examinations is underway. Unified multidimensional content matrices have been created, one for Part I and one for Part II, and plans have been developed to reduce the total number of items on the examinations to allow more time for questions that test higher reasoning skills. Much work remains to refine specifications within the matrices, evaluate model examinations from different standpoints, and in other ways follow

continued on page 4

The National Board of Medical Examiners

Lawrence Tsen
U. of Kansas

The National Board exam should be reported on a pass-fail basis. To fully understand this postulate it is necessary to know a brief history of the Board exam's purpose. The National Board of Medical Education (NBME) was founded to provide examinations of high quality that would be acceptable for licensing purposes by state agencies. In 1983, however, a grand shift was made—the exam was now to function primarily in the evaluation of student performance on content taught in LCME accredited institutions and, secondarily, as a mechanism for licensure. At that time, in accord with the GPEP Panel recommendations, it was suggested that the exam not report students' individual scores in the various disciplines, but that each medical school would be provided with the aggregate disciplinary scores of their students. Today, we have a system which not only reports scores in each discipline, but also tightly embraces their usage.

Perhaps the greatest detraction of Board exams being numerically reported is the pronounced effect of these results on curriculums. The proceedings of the Josiah Macy, Jr. Foundation's National Seminar on Medical Education, summarized by David E. Rogers, M.D. in "Clinical Education and the Doctor of Tomorrow," concluded that, "the National Board examinations overly influence medical education and tend to inhibit educational experiments . . . some medical schools assess their educational programs on the basis of National Board scores, thus limiting innovation." In addition, the NBME's own Study Committee of 1983 deemed that the dependence of faculties on the national Board exam as the

continued on page 9

Evaluation of Medical Education

Parker A. Small, Jr., M.D.
Professor of Immunology and Medical Microbiology and Professor of Pediatrics
U. of Florida

The evaluation system used in medical schools is the major force driving medical education. I believe the system in most medical schools has substantial errors of omission which lead to significant adverse consequences for medical education and health care delivery. I will discuss what I perceive to be the two most common major errors of omission—the lack of self-evaluation and the lack of peer evaluation.

Our evaluation system is largely "selfless"

The single most important skill for a physician to develop is accurate, reliable self-evaluation. Appropriate confidence is based on accurate self-evaluation and, ultimately, competence arises from this accurate self-evaluation. Doctors who know "what they know" and know their own limits are going to do minimal harm, and the first rule of medicine is "do no harm". Unfortunately, the development of accurate and reliable self-evaluation skills are rarely addressed in college or the basic science years of medical school and are not always addressed in the clinical years.

In some environments, self-evaluation is not only neglected, but perhaps inhibited. To be admitted to medical school, one needs good grades and good letters of recommendation. To get good grades in large universities, one needs to do well on multiple choice exams. This promotes guessing on these exams and the feedback doesn't differentiate between what is known and what is a good guess. To get good recommendations, students need faculty who believe in them. Few students are secure enough to share their self-perceived weaknesses with faculty, so there is apt to be little feedback to help college students develop their self-evaluation skills. Due to years of conditioning, most medical students hide inadequacies and do not develop the kind of personal and trusting

continued on page 5

Federal update

Sarah Carr, AAMC

The dominant issue in Washington these days is the FY 1990 federal budget. The budget process this year is complicated by the fact that President Bush has amended the FY 1990 Reagan proposal. Moreover, even though Bush's budget outline was sent to Congress February 9, it left many questions unanswered about specifically where cuts will be made to meet the deficit reduction target of $100 billion. Instead of pinpointing reductions in certain programs himself, Bush is relying on negotiations with Congress to sort out the details.

AAMC is closely following the budget/appropriations process, especially as it affects programs of special interest to medical schools, students, and teaching hospitals. These include Medicare reimbursement for graduate medical education, Medicaid, NIH and ADAMHA research and training programs, health manpower (Titles VII and VIII), National Health Service Corps, Veterans Administration, student financial assistance programs (Department of Education), and the National Science Foundation. Regarding health manpower programs, the Reagan budget requested no funds for the health professions and nurse training programs in Title VII and VIII. In the past two fiscal years, Congress agreed to slight reductions in health manpower because of the deficit, but members have never accepted the Administration's desire to gut the programs completely.

Other health and education issues are also drawing attention in Congress. A number of bills have been introduced to address access to care issues. The rural health care problem has drawn a good deal of attention and several legislators have proposed bills which seek to equalize Medicare payments to urban and rural hospitals. A bill by Rep. Stark (D-Ca), Chairman of the House Ways and Means Subcommittee on Health, would support care for the indigent by imposing an excise tax on employer's cost of providing employee medical benefits. Rep. Dingell (D-Mi), Chairman of the House Energy and Commerce Committee, has introduced a bill creating a national health insurance program financed by payroll deductions. Other bills seek changes in medicaid to improve basic access to health care for needy children and expanded services to pregnant women and infants in order to reduce infant mortality.

Education is expected to be a priority for both Congress and the Administration this year, at least in a rhetorical sense. "Education President" Bush has made strong statements in support of education and included several new education initiatives in his budget plan. While most of these target elementary and secondary schools and seek to foster and reward excellence in teaching and learning, particularly in science, Bush is also expected to be kinder to higher education as well. Nonetheless, given the budget deficit, the likelihood that this renewed commitment to education will translate into increased education spending is remote.

The default problem in the Stafford Student Loan program is expected to remain an important issue this year. The Senate is planning to reintroduce the default bill it passed last fall. Action in the House is less clear. Meanwhile, the Department of Education has proposed stringent regulations that

continued on page 11

continued from page 3

through on the recommendations of the Study Committee. We anticipate that if all goes well the target date for introduction of the new design will be 1991. A detailed progress report about these plans will be distributed widely in the latter part of 1989.

One topic receiving wide discussion in 1989 is the proposal to develop a single examination for medical licensure. In view of the current dual pathways (the NBME Part I, Part II, and Part III examinations on the one hand, and Components 1 and 2 of the Federation Licensing Examination (FLEX) of the Federation of State Medical Boards on the other), the proposal visualizes a single examination that would consist of three steps. Plans for the Part I and Part II Comprehensive Examinations appear to fit well with that proposal.

Computer-Based Examinations (CBX)Patient Simulations: In 1987, the NBME conducted a relatively large pilot study involving participation of medical students and house staff. Results indicated that CBX/patient simulations, long a research focus of the NBME, hold appreciable promise and potential for assessment of patient management skills. NBME has embarked on a program of further development that involves distribution of the CBX simulations to a substantial number of medical schools for use in both educational and evaluative contexts. Work is underway to provide, in certain clinical disciplines, "subject tests" that consist of multiple choice questions in combination with appropriate CBX/patient simulations. The resultant experience should help lay the groundwork for subsequently determining the role of CBX/patient simulations in the national certifying examination program. The simulations offer means for assessing aspects of competence that multiple choice questions do not address. They appear to represent a significant step forward in evaluating clinical competence.

Clinical Skills AssessmentStandardized Patients: Direct observation with "standardized patients" has enjoyed increasingly broad use in medical education and in the evaluation of clinical skills. Such methods extend the bases for evaluation beyond those of paper-and-pencil tests and computer simulations. They offer means to assess, for example, communication skills and certain technical skills, including history taking, and physical examination. NBME will be working to facilitate further development and application of evaluative procedures that involve standardized patients. Ways that tests with multiple choice questions, CBX/patient simulations, and direct observation with standardized patients can complement each other in evaluation will receive attention.

Evaluation of Learning in the Basic Sciences: Potentialities the computer offers are yielding an increasingly wide array of capabilities that are proving to be of educational value not only in the clinical sciences but also in the basic sciences. Abilities to elicit information from various sources and to relate diverse pieces of basic information to a broader picture are examples of areas that merit study. New formats, including simulations of basic science phenomena, may afford improved means through which to assess critical thinking and problem-solving skills.

The Outlook: Knowledge and ability to apply that knowledge will remain a cornerstone in medical education, medical practice, and evaluation. New methods of evaluation may add appreciably to that cornerstone in the years ahead to address increasingly well other important components that undergird clinical competence. □

LCME

The Liaison Committee on Medical Education (LCME) is the accrediting body for U.S. medical schools. It is the joint responsibility of the AAMC and the AMA. Every seven years, each medical school has a site visit for re-accreditation. To prepare for each visit, the medical school conducts a self-study. This is followed by a site visit of four individuals who come to the school and conduct in-depth interviews with the deans, faculty, and students. This year the following medical schools have scheduled site visits:

U. of South Florida, Tampa
Northwestern, Chicago
U. of Massachusetts, Worcester
U. of Michigan, Ann Arbor
U. of Minnesota, Minneapolis
U. of Mississippi, Jackson
Creighton, Omaha
UMDNJ—NJ Medical, Newark
East Carolina, Greenville
U. of North Carolina, Chapel Hill
U. of Cincinnati, Cincinnati
Medical College of Ohio, Toledo
Ponce School of Medicine, Ponce
Meharry, Nashville
U. of Texas, Houston
U. of Vermont, Burlington

The self-study process can be an important vehicle for change. Students can play an essential role in this evaluation by assessing the strengths and weaknesses of the curriculum and deficiencies in student support services, and providing that information to the site visit team. In many cases students will have to actively seek ways to participate in their school's self-study, but it is important to realize that each visit requires student input. It is the students' responsibility to provide that input in a thoughtful and constructive manner.

A workshop was held at the OSR Annual Meeting on how students can organize this input. If your school is scheduled for a visit this year and you would like to help, contact the OSR representative at your school. If you would like further information, please contact the OSR representative to the LCME, Tom Ptak at 518/462-4935 or the AAMC Section for Accreditation at 202/828-0596. □

---

continued from page 3

relationship with faculty that encourages the exchange of self-evaluation of a student's strengths and weaknesses—a key component of the development of accurate and reliable self-evaluation.

Few medical schools make any attempt to evaluate students' self-evaluation skills. Without appropriate feedback, learning is very difficult, if not impossible. If your faculty are not helping you to develop your own self-evaluation skills, ask them to look into evaluation systems like the McMaster's "Triple Jump Exam", which evaluates not just what students know, but how students identify what more they need to know to solve problems, how they teach themselves the requisite new knowledge, how they then utilize the information to solve the problem, and, finally and most important, how they evaluate their own performance. (The Triple Jump Exercise—A Structured Measure of Problem Solving and Self-Directed Learning; C. Painvin, V. Neufeld, G. Norman, I. Walker, G. Whelan; Proceedings of the 18th Research in Medical Education Conference; p. 73, 1979.)

Our evaluation system is largely "peerless"

Success in practice depends, in no small part, on how one is judged by ones' peers. Referrals and hospital privileges are based on evaluation by ones' peers. As a profession, we are supposed to police ourselves. But where are students given practice for peer evaluation and peer feedback? For the last decade, my colleagues and I, with the generous cooperation of the medical students at the U. of Florida, have been experimenting with two different forms of peer evaluation and feedback.

The first system is designed to help students improve their interpersonal skills while working in groups of four, utilizing the Patient-Oriented Problem-Solving (POPS) system. After each POPS, the four students evaluate how effective each peer was in helping them learn, i.e., evaluate their cooperative learning skill. Many students write brief comments such as "Kim was unbelievably patient", "Bill had the ability to ask just the right question to help me understand my misconception." These comments are shared with the students (anonymously) at a later time.

The second form of peer evaluation is designed to evaluate the professional competence of our senior medical students. We use a modified version of a questionnaire developed at Case Western Reserve in the 1950's. It consists of 8 questions, such as: name the three classmates you would most like to have at your side in a medical emergency; name the three classmates you think would make the best all around doctor; name the three classmates that would be on your list for a party. When we factor analyze these questionnaires, we are able to "factor out" the social components and get the "professional competence" score for each senior. We can then identify and rank the top quarter of the class. The best predictor of the senior year peer evaluation of professional competence is the freshman year evaluation of cooperative learning (r=.5). Medical school GPA correlates less well with the senior year measure of professional competence (r=.25 to .35).

From the student's point of view, the most important aspect of the peer evaluation of professional competence is that our Dean of Students incorporates the peer class rank into the Dean's letter for those students in the top 25% (bottom 75% are not discernibly different because we only ask for positive nomination). His experience has been that some residency programs have given the peer evaluation as much weight as the GPA, and this has enabled some of our students to get more desirable residencies than they would have otherwise obtained.

In summary, peer evaluation is in use both as a teaching tool (formative evaluation) and as a final evaluation instrument (summative evaluation). Intuitively, it also seems that the formative peer evaluation should help students improve their self-evaluation, but we have not evaluated this hypothesis. I believe that a decreased utilization of multiple choice exams and more widespread evaluation of both self and peer evaluation would improve medical education and, ultimately, health care delivery. □

the bulletin board

200 Medical Student Scholarships Available for Alcohol and Drug Abuse Training in 1989

Scaife Family Foundation, and the J. M. Foundation have announced the availability of 200 medical student scholarships for alcohol and other drug abuse education in the summer of 1989. The purpose of the medical student program is to provide students with a comprehensive understanding of alcoholism and other drug dependencies; enhance knowledge and basic skills on the identification, intervention, and treatment of alcohol and other drug dependent people; and encourage a positive attitude toward patients with alcohol and drug problems. The training scholarships cover tuition, room and board, and a travel/expense stipend for fourteen 1-week to 3-week institutes and summer schools of alcohol and drug studies held across the country.

For further information contact the Scaife Family Foundation, P.O. Box 268, Pittsburgh, PA 15230, (412) 392-2905 or The J. M. Foundation, 60 East 42nd Street, Suite 1651, New York, NY 10165, (212) 687-7735.

Match Deadline Moved to March

The National Residency Match Program (NRMP) has permanently changed its deadline for the submission of rank order lists by both student applicants and residency programs to March 1. This deadline is the latest in the history of the NRMP, contrasting with the early January deadline that was the rule until last year, and cuts six weeks from the overall process. The match results will be announced on March 22.

The late deadline, which as extended the time available for both students and programs to make their selections, was made possible by the development of the computer-based Rank Order List Input and Confirmation System (ROLIC). Through this system both applicants and programs enter and confirm their confidential lists directly into a microcomputer, eliminating the time-consuming mail confirmation process used in the past.

Basing their calculations on last year's experience, when the deadline was moved from early January to February 19, NRMP officials expect that the March 1 deadline will provide sufficient time for processing the match and preparing announcement materials.

Learning and Study Skills: An Intensive Five-Day Workshop

The Section for Minority Affairs will be holding a five-day workshop on Learning and Study Skills, July 30-August 4, 1989, at the Holiday Inn-Emerald Beach, Corpus Christi, Texas. This workshop is supported by a grant from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Division of Disadvantaged Assistance.

The workshop is designed for medical students, directors and staff of academic support programs, professors, and instructors. The objective of this workshop is to assist medical school faculty and staff to develop retention programs at individual medical schools, and to enhance programs already established in order to improve the retention of minority students enrolled in medical school.

Some of the topics to be discussed are: study skills problems, time management, using course objectives, lecture note-taking, test-taking techniques, study plans for laboratories and lectures, and organizing information using the indented and the chart formats.

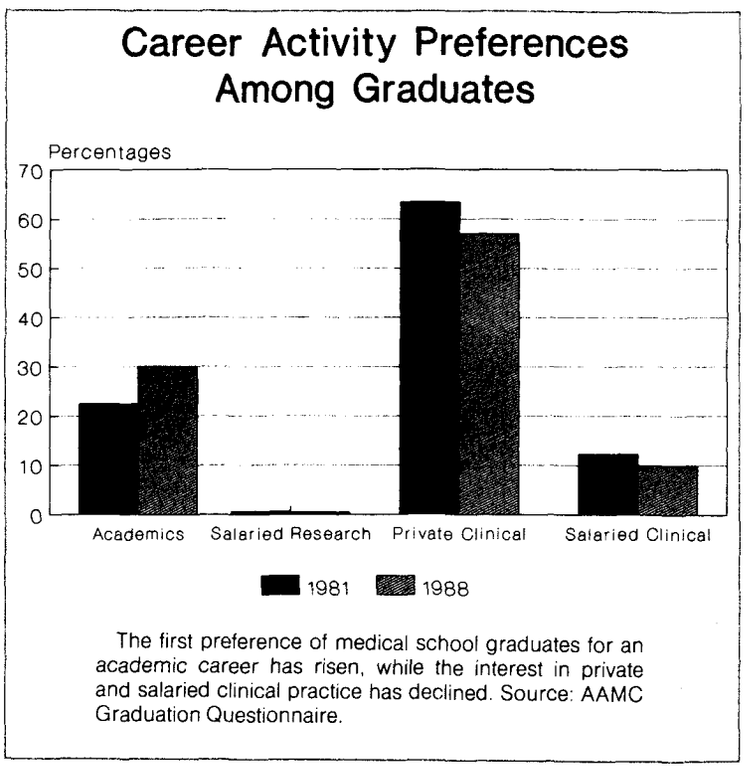
For further information and registration materials, contact the Section for Minority Affairs at (202) 828-0572.

MEDLOANS Program Enhanced by Lower Interest Rates

Medical students who borrow money to help finance their education stand to save up to $12,000 under an improved AAMC MEDLOANS program. MEDLOANS, developed by AAMC specifically for students at all allopathic medical schools, is a package of loan programs from a variety of governmental and private sources.

These savings will result from changes to the Alternative Loan Program (ALP) component of MEDLOANS. The new ALP has an interest rate based on *the 91-Day Treasury Bill plus 2.7% throughout the life of the loan.* Capitalization occurs once, at repayment. There is an 8% insurance fee, and an 18% cap on the interest rate. On a typical $10,000 loan to a first-year medical student, after seven years, when repayment starts, the savings could be as much as $4,262—just on the first year's loan. During the life of the loan, the student would save a total of $12,022 in interest costs.

Stafford Loans (GSL), Supplemental Loans for Students (SLS), and the Health Education Assistance Loan (HEAL) are also available through MEDLOANS. *For current terms and conditions, an application form, or additional questions, call the MEDLOANS Customer Service Unit Toll Free at* 1-800-284-0936. □



The first preference of medical school graduates for an academic career has risen, while the interest in private and salaried clinical practice has declined. Source: AAMC Graduation Questionnaire.

OSR Administrative Board 1988-89

Clayton Ballantine '89 U. of Louisville 502/895-6997	Caroline Reich '91 Emory 404/325-9407
Kathleen Huff '90 U. of South Florida 813/968-5107	Beth Malko '89 U. of Connecticut 203/272-8172
Anita Jackson '90 U. of Illinois, Chicago 312/413-4513	Sheila Rege '89 U. of California, Los Angeles 213/825-6281
Cindy Knudsen '91 U. of Colorado 303/377-7028	Lee Rosen '91 Baylor 713/529-8332
David Kostick '89 Tulane 504/588-5588	Lawrence Tsen '90 U. of Kansas 913/384-2172
Joan Lingen '89 Chicago Medical 312/861-0242	Kim Dunn '90 U. of Texas, Houston 713/799-1588

What is AAMC?

The Association of American Medical Colleges provides a means of national expression on matters of concern to medical school deans, teaching hospital administrators, faculty and students in the areas of medical education, biomedical research, and patient care. It maintains numerous data sources, works cooperatively with other organizations involved in medical education and has close liaison with the U.S. Congress and Federal agencies. AAMC represents all 127 U.S. medical schools plus 435 teaching hospitals, and 85 academic societies.

What is OSR?

The Organization of Student Representatives, AAMC's student voice, is composed of one representative from each medical school. Schools are also urged to select one "alternate" or "junior" member to assure continuity of OSR participation. OSR members gather at an annual meeting each fall when the Administrative Board is elected; this 12-member body meets three times each year, along with the Boards of the other AAMC Councils, to formulate AAMC's programs and policies. OSR business is also conducted at regional spring meetings. OSR operates effectively to the extent that its members channel information from AAMC to their student bodies and vice-versa; therefore, contact the OSR representative at your school with your concerns about medical education.

NHSC Student Opportunities

• The Commissioned Officer Student Training and Extern Program (COSTEP) commissions students in health-related subjects as Junior Assistant Health Service Officers, serving from 31 to 120 days per assignment in any one of sever PHS agencies. COSTEP provides an opportunity for qualified students to apply their classroom knowledge in a professional setting with responsibilities ranging from research to clinical services in Community and Migrant Health Centers (C/MHCs). Opportunities are offered to medical students and health science majors including nursing, dentistry, veterinary medicine, dietetics, engineering, pharmacy, therapy, sanitary science, and medical records. Each student is assigned to a preceptor/mentor, who is responsible for providing an educational and rewarding experience. COSTEP is an excellent opportunity for students who have already had previous clerkship experience. The salary is approximately $1,600 per month. Four hundred COSTEPs were appointed in 1988 and it is anticipated that during 1989, the PHS Centennial Year, 1,000 will be placed with the various agencies and federally funded community health centers.

• The Health Promotion and Disease Prevention Program (HP/DP), funded by the Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, and the American Medical Student Association, places first- and second-year medical students in federally funded C/MHCs on rotation for 6 to 8 weeks throughout the year. Each student has a C/MHC physician assigned as a preceptor and a coordinator who supervises the specific HP/DP project. School credit is usually given for participation, and payment is made for living expenses. These nonclinical placements serving disadvantaged populations in inner cities and rural areas enable students to gain experience in the clinical, administrative, and community responsibilities of the C/MHCs. Students find the experience useful when decisions are made about the type and location of their practice after graduation.

• The Indian Health Service Clerkship Program places students at Indian Health Service sites within the PHS. School credit is usually given for participation, and payment is made for living expenses.

• The Indian Health Service Scholarship Program, funded by Public Law 94-437, Title I, enables students—preferably Indian—to receive up to 4 years of financial aid in exchange for 1 year of service for every year of scholarship. The students are encouraged to work as COSTEPs during school breaks and receive the same salary and benefits as COSTEPs.

• The Epidemic Intelligence Service Clerkship Program is sponsored by the Centers for Disease Control and offers a 6 to 8-week elective in epidemiology to senior medical and veterinary students from September through early June of each year. The program includes preventive medicine, public health, and techniques of surveillance and field epidemiology. School credit is usually given for participation.

• The Food and Drug Administration (FDA) Pharmacy Clerkship Program offers an elective during the school year for pharmacy students through their academic institutions. It assigns students to a division within the FDA for 1 month, working with an agency pharmacist. An evaluation is prepared by students' preceptors on completion of the course, and school credit is earned.

These student programs are effective, long-term, recruitment tools; ideally, every C/MHC should have on or more students assigned to its facility during the year. The students become advocates for the PHS when they return to school and often elect to work in medically underserved areas as commissioned officers of civil servants after graduation.

Any eligible student interested in applying for one of these programs should telephone (301)443-5740 for further information. □

project forum

Task Force on Care of Vulnerable Populations

At the OSR Annual Meeting, a group of students interested in indigent care formed a network. This group determined their goals to be:

- studying the nature of the problem
- discovering how to educate physicians-in-training about special needs of underserved populations
- identifying suitable models of public health training which occupy substantive and prominent roles in overall curricula
- interacting with local, state, and federal policymakers as they create, modify, and eliminate health care programs
- encouraging discussion on a local and national level of the academic health center's role in indigent care

Recently in Houston, the students at Baylor and U. of Texas, Houston formed a task force and began several pilot projects which will serve as models for student activity.

- Students are encouraging administrators to formalize joint MD/MPH programs.
- Following the lead of many other schools' student initiated free clinics, they established a joint U. of Texas, Houston-Baylor free clinic staffed by volunteer students and faculty. However, in addition to providing primary medical care, the clinic provides a site for student projects designed to determine the needs of the community served. With time, they hope that this need identification process will be incorporated into the curriculum. Project examples include an epidemiologic assessment of the patients' medical problems, a cost-and risk-benefit analysis of types of therapeutic agents needed, and an effort to secure an ongoing supply from pharmaceutical firms.
- In the Houston task force's attempt to educate itself about the problems of indigent care in the Houston area, it is becoming increasingly clear that public and private hospital directors, medical school faculty and administrators, community physicians, service providers, and local and state policymakers would benefit from meeting together to discuss this problem. This fall the Houston group will sponsor round table policy conferences with an agenda to be generated by conference participants. The task force is particularly excited by the enthusiastic response of these groups to date.
- the Houston task force is currently developing a spring speaker series to educate interested students, residents, and faculty about indigent care and implications for medical practice.

For more information about these activities, contact Lee Rosen, Baylor, 713/529-8332 or Kim Dunn, U. of Texas, Houston, 713/799-1588. □

Fourth-Year Flexibility: Medical Education Made to Order

Anita Jackson
U. of Illinois, Chicago

As the third year winds down, it is time for junior medical students to take charge and improve upon their medical education curriculum. Although most schools have required electives which one must fulfill in order to insure some standardization in medical training, most also set aside time for you to broaden your medical knowledge in experiencing fields that are of particular interest to you. Thus, with the proper scheduling techniques, one can experience new modes of medicine—in new cultures either domestic or international—making the learning experience an adventurous one.

In planning your elective schedule, you should first know specifically what your own school has to offer and will accept for elective credit. Pay close attention to time commitment, credit hour, and learning goals and styles of each course. There is nothing worse than a course that does not meet your expectations. When designing a new curriculum, first make a list of the courses which spark your interest and their locations. Then, if being in a particular location for a maximum period of time is important, look around for multiple courses offered in that area to increase your length of stay. If time commitments require you to remain at your own school, then increase curriculum diversity by developing your own course. Seek out student support in the topic, acquire letters of support and meet with your school's curriculum committee to arrange lecturers, preceptors, and teaching sites.

It is important to first be sure you are not re-inventing the wheel by investigating other established programs that may meet your educational needs. Programs which offer a unique medical training include:

- Family/Community Medicine electives in Prepaid Health Care or Interpersonal Violence at U. of Arizona;
- Family Therapy elective in Community Science integrating genetic counseling and sexual and contraceptive dysfunction in medical family practice at Mercer.

If your interests are focused more in Health Care Policy, Ethicacy, or Law, consider:

- Topics in the Economics of Health Care;
- Medicine and Society—Historical and Sociological Perspectives;
- Computers and Patient Care at Harvard;
- Medical Jurisprudence and Humanities at U. of Nebraska;
- Thanatology: Medical and Psychosocial Care of the Terminal Patient and His Family, an externship in Human Rights, or a research clerkship on Social and Ethical Aspects of Medicine at Columbia.

If your interests are more exotic and cross-cultural, consider:

- International Health/Tropical Medicine at Charles Drew/U. of California, Los Angeles;
- Rural Family Medicine at Albany Medical;
- The renown Indian Health Service elective sites offered through the Public Health Service in South Dakota, Arkansas, New Mexico, Montana, Minnesota, Arizona, Oklahoma, Oregon, Tennessee, or Maryland.

Don't forget that elective experience is not equivalent to any one type of medical training. Research can enhance medical training as can externships at the NIH or NCI or even one in Biochemical Radiochemistry or Bacterial Ultrasound at the U. of California, Davis. Thus, fourth-year is more than flexible—it is a wonderful opportunity to learn medicine on a different level. Take the challenge and use this window to learn and experience medicine for your personal and professional development. □

books

Joan Lingen
Chicago Medical

The House of God by Samuel Shem, M.D., Ph.D. Dell Publishing, New York, NY, 1978.

and

The Making of a Woman Surgeon by Elizabeth Morgan, M.D. Berkley Books, New York, NY, 1980.

Reading these two diametrically opposed accounts of post-graduate medical education in succession makes for a fascinating comparison-contrast study. Incredibly cynical, yet often painfully realistic, *The House of God* has recently achieved the status of being "the" book to read in medical school and has become the foundation of much of the current medical student clinical "lingo." On the other hand, *The Making of a Woman Surgeon* has been far more popular in the press than among the medical community and offers a far more optimistic view of residency training. One can not help but wonder what factors contributed to these two different views of the same period of medical training. The most obvious difference between the two is the settings in which the stories take place: Elizabeth Morgan describes surgical training in a university hospital whereas Samuel Shem's book revolves around an internal medicine program in a city hospital.

Several questions came to my mind as I read and compared these two books, including: to what extent, if any, are their opinions and experiences related to the difference in the approach of men vs. women to residency training?, what percentage can be attributed to the intrinsic "doer" role of a surgical field vs. the "thinker" role of internal medicine and, of the personalities that each attracts, is House of God really the story of a resident who initially, erroneously, chose medicine over psychiatry only to discover to his frustration that his was the wrong field for him?, and finally, how much of the harsh reality of surgical training is actually glossed over by Dr. Morgan since she herself admits to over-working herself in order to not appear "soft" to colleagues or superiors?

As with most polar viewpoints, I suspect that most resident's overall experiences lie somewhere between the cynicism of Dr. Shem and the optimism of Dr. Morgan and that most probably vacillate between the two extremes at various points in their training. Another previously unmentioned difference in these two books involves just that point—Shem's book was written at the end of his internship whereas Morgan completed her's after having finished her residency.

In terms of similarities: both books obviously deal with the subject of the authors experience of residency training, involve approximately the same time period (the mid to late 1970's), and take place on the East Coast of the United States. Of the two, I truly feel that *The House of God* can only be fully understood by the med student who has had some clinical experience and dealt with his/her own rising cynicism and self-doubt. There are times when this book is blatantly painful, since it addresses many emotions and fears which we often do our very best to ignore, or at least, suppress.

I found that I actually enjoyed *The Making of a Woman Surgeon* more as a pre-med than as a fourth year med student, when I frequently found myself irritated by Dr. Morgan's lack of cynicism. Yet, she too has many valid points and does deal to some degree with the emotional tolls of and difficulties of residency training.

While both books have their merits, it is *House of God* which really requires the most soul-searching on part of the reader. In contrast, *The Making of a Woman Surgeon* can be read and essentially taken at face value as a biographical account rather than as a consciousness raiser. Read in succession, they form a fascinating study of the attitudinal differences of two physicians toward residency training. □

continued from page 3

mechanism responsible for student evaluation was excessive. For schools locked in the pit-bull grasp of Board scores, suddenly an external review that was developed as an additional check of curriculums had become the driving force behind them; one gets the strange sense of the proverbial tail that wags the dog instead of the dog wagging the tail. Today, schools strictly tethered to Board scores have witnessed an evaporation of the desire to develop and implement a more integrated curriculum; the curriculum is rigid and locked into the over-worked pattern of 2 years of basic sciences and the 2 years of clinical work. At this cleavage between the basic sciences portion of our curriculum and the clinics stands the watch dog of Board exam Part I; indeed some schools even use the scores as a barrier to advancement. Consequently, professors savvy to the idea of tenure develop curriculums which cater to passage of the test—the result is stagnation. Gone is the desire to bridge the abyss by making curriculums more clinically relevant. Gone is the desire to escape from the purely rote memorization of facts with the teaching of information management. This seems strange in a litigious world that emphasizes our skills as clinicians and not as basic scientists.

This is not to say that we are locked in to this design due to a lack of examples to follow—a few gems of innovation *are* out there. Experimental curricula have been launched at Case Western Reserve, McMaster, U. of Missouri, Southern Illinois, and Harvard—to name but a few. Many schools now integrate basic and clinical sciences and, in several schools, students are introduced to clinical medicine in ambulatory settings. The emphasis on National Board exam scores distorts the educational system. A pass-fail report would reduce the effects of the standardized test results and foster curricular experimentation and innovation.

Board exam scores' malignant spread has also been detected in the residency selection process. Bestowing residency program directors with a numerical distinction between students provides an irresistible method of ranking an applicant in relation to nearly all U.S. medical graduates in a given year. This is not in keeping with the purpose of the Boards. Robert Volle, Ph.D., president of the NBME, in a letter to residency directors, implicitly stated that, "Program directors who use Part I or Part II scores as a factor in selecting residents, must recognize that these examinations are not designed for that specific purpose." One must speculate that these examinations are not designed for the evaluation of medical students by medical school faculties. This development is of concern because it shifts the meaning away from those qualifiers that describe the student more

continued on page 10

continued from page 9

precisely—faculty input vis-a-vis medical school grades, clerkship evaluations, and Dean's letters. Additionally, it inappropriately suggests the idea that scores can predict performance as residents and, furthermore, as physicians. Dr. Volle emphatically states that, "it is important to understand, however, that the examinations have not been developed for the purpose of assessing preparation for post-graduate education." Robert J. McCollister, M.D. in an article published in the January 8, 1988 issue of JAMA identifies two studies published in the Journal of Medical Education which conclude that the relationship of clinical skills to performance on tests covering subjects in the basic medical sciences is at best inconsistent. This analysis is particularly true of the National Board Part I, which does little to assess clinical competence. David Rogers, M.D. concurs that, "Students and teachers are under considerable pressure to emphasize learning that will yield high scores on these standardized tests, even though the scores correlate poorly with subsequent performance."

Eventually, approximately 80% of the graduates of Liaison Committee on Medical Education (LCME) schools satisfy licensure by this mechanism, which requires successful completion of a three-part examination, graduation from a school of medicine approved by the LCME, and satisfactory completion of one full year in an accredited graduate medical education program. Adoption of a pass-fail report would focus more attention to less easily quantifiable items that are important in identifying a good resident and future doctor.

Finally, numerically reported Board exam scores evoke discrimination towards certain student populations. The wide spectrum in how Board exams are utilized at various medical schools induces wide differences in students' preparation and subsequent results. Some schools require that students take the Board exam as a candidate and record passing scores for promotion—enhancing the importance of good scores. Other schools give both formal review courses and time off to study. Yet other schools require shelf examinations similar to the Board exams to benefit their students by the "practice effect." This lack of standardization, subvertly hidden in the students' scores, lends less validity to the use of the scores in the comparison of students. A pass-fail report, while not able to eliminate the possible inconsistencies at individual schools, would diminish the subtle distinguishing marks generated by them.

Many of these messages are not new. But repeating and reiterating these themes emerging from many recent reports may speed the process of change. Numerical score reports do not encourage innovations in medical education, nor do they play a necessary role in the licensure or evaluation of students as prospective residents, nor do they emulate true standardization. OSR does not stand alone in the identification of these problematic themes, but clearly we stand in one of the best positions to suggest the idea of a pass-fail report as the solution. □

Help for HEALers with Student Loan Troubles

Michael Heningburg, Director
Division of Student Assistance
Bureau of Health Professions
Health Resources and Services Administration

A small number of health professionals who default on their student loans are causing big trouble for a federal loan program that helps 1 in 5 allopathic medical students pay for their education.

The program is the Health Education Assistance Loan Program, commonly known as HEAL. In 1988, it helped 12,212 allopathic students—and 28, 907 health professions students overall—finance their professional education. Loans to allopathic medical students accounted for 40 percent of all HEAL loans in 1988.

HEAL originally was intended as a funding source of last resort, offering market rate loans to students who had exhausted all other sources of financial aid. Since its inception in 1979, however, HEAL has grown tremendously in size. The total value of HEAL loan principal and interest outstanding now approaches $2 billion, but this growth has been accompanied by substantial increases in loan defaults by former students.

In 1988, federal payments to private lenders to cover these defaults is expected to reach $35 million, compared to only $1.9 million in the first 4 years of the program. This growing default burden means that the future of the program may be in jeopardy.

HEAL loans are federally insured loans that provide money through nonfederal lenders to students in eligible health professions schools. Students pay market rates of interest and are required to begin repayment 9 months after they cease to be full-time students. Deferral of repayments is available to those who go on to approved internship or residency programs or to full-time service in the military or Peace Corps. The federal insurance is funded through an 8 percent premium charged to lenders and passed on to the borrower.

Medical students may borrow up to $20,000 a year, with a lifetime maximum of $80,000, from eligible lenders such as banks, credit unions, savings and loan associations, pension funds, HEAL schools, state agencies, and insurance companies.

The program is administered federally through the Health Resources and Services Administration (HRSA) of the U.S. Public Health Service, and specifically through the Bureau of Health Professions' Division of Student Assistance.

To date, about 92 percent of all HEAL recipients, and nearly 95 percent of allopathic medical student recipients, are successfully repaying HEAL loans. But a minority—in allopathic medicine 5 percent of borrowers—have defaulted. Between 1987 and 1988, default claims for HEAL loans to allopathic medical students rose from $5.2 million to $8.1 million.

Default is not the only option for a student or graduate with repayment problems. A variety of sources of help is available, and the consequences of default can be serious.

First of all, if you default, your loan holder—generally a bank—must take you to court and obtain a judgment before HRSA will pay the lender's default claim from the Student Loan Insurance Fund. A judgment is likely to end up at the Department of Justice for collection, and subsequently may be referred to a collection agent. A practitioner's exclusion from Medicare reimbursement or a tax offset by the Internal Revenue Service also could result. A loan defaulter employed by the federal government could have his or her salary offset to pay the judgment. At the very least, one's credit rating will be seriously affected by the default.

continued on page 11

continued from page 10

If overall default rates remain high, schools with high default rates could face the possibility of being expelled from the HEAL program. A rulemaking proposal to set out criteria for the expulsion of schools with high default rates is being developed in HRSA. Such measures already have been introduced into other federal student loan programs.

These severe consequences are not inevitable. It is critical for a student contemplating a HEAL loan to become an informed consumer, and for a student or graduate facing payment problems to talk with his or her lenders as soon as possible.

One option for an individual with payment problems is forbearance. This is a suspension of payments for an individual who is having temporary payment problems, or temporary health or income problems affecting repayment. Up to 3 years forbearance is available over the lifetime of a HEAL loan.

Secondly, HEAL lenders will work out graduated repayment schedules for individuals with repayment difficulties. These typically involve small monthly payments during early years when a practitioner's income is less, and substantially larger payments in later years.

For students who have educational loans in addition to HEAL, consolidation loans and combined payment plans are available. A consolidation loan enables a borrower to consolidate loans administered by Department of Education such as *Federally Insured Student Loans, Guaranteed Student* Loans, Perkins Loans, and others. Health professions student loans also may be included in a consolidation. While a consolidation loan has drawbacks, it does permit a greater choice of payment terms, lower monthly payments over an extended period, and a single payment each month. Under a combined payment plan, a borrower may combine various HEAL loans, or a combination of HEAL loans and a consolidation loan. A combined payment plan has advantages and disadvantages similar to those of a loan consolidation.

To take advantage of these options, talk with your lenders when you first begin to face problems. Loan holders have a real stake in keeping good payers, because they can collect more interest in the long run. Similarly, HRSA has a stake in such agreements, because they reduce the size of its default payments. And the schools have a stake, because reduced defaults will keep the program healthy so that future students will have the option of using HEAL.

For those individuals who are considering HEAL to pay for their education, there are several things to consider carefully.

- HEAL loans are not cheap. HEAL charges an initial 8 percent insurance premium to borrowers. Thus, if you borrow $10,000, you actually receive $9,200. The remainder pays for the insurance premium.
- Expenses over the life of a market rate HEAL loan can be high. If you borrow $30,000 and enter practice immediately after graduation, a 10 percent interest rate over the life of a 15-year loan means that your payments could total $127,000.
- Interest rates are adjusted quarterly. While capped at the rate paid by the 91-day Treasury bill plus 3 percent, most loans are made today at the T-bill rate plus 2.5 to 3 percent. The federal government is making changes in the way HEAL loans are marketed to help make applicants more aware of the program's requirements and to reduce the likelihood of default.
- This includes requiring all new applicants to complete a financial needs analysis that takes into account all financial resources, including those of parents and spouses. It also includes a credit check and entrance and exit interviews with students in school to go over the terms and obligations of borrowing from the program.

Ultimately, there is no substitute for becoming an informed consumer when it comes to taking out or repaying a HEAL loan. For the student it means making a realistic assessment of what one's practice income is likely to be, and whether it will be large enough to justify borrowing from HEAL. For the practitioner with HEAL loans, it means consulting with one's lender when payment problems arise in order to avoid more serious problems later. And for both groups, it means insisting on clear explanations of the advantages, disadvantages and obligations of HEAL loans.

Students should consult their schools and potential lenders for thorough explanations of loan terms, obligations, and payment requirements. Practitioners with HEAL loans should consult their lenders. And we in HRSA are available to point you in the right direction if you need help. □

---

continued from page 4

could prevent students at a number of (mostly undergraduate and proprietary) institutions from receiving student aid. AAMC and most higher education organizations have opposed the proposed regulations.

The Senate may also reintroduce legislation prohibiting the use of student deferments during residency. AAMC is working hard to advocate a longer internship deferment; the current internship deferment is limited to two years.

Defaults in the HEAL program are also causing concern (see "Help for HEALers", this issue). The student loan insurance fund (SLIF) which is designed to cover defaults through the eight percent insurance premium paid by borrowers is projected to be insolvent at some point during the current fiscal year. The Administration is planning to propose that other Title VII monies be used to infuse the SLIF with necessary funds to cover defaults. Regulations more stringent than the Department of Education's are expected to be developed for HEAL in the next few months.

The other education-related issue receiving attention in Washington is national service. Both the President and Congress are trying to rekindle a willingness on the part of citizens—mostly young people—to volunteer for national or community service. Several bills have been introduced to develop programs that provide educational assistance in return for service. One bill by Senator Nunn (D-Ga) would eventually limit eligibility for student financial assistance programs to those who have fulfilled a national service requirement. Though much debate will take place on these proposals before one is adopted, some form of national service legislation is expected to pass in the 101st Congress. □

On the Other Side of the Bedrail

Tony Ficalora, M.D.
U. of Tennessee, Memphis

I was recently approached to write an article about my thoughts and feelings about my "recent bout with leukemia." At first I rejected it soundly—I figured an article and a few well-placed tears and I was a shoo-in for martyr of the year. I'm also not one for baring my soul—I rarely open up—so why should I let it all out for everyone at UT? Well, I said no, and then was asked to think about it more because it would really help people out. "We're not trained to be compassionate in med school or our residencies." Which is true, I guess—I mean, there is no human compassion and feelings course. There's also no "How to Appreciate Your Life" class offered either.

O.K., just a little stick. How many times have you said that? It's practically reflex, you say it almost unconsciously. Well, I've got news, folks—it's not just a little stick. It hurts. It really does. It hurts when you get one every day or several at once. So should we stop ordering blood cultures and lab work? No, but maybe we can stop and think about what our patients are going through. And how we can show them a more caring attitude.

O.K. class, today we learn about life. Do you appreciate it? Do you really? Have you thought about dying? Poof—you are dead—you are gone. You can't talk to anyone anymore. You are gone, they will go on living their lives—they'll be sad for a while but then their old routines will kick back in and they'll live out the rest of their lives, without you. You're dead. You can't smell pizza or your cologne or cinnamon or anything. You can't enjoy that weather anymore. Not just the warm sunshine and blue skies but the rain and the lightning and the humidity and the crappy weather and everything. Man—it's all gone. No more ice cream. You'll never have kids. You'll never get married. You'll never have grandchildren. How much have you thought about taking your grandchildren fishing? Or buying them a kite, or just visiting them?

All your friends and family—are you happy with the way you left them? You're gone—everything is unchangeable now. Can you honestly say that if you died at this instant you'd be happy with the way they think of you? Of all the things that were unsettled and unsaid? All that petty trash that we love to thrive on.

O.K., so what's my point? All I'm saying is the old cliche, "Live every day like it's your last." I know it sounds like it's off a cutesy poster with fuzzy kittens and Smurfs, but it's actually a wise statement. It took a catastrophe to make me realize how serious the whole deal is. So now I look at the colors, and I notice the smells. I'm thankful that I can walk, and I'm thankful that I can taste chocolate, and I'm thankful for my family and my friends. I really hope the sames goes for you.

Anthony "Tony" Ficalora, M.D., died on February 18, 1989, after a 21 month battle with leukemia. He wrote this article at the request of his fellow classmates just prior to their graduation last June.

Free Places to Stay on Residency Interview Trips

Each year the OSR coordinates a nationwide housing exchange network for medical students on interview trips. Over half of the schools in the country participated last year, and many students saved money by staying with student "hosts" in the area they were visiting.

The system is simple. Each school which submits a list of at least ten volunteer "hosts" will have its list included in the network directory. Directories are then sent to each participating school's OSR representative and Student Affairs Dean for use by their entire class of interviewing students. Only participating schools receive directories and it is up to each senior class to get together with the help of your OSR representative. Full details and sign-up sheets will be sent to your school's OSR rep this summer in order to prepare the directory for the fall's interview season. If you are interested in participating, contact your school's OSR representative.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AAMC

Volume XIII
Number 2
Fall 1989

M.L. Littleyer

progress notes

Medical Education News from the Organization of Student Representatives

perspective from the chair

Clayton Ballantine
U. of Louisville

Hello Everyone!

Sometimes I wish (not too heartily) that I could be a member of the class of 1999 instead of the class of 1989. Several transitions are occurring now which point to better medical education in the upcoming years. By gradual steps, the necessary critical mass may be accumulating to adapt the educational system to the information revolution and other unaddressed forces which will affect our medical careers. Recent developments include:

National Boards

The National Board of Medical Examiners (NBME) has been at the center of many discussions about medical education. One focus has been the reporting of exam scores. The OSR and many medical educators have long advocated a switch to strict pass/fail reporting instead of the currently used numerical scores because of limitations in the evaluation capabilities of the exams, the misuse of scores in the residency selection process, and the indirect backwash effects on medical school curricula. After many years without much change, the NBME is now showing subtle yet major shifts in direction to address these issues.

The content and format of the exams draw criticism for their heavy emphasis on factual recall without stressing problem solving and other reasoning skills. The NBME is in the midst of a thorough review of the way the exams are written and an evaluation of just which skills can be tested by the different testing methods available. Roseann Jones' article in this issue details how this revision is taking place.

Recently, the NBME has also made efforts to inform residency program directors about the exams' limitations as predictors of success in residency training. The latest data from the residency match shows decreasing reliance on scores in the selection process.

On the issue of faculty "teaching to the Boards," it is all too easy for a school's curriculum committee to resist innovation on the grounds that changes may jeopardize student performance on the NBME exams. This reasoning calls up major questions about why the isolated skills required for getting high Board scores are used to judge the overall success of a school's educational program and the individual merits of its academic departments. Going beyond these questions though, the results from those schools with more innovative, problem-based learning approaches show no decrease in Board scores. So the ultimate responsibility for updating the teaching methods and content comes back to rest with the school's individual faculty. It is in helping to break this stubborn grip of inertia locally that pass/fail reporting would have its greatest benefit.

continued on page 2

AAMC Airline Discounts for Residency Interviews

This spring, the Association of American Medical Colleges (AAMC) contacted all of the major U.S. airlines to ascertain which might be interested in offering discounted air fares for senior medical students interviewing for residency positions. The AAMC is very pleased to announce that contracts have been signed with NORTHWEST AIRLINES, INC., and TRANS WORLD AIRLINES (TWA). The two airlines have agreed to a co-carrier arrangement, which will be advantageous to more students than an agreement with a single airline.

The specifics of this year's airline discount program follow.

Northwest Airlines, Inc.

Discounts

*40% off the full round trip Coach class fare (Y, YN, Y9)
* 5% off the lowest applicable round trip fare (all rules/restrictions apply)

Dates Available

November 1, 1989, through February 28, 1990

For Reservations

Call (800) 328-1111 and refer to this special code, to be used only by senior medical students for residency interviewing: 01033

Trans World Airlines (TWA)

Discounts

*50% off the unrestricted Coach (Y) fare
*20% off First Class fare
*15% off Business Class fare
*5% off Excursion Fares meeting all restrictions
*5% off One-Way fares

Dates Available

November 1, 1989, through March 1, 1990, except for the following black-out dates:
*Systemwide: November 21-22, 26; December 19-23; and January 1-4
*Northeast-Florida: Southbound—February 14-16; Northbound - February 19-20

For Reservations

Call (800) 325-4933 or (314) 291-5589 Monday through Friday and refer to this special code, to be used only by senior medical students for residency interviewing: 9911299 □

Inside this issue . . .

continued from page 1

Another change involving the exams we take to get our medical licenses is coming in the form of the Uniform Examination Pathway. There are now two routes to a license — the NBME exams or the FLEX exams. The FLEX exams are written by the NBME in cooperation with the Federation of State Medical Boards. About one fourth of U.S. medical students take FLEX. Recently, there has been pressure from legislatures and the courts to do away this these "separate but equal" routes. If the details continue to be worked out smoothly, a resulting merged set of exams, closely resembling the current NBME series, developed in a new cooperative effort between the NBME and the Federation, will be phased in starting with part I in 1991. This Uniform Examination Pathway will be a major focus of concerns about how we evaluate competency for licensure. By raising awareness of the pertinent issues through participation in the decision-making at the local school level, the ensuing discussions can help to improve this crucial link in our evaluation system.

Accreditation

Medical school accreditation is a great opportunity to work for improvement at individual schools. The accreditation site visits by the Liaison Committee on Medical Education (LCME), composed of AMA and AAMC representatives, occur on a newly modified seven-year cycle. As part of the shift to this new pattern, most schools will have surveys over the next few years. Additionally, follow-up visits are scheduled in mid-cycle to check progress in specific problem areas.

Each accreditation, with preceding data gathering, actual site visit and subsequent follow-up spans two to three years. The LCME spends a great deal of time and effort checking student opinions about the educational program and other aspects of each school visited. They rely on students for identification of strengths and weaknesses of the school. The LCME then requests that the school address its specific problem areas as a contingency to accreditation. Their assessment is very thorough.

At several medical schools, including Duke and the University of Wisconsin, students have organized in advance and submitted their own team-written assessment reports to the LCME. The LCME teams finds such reports to be invaluable resources in working with the school toward improvement. The OSR has been working with the LCME to more clearly define the students' role in the process. A packet of materials under development by the OSR will be available this fall to explain the accreditation process to students. This will include a guide to writing a useful student assessment. The OSR annual meeting, October 27-29, will have a special orientation session for the OSR reps from the schools with upcoming visits. If your school has an upcoming site visit, contact your OSR representative for information about how students can participate. The goal is to increase awareness and make it easy for interested students to get involved.

The Residency Match

Administration and operations of the National Resident Matching Program (NRMP) are being shifted to the AAMC over the next few years. Several improvements are in the works, including a more useful standard application form, better leverage over the residency program directors to protect against abuses, and possibly development of more effective career decision-making counseling. As part of the reorganization, the NRMP Board has been increased to include four students — each representing a different medical student organization — to further fill in the picture of what happens to students as they go through the medical school process. Information from the match will also be coordinated with the existing AAMC database of premedical student, matriculating student and graduation questionnaire results.

Innovation in Curriculum

Less visible, but no less important, is the work of many students and educators who are trying new approaches to teaching, evaluation, and curriculum content analysis at schools around the country. More schools are incorporating problem-based learning and other innovations into their curriculum. Dr. Howard Barrow's article about standardized patients describes one of the most promising new tools. At the AAMC, the Assessment of Change in Medical Education (ACME) project is aimed at helping schools find out what new approaches are being developed across the country and how they are being implemented.

It is amazing how readily many medical students will complain about ten dollar parking tickets or expensive cafeteria food and yet spend tens of thousands of dollars on a medical education with obvious shortcomings without uttering a word of dissatisfaction or working to improve what they are offered. The shape of medical education is changing. Answers are available to many of the long standing problems.

One of the best mechanisms for improvement is student involvement at the local level, working with the faculty and administrators. Through a school's OSR rep, students have access to the AAMC's vast array of information and help in solving the problems. The efforts of individual students can really make a difference. □

---

continued from page 6

Summary

The National Board of Medical Examiners has spent the past 6 years developing the Comprehensive Part I and Part II Examinations from initial conceptualization to test development. At each stage, the National Board has had the benefit of testing specialists working with leaders in the field of medicine and education. Reviewers of this project include numerous basic biomedical scientists and clinicians from across the country who serve on test committees and task forces. Presentations by NBME staff to constituent groups have served to provide a basis for additional review. The National Board is committed to widely disseminating information about the development of the Comprehensive Part I and Comprehensive Part II Examination to all constituents. It is hoped that this initial overview of the Comprehensive Examinations has contributed to this purpose.

The NBME has published information about the Comprehensive Examinations in previous issues of the National Board Examiner *(Spring 1985 and Fall 1986). An article published in the July 1989 issue of the Federation Bulletin* highlights additional current information. Updated information will be published in a special Fall 1989 issue of the National Board Examiner *and the 1990 and 1991 issues of the* Bulletin of Information. *Presentations at the 1989 AAMC meeting in Washington, D.C. will provide opportunities to meet with NBME staff to discuss development activities. Published materials will be available at an Innovations in Medical Education (IME) exhibit sponsored by the NBME.* □

progress notes

Published by the
Association of American Medical Colleges
for the Organization of Student Representatives

One Dupont Circle, N.W.
Washington, D.C. 20036

Wendy H. Pechacek, Editor

perspectives
on evaluation

Changing the National Board Part I and Part II Examinations: An Introduction to the Comprehensive Examinations

Roseann M. Jones
Associate Director for Development
of Comprehensive Part I and II Examinations
National Board of Medical Examiners

This article has been written to explain generally the development of standardized examinations and to highlight specifically the development of the Comprehensive Part I and Comprehensive Part II Examinations. It is anticipated that a series of articles will be prepared on this topic in order to inform students about the examinations developed by the National Board of Medical Examiners (NBME) and the process used to develop high quality standardized tests.

Introduction

The Comprehensive Examinations are designed to replace the current Part I and Part II Examinations in 1991. The information presented in this article is intended to provide an overview of the developmental work completed to date as well as further developmental work in progress. The information is presented in a format that explains which issues have been addressed, how the issues were studied, what recommendations have been proposed by the Comprehensive Examination Committees, and how the recommendations will change the Part I and Part II Examinations.

Background

In 1983 the National Board of Medical Examiners (NBME) appointed a Study Committee to review the Part I and Part II Examinations. As part of an ongoing interest by the NBME to provide high quality examinations for certification for medical licensure, the National Board of Medical Examiners and its constituents recognized that it was appropriate to review these examinations in light of many factors including recommended changes for medical education and evaluation expressed in the "GPEP Report" (Report of The Panel on the General Professional Education of the Physician, 1984). The Study Committee was charged to review the content and methods used to develop the Part I and Part II Examinations and to propose guidelines to improve these programs. In 1985, the Study Committee presented its recommendations to the National Board for endorsement. The recommendations described the characteristics and processes for developing new examinations, the Comprehensive Part I and the Comprehensive Part II Examinations. The Comprehensive Part I and the Comprehensive Part II Examination Committees (two interdisciplinary committees of basic biomedical scientists, clinicians, and house staff representatives) were appointed in 1986 to develop further the testing policies for these programs. The committees were charged to review all aspects of the test development process in order to design and implement the Comprehensive Part I and Comprehensive Part II Examinations.

The Comprehensive Examination Committees began their work with a thorough review of the test development process which would serve as a framework for determining the policies and procedures for designing the Comprehensive Part I and Part II Examinations.

continued on page 6

Standardized Patients

Howard S. Barrows, M.D.
Associate Dean for Educational Affairs
Southern Illinois U.

Standardized patients are patient surrogates trained to present the same clinical picture whenever they are encountered in a specific patient's role. They are employed for clinical teaching, testing, and research. Most people who are coached to be standardized patients are normal folks, to begin with, without symptoms or signs. They are coached by a specific method to simulate the symptoms, physical signs, emotional responses, and behavior of an actual patient, whose problem is selected for its educational value. Standardized patients are coached to present the clinical picture that occurred at one point in the course of that actual patient's illness. People that may actually have had symptoms in the past and still have abnormal physical findings are also used as standardized patients. They can be coached to present their own clinical picture in a consistent fashion or to simulate patients, other than themselves, who have physical findings similar to their own. Although standardized patients can be coached to present a surprisingly wide variety of abnormal physical signs, the use of people with physical findings further extends the variety of physical findings that can be presented by standardized patients.

There is no difference between standardized patients who, in real life, do not have the symptoms and signs they portray, and standardized patients who do have the symptoms and signs they portray. Those with real symptoms and signs have to be just as carefully coached to consistently simulate their own history and physical at a fixed point in the course of their illness. A study by Goeff Norman showed that residents could not distinguish the standardized patient from the real patient. He also showed that the resident's history and physical examination performance and their diagnoses were essentially the same, regardless of which they were working with, the real patient or the standardized patient (Norman, et al. A Comparison of Resident Performance on Real and Simulated Patients. *J. Med. Educ.*, 57:708-715; 1982).

Norman's study only proved the obvious, standardized patients are real. First of all, they are actual living, breathing, feeling people with a complaint and with whom the examiner has to interact. Secondly, as has been proven over and over in so many different ways, they cannot be distinguished from real patients by skilled clinicians, unless these clinicians are told ahead of time that the patient is simulated. The secret to this fidelity is in the proper coaching of a simulated patient. Although we do not necessarily use actors as standardized patients, I have been told innumerable times, over many years, by those actors I occasionally do coach to be a standardized patient, that the method is similar to method acting. By using a number of deliberate coaching strategies, simulators are encouraged to take on the patient's problem as their own, and, for all intents and purposes, become the patient. In this coaching process they are never educated about the actual illness from a medical standpoint and the use of medical terminology is avoided in the coaching process. To be real to the examining students they should be as medically naive as actual patients and express themselves naturally, without any coloring provided by a medical education. This causes the simulator to look and act like the patient, preventing the

continued on page 4

Federal update

Student Status Deferment Restriction and Mandatory Forbearance Incorporated Into Congressional Budget Reconciliation Packages

Sarah Carr
AAMC

House and Senate Committees with jurisdiction over federal education programs have incorporated into their Budget Reconciliation bills a restriction on the use of student status deferments by medical residents. Such a restriction will mean that medical residents may no longer use student status classifications in order to be eligible for Department of Education loan deferments beyond the two-year internship deferment explicitly provided in the law. The Congressional Budget Office has estimated that the restriction will save $10 million in the first fiscal year and $40 million over three years. Congress is expected to complete action on Reconciliation in the fall. The effective date of the student status restriction is October 1, 1989.

In addition to restricting the student status deferment, the Senate Labor and Human Resources Committee also included two other provisions in its Budget Reconciliation measure, mandatory forbearance for medical and dental residents, and a study of indebtedness among graduate and professional students. AAMC has advocated a study of indebtedness so that additional data would be generated on debt burdens faced by residents in PG year three and beyond. Such data could bolster arguments for lengthening the existing two-year internship deferment.

The mandatory forbearance provision would require lending institutions to grant loan forbearance to medical and dental residents who are in the process of repaying Stafford Student Loans (formerly GSL loans). Loan forbearance allows a borrower temporarily to curtail all or part of their loan repayments. Current law provides lenders with discretion over the granting of forbearance and some lenders have been refusing residents' requests for the action. The Labor Committee's provision would not only mandate lenders to provide forbearance, renewable at 12-month intervals, to any resident who requested it in writing, it would also prevent a lender from charging a fee for the action. Further, to ensure that a resident's credit rating is not adversely affected, reports of the action to credit bureaus would be prohibited.

Forbearance helps highly indebted medical residents whose deferments have been exhausted and whose monthly loan payments are unmanageable. Under forbearance rules, interest accrues to the loan principal, and the 10-year repayment period provided for Stafford loans is not extended. In the long run, forbearance adds to the cost of borrowing and would be advantageous in most instances only to those residents whose financial circumstances put them at risk of defaulting on their repayment obligations. □

continued from page 3

wooden and artificial performance seen in those simulators asked to memorize a patient script. This method of training is not difficult to learn by anyone who wishes to be a simulated patient coach. It produces a high fidelity simulation with only a few hours of simulator training.

The term "standardized patient" emphasizes one important educational advantage offered by these patient surrogates. The clinical teacher can specify the exact patient problem to be used for teaching, assessment, program evaluation or research and have that problem available whenever, or wherever desired, and their presentation will be consistent. One disadvantage to the word "standardized" is that it may suggest to some clinicians and students that the problem presented is a classical or straightforward example of a particular disease entity, but this could not be further from the truth, as the simulations are based on real patients with all the usual ambiguities in place. They are often patients that may not have a well established diagnosis, but present an important problem for evaluation and treatment.

There are other educational advantages as well. The clinical teacher has a patient that can be used in ways impossible with actual patients in the health care system. They can be examined many times a day by different students, residents, or physicians. They can be used in other than clinical settings as, for example, in a classroom. Emergencies such as shock, angina, coma, seizures, depression, suicidal ideation and the like, can be directly examined by the student without concern for risk to a patient in a crisis. The patient encounter can be interrupted for educational discussions and even for replay. Last, but not least, the standardized patient can give the examiner accurate feedback about interpersonal skills and professional manner. The critique comes straight from the direct recipient of their ministrations, a person who sees directly every nuance of the examiner's body and facial language, and feels every nuance of the examiner's touch. It is feedback that cannot be equaled in accuracy by faculty observing the student-patient encounter. Unlike real patients who are in a dependent role, the standardized patient is taught how to give accurate feedback to the examiner.

The use of real patients to assess students' clinical performance has a variety of limitations. The patient used to assess a student is the patient who is available and may not have the most appropriate problem. Finding patients who would be able to, or would agree to being examined by a number of students further limits the choice of patients available. Faculty do not have the opportunity to decide amongst themselves ahead of time what the appropriate expectations are for a student's performance with a patient selected for student assessment from among those patients available. The patient may change over time and can become quite a different person to different examinees. Testing students with a patient who is available and not standardized is only one uncontrolled variable in student assessment. The performance of the particular examiner observing the student is another uncontrolled variable because of personal, often tacit expectations and criteria. This makes the potentially highly valid method of observing students with real patients highly unreliable, and therefore not valid. Ironically perhaps, the case can be made that the standardized patient with whom a known, standard test can presentation that can be chosen for its appropriateness, and with whom decisions can be made ahead of time by the faculty about their expectations for student performance is of greater value in the assessment of student performance than is the real patient. The standardized patient provides us with a reliable and valid tool for the assessment of clinical performance. In summary, the standardized patient is a most effective tool for both teaching and evaluation. Further information for those interested in the training and use of standardized patients can be found in *Simulated (Standardized) Patients and Other Human Simulations* (H.S. Barrows, 1978, Health Sciences Consortium (HSC), Chapel Hill, NC.) There are also instructional videotapes on standardized patient training available through the HSC. □

AAMC focus

Assessing Change in Medical Education (ACME)

Louis J. Kettel, M.D.
Vice President, Academic Affairs
Association of American Medical Colleges

The AAMC project to Assess Change in Medical Education (ACME) has passed the midpoint of its first year. This three-year project is funded by the Charles E. Culpeper Foundation. Its purpose is to define the present state of medical student education and implement change appropriate to the medical practice environment of the present decade.

In reports of major studies, the AAMC and others have recently recommended changes based upon analyses of the health care environment.1-6 These recommendations have asked medical educators to address a number of areas. Chief among these are:

- The intensive, information-transfer mode of instruction that inhibits the acquisition by students of needed learning skills;
- The low priority faculty seem to accord teaching of medical students;
- The largely elective senior year of medical school;
- The limited ambulatory care experiences offered in most medical schools.

Although the reports have been widely accepted, the extent to which their recommendations have been implemented has not been quantified. Additionally, the reports failed to recognize or acknowledge the changes in medical education that had already taken place, that were in progress, or that were being planned. The ACME project will determine the impact of these reports and recommendations on medical school curricula and student education. Of particular concern is the identification of impediments to change, roles of faculty, curriculum committees, and administration, as well as external agencies, local constituent attitudes, and funding sources.

Many of the recommendations for change had already been made more than a decade ago. A number of explanations have been made to explain this slowness to act. The limited participation and therefore limited sense of ownership of leadership and faculty present in the processes that yielded these recommendations has been postulated as a cause for slowness to change. Other explanations include the conservativism of medical educators, the system ambiguities of authority and structure for management of change, honest disagreements with recommendations, and cost and impracticality of implementations. The relatively low status of education competing for resources and faculty time with clinical care and biomedical research in complex academic medical centers is also offered as an explanation for slow implementation.

ACME Status and Plans

Since the ACME project began in December 1988, an advisory group chaired by Harry N. Beaty, M.D., professor of medicine and dean, Northwestern University Medical School, has met on two occasions. The major recommendations for change in these recent reports have been analyzed, are being summarized, and will be put in priority. They can then be studied against the longitudinal databases on medical school curricula and the demographic, biographic, and academic characteristics of applicants, matriculants, and graduates available from the AAMC database. A literature survey seeking evidence of actual changes made in medical education is also being conducted.

Based on the change information, a model taking into account all of the internal and external factors resisting change in the 143 North American medical schools will be developed. A survey instrument distributed through the deans will be used to confirm the data, the model of educational change, and the quantity of changes that have occurred and been accomplished. Attention will be directed to administrative accommodations used to facilitate these changes. It is unlikely that any school has not considered revisions in the education of its medical students since the health care environment has been changing so dramatically over the last decade. If institutions have not changed, therefore, it is important to determine what accounts for the lack of change.

A group of schools that have made curriculum change and a group that have not will be visited. From these visitations and the analyzed database, implementation strategies will be designed. Based on these findings a practical set of recommendations that are currently appropriate will be developed and strategies for implementation will be begun. These recommendations and strategies for implementation will be disseminated nationally.

Beginning in 1990 workshops will be organized to prepare teams sent from particular schools to implement educational change. Individuals will be identified throughout the study who can both serve as workshop faculty members and as on-site consultants to schools that ask for assistance in implementing changes recommended by this and other reports.

Change must occur. The possibilities for physicians to intervene effectively in human illness is perhaps the most important reason. The exponential rate of increase and the number and complexity of these interventions demand that the educational method provide students with skills for self-directed, continued learning throughout their careers. Compassionate, knowledgeable, skilled physicians so equipped are needed today as never before. □

1. Graduate Medical Education: Proposals for the Eighties. J. Med. Educ., 56, Part 2 (September 1981).
2. *Future Directions for Medical Education. A Report of the Council on Medical Education.* Chicago, Illinois: American Medical Association, 1982.
3. *Medical Education and Societal Needs: A Planning Report for the Health Professions.* Washington, DC: National Academy of Sciences, Institute of Medicine, 1983.
4. Physicians for the Twenty-First Century. *J. Med. Educ.*, 59, Part 2 (November 1984).
5. Barrows, Howard S., *Newer Approaches to the Assessment of Clinical Performance.* Report of an Invitational Conference. Springfield, Illinois: Center for Professional Development, Southern Illinois University School of Medicine, 1984.
6. Gastel, Barbara, and Rogers, David E. (Eds.). *Clinical Education and the Doctor of Tomorrow.* New York: The New York Academy of Medicine, 1989.

continued from page 7

cy that handles discrimination claims. It is not illegal for an interviewer to ask questions based on any of these subjects. If a program chooses residents on the basis of answers to these questions and charges are filed, the fact that the questions were asked can be used against them at that time.

Note 1: Title VII of the Civil Rights Act of 1964 protects the individual's right to be free of intentional discrimination. It states "it shall be an unlawful employment practice for an employer: (1) to fail or refuse to hire or to discharge any individual, or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment because of such individual's race, color, religion, sex, or national origin; or (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or intend to deprive any individual of employment opportunities or to otherwise adversely effect his status as an employee, because of such individual's race, color, religion, sex, or national origin."

Comments to this article should be directed to Randolph Park, Section for Student and Educational Programs, Association of American Medical Colleges. □

books

Carolyn Reich
Emory U.

Becoming a Doctor—A Journey of Initiation in Medical School
by Melvin Konner, M.D.

Books which describe the medical school experience are often eagerly devoured by "pre-meds" and freshman medical students as they anxiously anticipate the challenges of clinical medicine. But the insights offered by Melvin Konner, M.D., in his book *Becoming a Doctor—A Journey of Initiation in Medical School* are probably most meaningful to those who have experience on the wards and can identify with his descriptions of the personal demands and ethical inherent in clinical training.

Konner, who received his doctorate in anthropology and taught for several years at Harvard University before entering medical school, cannot resist commenting on the pedagogical techniques employed during the first two years of preclinical training. He decries what he calls the "throw-it-against-the-wall-and-see-ifit-sticks" method of instruction. But Konner, who is not only a skilled observer but also a respected authority on certain aspects of human behavior, chooses to focus on the initiation of the student into the realm of patient care. During the third year of school the student usually passes through the first phase of the socialization process which so greatly shapes the values of the future physician. Using the "prism of participant observation" he traces the journey through junior clerkships and colorfully portrays the excitement, drama, and frustration characteristic of student encounters with patients, house officers, and attendings. These clinical vignettes extend beyond a mere description of ward medicine. They capture the essence of the universal conflicts and joys experienced by students. His penetrating insights bring to conscious awareness aspects of the depersonalization of medicine that threaten not only to dehumanize the patient but the medical student as well.

Konner's reverence for medicine is evident as he reveals the factors which influenced his decision to pause in the midst of his successful career in anthropology to submit to the rigors of medical training. This deep respect for the profession probably enhanced his keen disappointment as he personally witnessed the imperfections of the physicians and inadequacies of the educational system. In the concluding chapter he analyzes some of the social forces shaping the training of physicians. But an air of resignation permeates this discussion because he sees so little movement in the direction of effective and permanent change.

In the final pages, Dr. Konner distances himself from his medical colleagues, shifting from participant to observer as he levels his harshest criticisms. While he acknowledges their brilliance, endurance, and competence, he uniformly categorizes physicians as arrogant, unreflective and narrow. As a medical student I found these sweeping judgments to be rather caustic. Disappointingly, Konner describes little interaction with other students beyond encounters on the wards. Had he made more of an effort to know his classmates he might have been more aware of their depth of character and breadth of interests. In addition, he would have realized that his concerns about ethics and principles are certainly not unique.

Nonetheless, *Becoming a Doctor* enhances the awareness of students, particularly those in their clinical training, to the subtle acquisition of new values which they are undoubtedly experiencing. Although many of these may be necessary to meet the demands of the profession, Konner mercilessly identifies those which are merely self-serving. Such knowledge empowers students who are currently facing this critical period of professional development to carefully evaluate and consciously choose the values which they will embrace during their training. □

continued from page 3

Each step in the test development process is an important element requiring significant study. In designing a test, developers were concerned with 1) the purpose of the test, 2) the design specifications (content, format, test length), 3) item writing and review procedures, 4) scoring, equating and standard setting methods, and 5) score reporting mechanisms.

The Comprehensive Part I and Comprehensive Part II Examination Committees reviewed these elements of test construction in order to make recommendations about the design and psychometric features of the examinations. A summary of the current recommendations is provided.

Recommendations

Purpose of the Examinations

The Comprehensive Examinations will be broadly based integrated examinations designed for the purpose of certification for medical licensure, rather than distinct achievement tests in individual basic biomedical or clinical science disciplines. The Comprehensive Examinations will emphasize concepts important as part of the current and future practice of medicine including concepts related to the prevention of disease. The Comprehensive Part I Examination will emphasize knowledge and application of basic biomedical concepts; the Comprehensive Part II Examination will emphasize knowledge and application of clinical science concepts.

Design Specifications

The Comprehensive Part I Examination will be constructed from an integrated content outline based on a test blueprint that includes topics related to Organ System, Process/Function, and Organizational Level. The Comprehensive Part II Examination will be designed from a blueprint that includes topics related to Population, Physician Task, and Normal Conditions and High Impact Diseases. Content topics will be drawn from disciplinary (e.g. anatomy, physiology, medicine, surgery) as well as multidisciplinary (e.g. genetics, immunology, neuroscience) domains. Items will emphasize application of information, rather than recall of isolated facts.

The Comprehensive Part I and Part II Examinations will use multiple choice questions to evaluate examinees' cognitive understanding of important scientific and clinical concepts. The multiple true/false item format (K-type) will not be used. Each examination will include a total of 800 items. The testing time is anticipated to be 12 hours for each examination.

Item Writing and Review Procedures

Items included on the examinations will be written by discipline-based test committees and multidisciplinary task forces. It is expected that all items will be pretested prior to their use on an actual examination. This process requires that a small number of items be included on an examination for trial purposes. Each pretested item will be reviewed to meet requirements of content accuracy and technical standards. Items that are identified as flawed will be either revised and pretested for further analysis or deleted. Pretest items will not be included in the calculation of examinees' scores.

Score Reporting

A total score and a pass/fail designation will be reported to the examinee. Medical schools will receive the same information for individual examinees plus group mean scores for each basic science or clinical discipline represented on the Comprehensive Part I or Part II Examinations. Discipline subscores will not be reported for individual examinees. Content-based and normreferenced standard setting methodologies are currently being investigated for potential use in determining the passing standards for the Comprehensive Examinations.

continued on page 2

the *bulletin* board

Committee Openings for Students, 1989-90

The following committees will have openings for student representatives in the coming year:

Group on Student Affairs (GSA) Committee on Student Financial Assistance
GSA Committee on Student Affairs
Flexner Award Committee
Liaison Committee on Medical Education
Association of Teachers of Preventive Medicine Board of Directors

A full description of the responsibilities for each position is available in the OSR Business Meeting Agenda for 1989 or from your OSR representative. Applications must be received by Wendy Pechacek at the AAMC by November 17 for the Flexner Award Committee and February 15 for all other positions in order to receive full consideration by the OSR Administrative Board. Students need not be members of OSR to apply to these positions. □

Animals in Research

Nancy Archibald
Program Administrator
American Medical Association

Medical students, in their quest for scientific knowledge, understand the critical role animals have played in the advancement of medical science. Life saving vaccines, drugs and treatments have been developed through the use of animals in biomedical research. Yet in spite of medical science's critical advancements resulting from the use of animals in research, animal rights activists are working toward the eradication of the use of animals in biomedical research. Specifically, some organizations are focusing their efforts on restricting the educational uses of animals.

In view of current opposition to the use of animals in research, misinformation, and propaganda, the American Medical Association-Medical Student Section (AMA-MSS) passed a resolution at its annual business meeting in June encouraging medical students to carefully investigate the positions of organizations before accepting a fellowship. Fellowships with organizations that align themselves with the animal rights/protection movement were specifically cited.

During the course of your medical education, you will have the opportunity to investigate internships and fellowships to augment your medical education. It is through these programs that students are able to expand their knowledge in areas of particular interest to the individual. Careful consideration, however, is necessary when selecting any potential educational experience that purports to examine a broad spectrum of the issues involved in the use of animals in research.

When investigating a particular program, be sure to understand the intent and philosophy of that program. Ask questions, review program and course descriptions, talk to past participants and program coordinators, discuss the appropriateness of the potential program with administration at your medical school; it is your responsibility to learn all you can about the program before enrolling. □

Residency Interview Encounters You Can Do Without

During the senior year of undergraduate medical education, medical students typically apply and are invited to interview for residency. Complaints from senior medical students about their residency interviews have reached representatives of various medical student associations. Anecdotal evidence from medical students seemed to indicate widespread encounters with offensive gender and ethnic specific questions from interviewers. Consequently, the Consortium of Medical Student Associations asked the AAMC to gather information about the kinds of interview questions being posed.

The AAMC was able to obtain this information through the Graduation Questionnaire (GQ), which has a section on the residency selection process. The GQ question on residency interviews asked for the number of incidental occurrences for several topics, and asked for comments about the specific nature of the questions, the context in which they occurred, and the position of the person asking the question.

Results from the 1988 GQ revealed that women were more likely than men to be asked about the stability of their interpersonal relations (25 percent of female respondents to 17 percent of male respondents) and their intention to have children (40 percent to 16 percent). For nonwhites, the issue of race tended to come up more often than for whites (28 percent of nonwhite respondents to 13 percent of white respondents). Anecdotal written comments from the students indicated that the incidents could occur with program directors, residents, attending physicians, or secretaries.

These results show that some residency interviews can take on a highly personal nature. Women were five times more likely to be questioned about their commitment to medicine and twice as likely to be asked about their spouse's support on some aspect of their decision to enter medicine or their decision to take a residency. Women were also seven times more likely than men to have an offensive incident occur during their interview. Some examples of inquiries and remarks deemed offensive by the questionnaire respondents were: "An attending asked me (sic) . . . 'Are you worried about having senescent ovaries?' in the context of probing [for] a desire to have children." "I was told by an interviewer I should be home having babies." "[I was] asked 'how does it feel coming from a lower class and entering an elitist profession?'" "Why do you think being Catholic makes you better than others?" "Our program is very demanding and you might get tired because you're older." "... an attending [asked] (sic) ... whether I had anything to tell him that I hadn't previously and why I was working at a clinic with many homosexual clients." Analysis of types of programs where offensive incidents occurred showed no significant difference of frequency by specialty.

The 1989 Graduation Questionnaire asked the same questions in attempts to track any variations in response. Results will be discussed at the meeting of the Forum on the Transition from Medical School to Residency, held each fall during the AAMC Annual Meeting. Here the leaders of the program directors' associations meet to discuss ways to improve this transition for medical students.

One source of information on responding to offensive questions during the residency interview is the brochure, "The Residency Interview: A Guide for Medical Students," which was published by the AMA Women in Medicine Project. In it the authors note, "the law prohibits discrimination on the basis of sex (including pregnancy and childbirth), race, religion, national origin, age, and handicap.1" If you are asked questions pertaining to any of these subjects, you are not required to answer. If a program is particularly flagrant in its pursuit of these questions, you may contact the federal Equal Employment Opportunity Commission or state agen-

continued on page 5

letters to the editor

Power Is In The People

The thought has occurred to me—and I have written about it that residency selection committees have a major responsibility for shaping up the process of the Match. There is responsibility, too, that is invested in applicants for residency positions. In this regard, there are some attitudes and behaviors that need reexamination—and some opportunity for healthy change in the implementation of the Match.

For example, not long ago, I talked with a student who had not achieved a first choice in the Match. This student was appropriately hurt—rejection always hurts—and not so appropriately angry. I'll admit that part of grieving for something lost not uncommonly involves a period of anger. In this instance, though, it may not have been entirely justified.

Firstly, the student offered an explanation that boggles the mind—an explanation that is heard with some frequency across the country. The suggestion was made that one particular program wanted that student so badly that the director called all his counterparts and told them to cease and desist in order to allow him to capture the prize. We do sometimes value ourselves highly, but it does stretch the imagination to conjure up a cabal amongst residency selection committees designed to route the most precious among the applicants to particular programs. This would pander to the notion that preciousness is easily definable and that the precious few would be ceded by some agreement to particular departments. The very competitive nature of American academic medicine would of itself argue against this possibility.

Secondly, this student did an "audition elective"—went off to another medical school, another academic center where greener pastures were supposed. The student forgot that audition electives are risky. There is a protective shade of gray which envelops applicants when they are considered on the basis of recommendations, interviews, and transcripts, a protective coloration which may be lost when an indifferent attending, an exploiting house officer, and the need to adapt to a new setting, new routine, and new telephone numbers can serve to intimidate the very best during a month elsewhere. The audition is more often a negative rather than a positive. Admittedly, demand for these auditions does not begin with the student; and I have not mentioned the incredible compromise of valuable electives that multiple auditions effect. Imagine, though, if, during one year, there were a collective decision, countrywide, amongst applicants to refuse to do auditions.

Finally, the student wrote a "bread and butter" letter, thanking interviewers and the residency selection committee, one and all, that this was the object of that student's heart's desire in a residency. Again, admittedly, these letters are frequently requested. Imagine, however, the collective power of applicants if they all, across the country, would say, "Enough! No one will write such a letter." Could there be this much trust within the full group? Would not the foolhardiness of these letters be eliminated by collective action?

In fact, the student with whom I spoke was not the victim of a cabal; rather, the victim of an audition elective and a meaningless "bread and butter" letter. A fine applicant was found wanting by a particularly crusty senior faculty member. All else fell by the wayside, the protective shade of gray was lost, the heart's desire was lost. Quite obviously, students have power if they choose to exercise it. Perhaps, the OSR could mount an effort across the country which would effectively bring an end to spurious letter writing and inappropriately requested auditions. Perhaps there is an untapped power—a collective refusal to yield to the unreasonable. □

Henry M. Seidel, M.D.
Associate Dean for Student Affairs
The Johns Hopkins University
School of Medicine

Calendar of Medical Student Events

10/27-29/89	AAMC-Organization of Student Representatives annual meeting, "Medical Education: Keep the Fire Burning." Washington, DC (202) 828-0400
10/25-29/89	American Medical Women' Association annual meeting, "The Cycling Woman." Beverly Hills, CA (703) 838-0500
11/1/89	Dean's Letter release date for 1990 National Resident Match
11/15/89	All changes to NRMP Match registration due to dean of student affairs
12/1-3/89	AMA-Medical Student Section interim meeting, "Community Projects: Beach Blanket Networking." Honolulu, HI (312) 645-4745
2/28/90	Deadline for submission of rank order lists for 1990 NRMP Match
3/21/90	Match Day 1990
3/21-25/90	American Medical Student Association annual meeting, "Community Responsive Practice: Heeding the Call for Change." Arlington, VA (800) 767-2266
4/12-15/90	Student National Medical Association annual meeting. Atlanta, GA (303) 371-1616

Free Places to Stay on Residency Interview Trips

Each year the OSR coordinates a nationwide housing exchange network for medical students on interview trips. Over half of the schools in the country participated last year, and many students saved money by staying with student "hosts" in the area they were visiting.

The system is simple. Each school that submits a list of at least ten volunteer hosts will have its list included in the network directory. Directories are then sent to each participating school's OSR representative and student affairs dean for use by their entire class of interviewing students. Only participating schools receive directories. If your school is has sent in their entry, directories are now available at the schools. If your school is not yet participating, contact your OSR representative, as there is still time to be included in the second directory for 1989-90. □