

SUMMARY OF REGIONAL CONFERENCE OF AMERICAN ASSOCIATION OF
MEDICAL COLLEGES: ORGANIZATION OF STUDENT REPRESENTATIVES
Montreal, Canada April 12-15

Key note speaker: *The Honorable Monique Begin, P.C., former
Canadian Minister of Health*

I. Inherent limitations to Medicine

- A. Health care is a process of adaption; the public should be aware of this
- B. Over specialization is a problem; This increases the fragmentation of care and is damaging to the process of healing
The patient may feel a loss of inner resources
- C. Medicine should be stressed as not an art but a science. Science is an inherently unfinished business.

II. Consumerism and Medicine

- A. A doctors life consists of a set of assumptions that have never been challenged. Change in the past has been based on questioning authority and economic organization; ex. decolonization and feminism
- B. Medicine is also being confronted with a change in consumers who are more demanding, growth of parallel professions such as nurses and midwives, and the growth of alternative medicines.
- C. People are confronted with an ambivalence of invasive technology in a "back to nature" society.

III. Women and the Elderly

- A. For some reason their diseases are not perceived as real diseases but as either natural aging problems or medicalized emotional problems. This is simply not true. Doctors have gone so far as to project the image of reducing wome to solely vehichles of reproduction.

So, how do we change doctors to humans? The knowledge of the changing society must be integrated into medical education; More courses on ethics, geriatrics etc.

Speaker:

*Dr. Maurice Mcgregor, M.D., Former Dean of University of Witwatersrand,
Johannesburg, South Africa*

"Immeasurable vs. Measurable qualities of a Doctor"

Information to know is changing and we need a regular examination of

competency.

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I. Immeasurable

A. Intergrity, social responsibility

Accusations: Loss of humanity, not caring; Lack of social responsibility; Our primary focus seems to be techonology. We should work to change societies idea that doctors are responsible for curing rather than preventing.

Our morality is in question; We no longer merit public trust.

This is probably because of loss of human contact with increased specialization; The intense interaction with patients is no longer possible.

A lot is needed to repair this disrupted human communication.

Student involvement has limited time he/she sees the doctor. Students should see the doctor establish contact and rapport with a patient. Preceptorship is way of improvement. Students must be a part of this.

B. Technology

There is a problem with public perception. We offer new services that are medically complex, but they don't look new. (like changes in air travel). Therefore it is hard to convince the public that new technology exists and we need compensation.

Remember 40 years ago no cures just comfort and suport;cost was little and one could die inexpensively. Now we insist on an ongoing diagnosis, changes with treatment, and the costs are also ongoing. Now living is expensive. Preventive medicine is lifestyle modification; this is for the public to react to.

C. Integrity

Students should have values and teachers should exhibit these ethics. To teach is to act and the ethics must be seen. We should increase the opportunity to learn values. Morality is taught by precept; Arrange for continuing contact with "good doctors".

Dr. Swanson encourages students to go back to their school and ask their deans-- **HOW WILL YOU KNOW I DESERVE A MEDICAL DEGREE?**
[DO YOU DESERVE TO EVALUATE ME?]

Small group discussion-Dr Cook

How to improve house staff's ability to teach us?

How to better deal with emotional issues during the clinical years?

--Need a person to talk to in exit interview who doesn't have any part in evaluating you so that student will not feel pressured and a truthful evaluation of the program can be given.

--Meet with doctors on a regular basis

--Stress that all staff are colleagues

--You are responsible for your education, faculty only foster enthusiasm [didn't go over well]

--Albany has in place a once a week discussion with students and faculty about issues with patients during their clerkship.

--Possibility of *neutral* advisor briefed on their role and totally separate from who writes the dean's letter

--Teach principles of feedback to students and faculty; seminars for the residents, students and program directors

--Assess non science ability before third and fourth years

--Develop an attitude of advocacy by the Office of student affairs and the Deans office; ex. problems that come before the committee should be more than passing grades

--Evaluations at the middle of the process [Dartmouth has]

--Concern the administrators see students walk across the stage at graduation and know they don't deserve a degree but for some reason or another their problem wasn't documented and people kept letting it "slide".

Students should get together with their complaints and concerns

Faculty need to improve their ability to evaluate so students receive solid truthful evaluations and not just "good student".

"Regulation of Student and Resident Training: The New York State Experiment"--Dr. Bertrand M. Bell, M.D., New York State Dept. of Health, Ad-hoc committee representative on Emergency Services;

Committee consisted of 4 House Staff supervisors, 4 residents, 1 Dean of Medical School, 4 senior and 1 junior attending.

I. Recommendations for regulations (some) in final stages of processing

--No more than 80 hours/wk over 4 weeks; scheduled

--No more than 24 consecutive hours with and 8 hour break between call

--At least one 24 hour period out of the hospital

--Full physician on staff 24/7

--No more than 12 consecutive hours in emergency services

B. Medicine has changed so much to warrant these changes

Course of illness is longer and people are much sicker

In a survey of NY city non-city hospitals average sleep per day of PGY I was 2.6 hours

Ability to carry out continuity of care is important and the present

schedule does not encourage this continuity and commitment.

PGY1 should not feel they are primarily responsible for patients. There should be an early introduction to sharing of the work load and responsibility.

Financial implications of hospital compensation. Need for outside sources. Dr. Axelrod the state health commissioner feels the "new money" won't be a problem. "We've gotten money before for heart transplants and kidney dialysis and this is just as important." [note that in two years Dr. Axelrod has changed from being totally against to being totally for these recommendations]

We have to decide the weight of education versus service.

Albany Med School --Plan to be instituted in 3 years to change curriculum to decrease lecture time and increasing problem based learning--Integration of Basic and clinical science through all 4 years

--Disbanded curriculum committee and instituted a separate office of Medical Education to deal solely with the changes in curriculum.

--Each department has a representative for the Educational council committee to implement this curriculum change. The objective of the council is to decide what a student needs to know in 4 years. These objectives should reflect the school and not the individual departments. Objectives are defined to have quality assurance.

--Faculty development has been through bringing representatives from other schools for models and actually acting out and discussing these alternative ways of teaching.

New Mexico and Mc Masters Univ. are models used

Tufts

Problem based learning already in place

Case studies done weekly in relation to subjects studied in class

6 students plus one faculty advisor who is there to answer questions and direct appropriately, not to give answers. The faculty advisors are trained by upper class students.

Students are asked to research and identify issues involved as the case unfolds. Only a few facts given at a time.

Class includes field trips to labs to see how tests are done etc.

- Goals: Decision making Identifying resources
- Knowledge Self-Evaluation
- Group skills

See AAMC regulations for AIDS and the Medical Student

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Women in Medicine

--Haneman U. has women's and men's support group and had a very successful experience when they both got together and talked

--Students should create and active program and incorporation into curriculum

--At university of Pittsburgh they have brunches with the faculty to discuss common concerns

--Role playing and guidelines of how to manage sensitive issues have been good topics for discussion

--American Academy of Family Physicians has a video called Women in Medicine. This shows vignettes on what can happen to women on the wards in the classroom etc., and leaves time for discussion on how to respond.

Its important for women to know how to handle a situation *before* it happens

Brown's women support group of students gives and award each year to a female faculty member

Dr. Judith Frank, Neo-natologist, of MHMC is our contact person

MINORITIES IN MEDICINE

ISSUES

Subspecialization

-over 80% overall

-34% minorities --self-selection or exclusion??

Issues of Historically Black Medical Schools

60% Black males matched

Unmatched 2-3x non-minorities-- student??? Program directors???

21% train in the same programs year after year--Comfort vs Program Directors???

Distribution--primarily Northeast and South, West

Need for matching data base program to include assesment of the program

NIH need to expand minority oppportunities

Development and advancement of minority faculty is on the table as an issue at AAMC. So far much support has been seen

Dr. James Story PhD, Dean for Admissions and Student Affairs, Meharry Medical College "Ethical considerations for minorities in Medical Education"

[had to leave early]