



association of american medical colleges

AGENDA OSR ADMINISTRATIVE BOARD MEETING

January 22, noon - 5:30 pm

January 23, 9:00 am - noon

Conference Room, AAMC Headquarters

- I. Call to Order
- II. ACTION ITEMS
 - A. Approval of September Meeting Minutes. 1
 - B. Nomination of Students to Committees (materials provided at meeting)
- III. DISCUSSION ITEMS
 - A. Annual Meeting Small Group Reports. 7
 - B. Draft of OSR Report on GPEP. 15
 - C. OSR "Challenges" Paper. 25
 - D. GPEP Follow-up Activities
(Executive Council Agenda, p. 42)
- IV. INFORMATION ITEMS
 - A. Summary of October LCME Meeting. 32
 - B. MCAT Essay Pilot Project
(Executive Council Agenda, p. 92)
- V. Old Business
- VI. New Business
- VII. Adjourn

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- January 23, 2:00 - 4:00 pm: Orientation for New Board Members
AAMC Conference Room
- January 23, 5:30 - 7:00 pm: Joint Administrative Boards Meeting on
Financing Graduate Medical Education
Georgetown West Room, Hilton Hotel
- 7:00 - 9:00 pm: Joint Boards Reception & Dinner
Georgetown East Room
- January 24, noon - 1:00 pm: Joint Administrative Boards Lunch
Conservatory Room, Washington Hilton

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES
MINUTES

September 11-12, 1984
Washington, D.C.

Pamelyn Close M.D., Chairperson
Ricardo Sanchez, Chairperson-Elect*
Ed Schwager, M.D. Immediate-Past Chairperson

AAMC Staff
Jim Bentley, Ph.D.*
Janet Bickel
Robert Boerner*
John A.D. Cooper, M.D.*
Elizabeth Short, M.D.*
August Swanson, M.D.*

Regional Chairpersons:
Dan Cooper (Colorado)
Roger Hardy (Cincinnati)
Tim Brewer (N.Y. Medical)

Representatives-at-Large:
Mary Smith, M.D. (Florida)
Mark Schmalz, M.D. (Minneapolis)
Steve Hasley, M.D. (Pittsburgh)*
Rick Peters (California, San Diego)

Guest:
David Levy, M.D.*

*present for part of the meeting

I. Dr. Close called the meeting to order at 1:00 p.m. and asked for and received approval of the minutes of the June meeting.

II. Students' Evaluation of Clerkships

Ms. Bickel reported that she had received a request from an educational researcher at Louisiana State University-New Orleans regarding students' evaluation of their clerkships. Board members' descriptions of the process employed at their schools revealed a wide range of activity--from schools with no use of student evaluations to Miami, where students' responses are computerized and form the basis of meetings between deans and department chairs (their system is currently being revised to include items on how often histories and physicals are observed and the percent of students' write-ups discussed with them by faculty). The OSR Board agreed that, despite likely variations among departments, it would be very useful to survey schools about their method of collecting information about students' experiences on required clerkships and about how this information is used and requested staff to draft a survey instrument. Interest was also expressed in how residents' evaluations of their programs are used.

III. Annual Meeting Activities

The Board applauded Mr. Hardy's news that the OSR reception on Saturday night can be held at Northwestern. Next it reviewed the vignettes provided by the director of nursing services at the University of Chicago which will provide the basis of the Saturday afternoon program on "Working with Nurses and

Other Professionals" (see program outline attached to minutes) and recommended some alterations in focus. The Board also discussed methods of helping OSR members to get the most out of the Saturday issue identification and small group sessions. Dr. Schwager agreed to write a description of group process to be provided to students in advance of the meeting so that their expectations of what will occur will be informed regarding space and time limitations and the fact that not all issues will generate OSR projects. Dr. Close requested Administrative Board members to convene at 11:00 a.m. on Friday of the Annual Meeting in order to acquire necessary group leading skills. The Board decided to invite any GSA members who care to participate in the small group sessions. Dr. Close noted that the purpose of Monday's session on the NRMP Match is to help students to become change agents regarding the quality of Match counseling available at their schools. Ms. Bickel said the negotiations with the publisher of Medicine as a Human Experience, the book which will form the basis of the other Monday program, are in progress in hopes of providing to program participants a copy of the book or preprint of a chapter.

IV. Financial Aid Developments

Mr. Boerner reported that health manpower legislation has been passed by both the House and Senate. A conference of the two bills is expected in the next two weeks. Appropriations legislation for FY 1985 passed the Senate on June 26 (S. 2836); the companion House bill (H.R. 6028) was passed August 1. Support levels for student assistance in both bills were generally at acceptable levels.

He told the Board that the HEAL insurance premium has been increased from one to two percent per year of the unpaid principal. Perhaps even more troubling is the proposal to permit the Health and Human Services (HHS) Secretary to announce future changes in the HEAL insurance premiums and interest rates, eliminating opportunities for public comment. These developments were partially stimulated by a consultant's report recommending that a six percent insurance premium will be necessary to maintain the solvency of the insurance fund due to the large number of expected defaulters. Mr. Boerner described why the AAMC questions the consultant's conclusions and his concern about the government's expecting schools to take on responsibilities for loan collection efforts of other agencies.

He said that, with regard to the Health Professions Student Loan Program, new regulations will be published before the end of the year containing a more reasonable formula defining default. What will happen with the 30 schools whose grace period from being suspended from the Program will soon expire remains in limbo. He reported that AAMC and other education associations have petitioned the HHS Secretary to raise Guaranteed Student Loan (GSL) annual borrowing limits from \$5,000 to \$8,000 and accordingly for the aggregate limit and suggested that mail from students to the Secretary on this issue would be helpful. He

noted that the indebtedness figures from the 1984 Graduation Questionnaire show that the average debt of seniors with debt was \$26,500 and that a slightly higher average emerges from preliminary analysis of the LCME Questionnaire data. The first 5,000 copies of the AAMC's Group on Student Affairs (GSA) "Financial Planning and Management Manual for Medical Students" has sold out, and investigations are underway to see if the next printing can be sold at a lower cost.

The last item of discussion was the issue of student loan consolidation. The Higher Education Act Reauthorization of 1980 gave Sallie Mae authority to allow those students with large amounts of debt in Title IV programs, i.e. GSL, National Direct Student Loan (NDSL) and Parent Loans to Undergraduate Students (PLUS) to consolidate their loans and extend repayment. Before the program got completely off the ground, its legislative authority lapsed, and its reauthorization has been plagued by controversy about whether state guarantee agencies should also be given the authority to consolidate. Mr. Boerner summarized more recent history and reported that S. 2941, introduced by Senator Stafford (R-VT), extends consolidation authority to guarantee agencies and proposes the new feature of "needs analysis" to individuals wishing to consolidate loans. Consolidation would only be permitted if ex-students can show that their incomes are less than 200 percent of their accumulated Title IV debt. The OSR Administrative Board supported this concept of "needs analysis" for consolidation eligibility and urged AAMC to work to secure acceptance of relevant provisions of S. 2941 if and when that bill is brought to conference with the House version.

V. Proposal to Change OSR Membership Requirements

Dr. Cooper explained to the Board why he and the Executive Committee could not support the OSR Board's proposal tabled at the June Board meeting. For purposes of AAMC governance, sub-entities of organizations, e.g., branch campuses of schools of medicine, are not separately represented; therefore it is not possible to recognize the Drew Postgraduate Medical School as separate from UCLA for purposes of membership of OSR. OSR Board members noted that their motivation had not been to undermine the AAMC philosophy but to allow as much participation in the OSR as possible but that they now have a better understanding of the broader issues involved.

VI. Matching Medical Students for Advanced Residency Positions

Dr. Short reviewed the history behind the Council of Academic Societies (CAS) resolution to stand behind the National Resident Matching Program as the means whereby all first-year and residency positions be offered to medical students. Much effort has gone into educating program directors of programs which do not participate about NRMP's capabilities and about the problems of forcing students to make premature career decisions and of dual application processes. Another provision of the CAS resolution is delaying as late

possible the medical school's release of deans' letters and transcripts until students have completed the basic clerkship cycle and their achievements can be summarized. Board members applauded the resolution as a basis for further discussions with specialties not now participating in NRMP but stressed that schools must be responsive to students' needs to meet graduate programs' deadlines for submissions of transcripts, etc. Questions were raised about it appearing self-serving for AAMC to support NRMP in this fashion; but Dr. Short explained that NRMP is not commercial and keeps the focus on the broad issues and on students' concerns, in contrast with the private specialty matches. She also noted that the CAS discussion of the resolution at its annual business meeting is likely to be quite controversial.

VII. Ethical Guidelines for the Clinical Years

Dr. Smith summarized OSR interest and activity over the past few years in helping medical students better handle ethical dimensions of problems encountered on the wards. One project which she has helped coordinate is generation of ethical guidelines, a copy of which was distributed to OSR members at last year's Annual Meeting. Additional consideration has revealed the need for a meatier document, perhaps along the lines of the booklet produced at Kentucky titled "Behavioral Standards in Patient Care." She stated that the goal is to offer guidelines which could help students with decision-making about their conduct. These would be provided to OSR members and student affairs deans as a stimulus to examine what is needed and as a launching point for adaptation. Also important is to motivate OSR members to work with faculty and deans to create a code of ethics and an ombudsman or committee that students would go to with related problems or evidence about infractions. She mentioned as well including in first- and third-year orientations discussions about ethical responsibilities and the need to recognize that medical ethics is not innate but requires study like any other area of inquiry.

Mr. Cooper noted that students need to be helped to make a commitment to the process, e.g., by signing a copy of the honor code, and that Colorado's Internal Medicine clerkship includes an ethical work-up which is effective in stimulating students to pay attention to ethical dimensions of patient care. Other Board members mentioned that questions in this area are appearing on the National Boards. Also noted was how at least one person in the role model hierarchy is needed to stress the importance of this area, for instance, by including one medical ethics question in an oral exam in surgery. The Board decided that this "biomedical ethics begins with you" approach could provide the basis of one of the OSR small group discussions at the Annual Meeting, the deliberations of which would provide additional input to this OSR project. The Society for Health and Human Values members could be requested to provide case studies which could be incorporated into the guidelines; the most recurrent student difficulties appear to fall into the following areas: what to do when

expected to be in two places at once; who to go to for help in making decisions; "ballparking" patient information instead of admitting lack of knowledge; and being expected to do things without knowing why.

VIII. Dr. Close adjourned the meeting at 5:30 p.m. and reconvened the Board at 9:15 a.m. the following day.

IX. Report of the General Professional Education of the Physician (GPEP) Project

Dr. Swanson told the Board that press conferences would be held on September 19 in Washington D.C. and New York, the date on which 8,000 copies of the report will be mailed. Deans were given a confidential copy during the summer, and over 40 responded with a range of anxieties, concerns and commendations. Dr. Swanson expressed the belief that the degree to which the principles of the report are implemented will depend largely on the talent and risk-taking abilities of the faculty. Board members asked about mechanisms by which AAMC could publicize innovative activities of risk-takers. He summarized the AAMC Curriculum Network, a new effort begun by the Division of Educational Measurement and Research, which will facilitate communication among faculty involved in research on teaching and evaluation methods; a special project within the Network is a task force on "Critique of Curriculum Innovations" which will develop guidelines for evaluation innovations, collect descriptions of innovations and prepare a critical review of them. He also noted AAMC's Clinical Evaluation Project which asks faculty to examine how comfortable they are with their methods of evaluating clinical clerks; 115 schools have signed on for the self-assessment program.

Dr. Close asked the Board for reaction to the report. Members noted in particular the lack of emphasis on student and resident contributions to the educational process. She expressed the view that an OSR response to the report should be written; even though it will be after the fact, it may still guide AAMC's use of the report in the development of policies and programs. The Board therefore decided to request the membership's reactions, especially on the areas that deserve the most effort and those which have been underemphasized in the report; preparing their "Musing on GPEP" will be one of the several pre-Annual Meeting activities expected of OSR members. The Sunday morning Annual Meeting sessions devoted to GPEP will highlight those areas most amenable to student impact, with the goal of motivating students to work toward the implementation of the report's recommendations. Board members reviewed the draft of discussion stimulus questions prepared by staff and made several recommendations.

X. Modifying the Medicare Payment System

Dr. Bentley summarized the Executive Council agenda item relating to the prospective payment system's inability to adequately adjust for either hospital-specific or patient-specific differences which influence

hospital costs. Hospitals have been examining adjustments to the system which could improve the equity of payments by more fully incorporating additional hospital-specific adjustments, such as New Jersey's present structure where the DRG adjustment is not limited to the use of a single intensity weight for each DRG but is modified to reflect real variation in observed costs for each case type. Dr. Bentley explained that some DRG's, such as Appendectomy, have a narrow range of procedures, whereas some lend themselves to a host of procedures and extra costs; when these are not randomly distributed among hospitals, the DRG system becomes inequitable to the extent that reimbursement does not reflect differences among cases. He added that inefficiencies and treatment styles may also contribute to variations in cost, and work is proceeding to explore reasons for differences in averages. The staff recommendation is that AAMC endorse the DRG specific price blending proposal of the American Hospital Association and that AAMC work with the AHA to incorporate this feature into the Medicare prospective payment system. He closed by noting that it is clear that this blending would create a more efficient payment method but that there are questions about its administrative feasibility. The OSR Board endorsed the staff recommendation.

XI. Compendium on Course Offerings on Computers

Dr. Levy, former OSR representative from Temple, joined the Board to present a compilation of information about computer offerings which he obtained from 94 U.S. and Canadian academic affairs deans as a result of a survey mailed last summer. The Board strongly commended him for the amount of work he had put into this effort and commented on the importance of printing copies in a timely fashion because of the number of seniors who can use one immediately as they select extramural electives. Staff raised budgetary considerations due to its length and the fact tht it was not an AAMC publication, per se. The Board agreed to discuss this matter in more depth and touch base with other AAMC staff after the meeting adjourned.

XII. OSR Liaison with International Medical Student Organizations

Dr. Close drew the attention of the Board to the letter from the Manitoba Medical Students Association in Canada requesting information on the goals and activities of OSR. She also described correspondence with the chair of the International Federation of Medical Student Associations (IFMSA) and said that she has been approached by student groups abroad who are looking at their connections with U.S. medicine. OSR appears to be the group of greatest interest, because AMSA does not have ties with all schools and encompasses so much more than medical education and AMA-MSS is viewed as more related to private practice issues. The Board agreed to welcome students from these organizations to national and regional OSR meetings as requested.

XIII. Dr. Close adjourned the meeting at noon in order for the OSR Board to join the other AAMC Administrative Boards for an afternoon session devoted to the financing of graduate medical education.

ANNUAL MEETING SMALL GROUP REPORTS

At the 1984 Annual Meeting, OSR selected eight general areas on which to focus its attention in small groups: A) recognition and support of individuality; B) improving teaching ability; C) curricular innovation; D) methods of evaluation; E) student involvement in the administrative process; F) clinical responsibilities; G) career counselling; and H) social responsibilities. The following summaries of the small group discussions appeared in the meeting minutes and are presented for the consideration of the OSR Board as ideas for projects to be undertaken and areas worthy of action.

A. Recognition and Support of Individuality

Ms. Sharon Austin (UCLA) reported that her group prioritized several topics, including minorities and women in medicine, growth and development of self, stress in medicine, but decided to work intensively on pregnancy and parenting issues. The group took as its goal to define what would be most supportive of parenting during medical education and proposed the following guidelines:

- acknowledging the right of medical students to start families
- keeping the fourth year of medical school flexible
- permitting deferment for maternity leave at the start of residency
- establishing flexible leave periods for caretaking of sick children and attending important childlife events in medical school and residency
- approving non-clinical type clerkships and similar time periods in residency, e.g., directed reading electives

- increasing availability of personnel to take care of sick children
- establishing and/or coordinating day care facilities
- approving six-week total leave time to be divided per-term and post-term as maternity leave
- approving four weeks of paternity leave to be chosen at any time postpartum
- condoning education of faculty and peers about responsibilities of parenthood
- continuing support of shared schedule residencies

Ms. Austin said that the group's intent is for students to work toward implementation of these guidelines at their institutions.

B. Improving Teaching Abilities

Dr. Hasley reported that the following points emerged from this group:

- the need for senior clinicians to spend more time teaching medical students
- awards to faculty for teaching excellence
- students on committees to choose new faculty; requesting a trial lecture before hiring faculty
- insuring the use of student evaluations of faculty
- including interest in teaching and teaching ability as part of evaluation during interviews for residency positions
- providing some orientation for residents to improve their teaching skills
- hiring a "teaching" resident, i.e., one whose major responsibility for a given time is to teach medical students and interns
- the need for more resident involvement in AAMC

Dr. Hasley reported that the main focus of the group was sharing examples of innovations and opportunities which encourage medical students to become better teachers:

1. Creighton (Mark Rolfe): Beginning this semester, in conjunction with the second year physical diagnosis course, third and fourth year students are assigned first-year students to whom they demonstrate the techniques of a physical. The small groups meet in the evening, have access to exam rooms, and cover individual aspects of the exam, starting with HEENT one week, Pulmonary/Cardiothoracic the next, etc. Beginning the next semester interested second-year students will be teamed up with third and fourth-year students who will show them around a hospital and introduce to them the responsibilities of the medical student, e.g., charting, writing orders, progress notes, etc.

2. Medical College of Georgia (Susie Lau): First year-- Early introduction into physical diagnosis; seniors teach freshmen basic skills. Second year--Clinical pathology--Lectures and breaking-up the class into small groups where each student presents a case about five times over the span of two quarters to other students and a clinical pathologist. Purpose: a) self-learning and research opportunity on the disease involved; b) a form of transition into third-year where students present patients; c) building confidence in giving oral presentations and learning to answer questions and to think on the spot; and d) learning to work with others in groups.

3. Medical College of Ohio at Toledo (Joanne Furth): a) Pathology labs: teaching assistants are 4th year students taking Path as 4th year elective that month. b) Preceptorship program: 3rd and 4th year student volunteers help teach three or four first-year students. When the senior student has an interesting case, s/he contacts the first- and second-year students and presents patient (with consent). c) POPS (Patient Oriented Problem Solving): Groups of 4 students "teach themselves" as they go through a two-hour learning situation using a pre-test, patient-problem, and post-test. Some schools use similar systems consisting of learning packages that address clinical problem areas, developed by Parker Small, M.D. (Department of Immunology; U. of Florida; Gainesville, FL 32610).

4. University of Alabama (Michael Manning): a) In Microbiology the students are divided up into groups of ten students; two of these read a relevant paper involving an aspect of Microbiology currently being studied and give a 15-20 minute talk on that paper to the students in their group as part of their course grade. b) In OB a student can give a "Student Grand Rounds" talk concerning a particular patient and/or subject of general interest for extra credit (one point added to final grade). The chairman of the

department and other faculty along with housestaff and students attend, and there is a general discussion by the faculty on the subject the student has chosen.

5. University of Missouri-Kansas City (Ken Fine): a) Senior-Junior Partnership--mainly active on Internal Medicine rotation. b) Student Learning Center--special funding for tutors and lecture supplementals. c) Classes--one month taught like graduate seminar classes--students involved with daily teaching. d) Opportunities on rotations for short presentations/talks as a formal part of clinical curriculum.

6. University of Pittsburgh: fourth-year medical students volunteer to take small groups of first-year students onto the wards. Patients demonstrating some aspect of recently learned basic science course materials are presented and used to amplify and reinforce the lectures.

7. University of Texas at Galveston (Buckley Eckert): a) Introduction to Physical Exam is taught by senior students on a weekly basis. Also included is introduction to the wards, charts, etc. b) Student tutoring by upperclassmen is available. Payment is available through Work-Study and university funds. c) Review sessions are taught on basic science courses by upperclassmen.

8. Washington University (Sheldon Litwin): Pharmacology Discussion Groups: 2nd semester, 2nd year, part of one afternoon per week is set aside (total of 5-6 sessions) for small groups of students to explore a specific topic, e.g., opiates and their receptors, cardiovascular pharmacology, etc. Each student researches 1-2 specific topics and gives a 15-20 minute talk on the subject to the group. These sessions are devoted to a more in-depth examination of an area of interest than what is covered in the basic curriculum. Each group is supervised by a member of the Pharmacology department who augments the discussion and acts as a resource for students preparing talks.

Dr. Hasley requested that the OSR Board investigate how schools can be encouraged to pay students for tutoring each other and the question of work/study payments being deducted by financial aid officers from the amount students can borrow.

C. Curricular Innovation

Ms. Yolanda Colson (Mayo) said that this group began by focusing on the need for curricula to be designed to the learning and information needs of the student. These needs are quite difficult for a student to assess early-on but become more apparent as clinical exposure is obtained. The group stressed the importance of students having early clinical experiences interspersed with their basic science courses (e.g., Duke, Mayo) since the division of medical school into basic science and clinical years is artificially simple and tidy. The number of clinical correlations brought into the first two years should also be increased. Ms. Colson noted that the group identified the following additional goals and numerous positive and negative forces regarding curricular change (the force-field analysis can be obtained from Ms. Bickel at AAMC):

- more integration of computer instruction and information management into the curriculum
- better regulation of faculty time demands and lecture hours
- more independent, small group, problem-solving learning
- more preventive medicine and primary care influences in the curriculum
- stressing that medical education is a life-long process
- more attention to mentor/mentee relationships
- better supervision of the development of clinical skills
- use of Biopsychosocial Model rather than the Biomedical Model alone

Two of the most difficult forces to overcome in changing the curriculum were found to be: the continuing use of orthodox evaluation methods to compare students in experimental tracks and overcoming

the structure and power already invested in curriculum committees. The group felt that students can adequately address those forces if they plan their approach, rely on a network of contacts at other schools, and are able to cite successful instances of innovations at other schools

Steps that OSR members can take at their own institutions were identified as follows:

- work to insure that the dean is a medical student lobbyist
- locate faculty who are sympathetic to student concerns
- create a faculty/student organization structure to devise comprehensive curriculum
- solicit alumni feedback on their education
- include student affairs dean in deliberations
- help faculty to devise creative evaluation methods, e.g. computer-aided

Ms. Colsen reported the following additional goals identified by the group:

- invite representatives from the NBME to next year's meeting to discuss ways in which the Boards are misused and the utility of changing the scoring to pass/fail and of reporting only aggregate scores to schools
- better evaluation of communication skills, verbal and written
- assuring that learning in medical school is more of an active adventure rather than such a passive experience
- institution of financial incentives for quality teaching
- motivating everyone at each school to participate in GPEP discussion groups

D. Methods of Evaluation

Mr. Roger Hardy (Cincinnati) summarized this group's discussion which focused primarily on schools' misuse of National Board scores and on the problem of program directors' looking at these in the selection of residents. Students noted the far-reaching effect that the NBME has on the curriculum of the first two years of many medical schools; instances were cited of innovative teaching methods being replaced by Board-oriented methods after one class performs poorly on Part I. The group commended the GPEP Panel's comments on the influence of evaluation methods on students' approach to learning. The group repeated the recommendation that the NBME provide only pass/fail scoring to deans, which would facilitate the Boards being used only for their intended purpose, i.e., licensure. It also noted that the items should be made more pertinent to clinical abilities and that some items appear to test cleverness at test-taking more rather knowledge. The group recommended that more distinction should be made between evaluation of performance in the basic science and the clinical years in medical school, with students' performance in the latter being a much more valid means of determining potential as a clinician. Students believe it is understandable that such evaluations will be subjective but that this is alright as long as they are concrete. While students appreciate program directors' need for reliable selection criteria, it recommended that evaluation of students' performance during clerkships should receive the most weight (instead of reliance on class rank, basic science grades, etc.). OSR, therefore, places a high priority on the AAMC Clinical Evaluation Program.

Mr. Hardy reported that a subgroup volunteered to assist him in developing a paper on these subjects which would carry more weight than a small group report.

E. Student Involvement in the Administrative Process

Mr. David Resch (Southern Illinois) and Ms. Kim Dunn (Houston) listed those institutional committees which this group concurred should have student representation: student government, admissions, student evaluation, financial aid, curriculum, faculty promotion and tenure, teaching awards, dean's executive council, and hospital administrative boards. For each committee, the group generated a list of positive and negative attributes students can bring and also barriers already in place hindering student involvement. For instance, pluses of an effective student government are: representation of entire student body, regularly scheduled meetings, published agendas; minuses include lack of communication of goals between the student body and representatives. Regarding student involvement in the administration of a medical school, the group felt that students' youth and inexperience were both a plus and minus. Positive attributes which students bring to curriculum committees are knowledge of the curriculum's overlaps and weaknesses. To evaluation committees, students can bring a very informed and compassionate perspective on peers and the ability to assist in defining evaluation criteria. The biggest barrier to more effective student involvement in the administrative process was seen as apathy and cynicism on the part of some students, which prevent faculty from considering appointment of students to certain committees and which erode the credibility of those already serving. A strong centralized student government is necessary to help overcome this problem. Such a government would control information flow to and from committees, hold student representatives accountable to the student body, support student representatives in their uphill battles, and provide a network among and within classes.

Mr. Resch and Ms. Dunn reported that the most important point emerging from the group is that students are effective progenitors of change to the extent that they know who to talk to and how to approach a goal. A specific plan is needed with the concrete support of the student body (i.e., numbers). -Students should show how the plan will benefit the school and what is working at other schools, and should approach the planning with the attitude that change will occur. The group noted that the most important and difficult aspect of effecting change is motivating people; it suggested that having regular student leader meetings and centralizing committee reports and keeping in close touch with peers at other schools are crucial in this regard. The group encouraged students to actively pursue the chance to participate in the development and revision of their schools' curricula and policies, for it is from well-planned, well-informed student representation that the greatest return to all arises.

F. Clinical Responsibilities

Mr. Tim Brewer (N.Y. Medical College) reported that this group examined the interaction between third-year medical students, patients, and residents. Suggestions for improving this interaction are: more contact with patients during the first two years of medical school; instruction in patient-interviewing; and opportunity for long-term patient follow-up. Improved student evaluation during clerkships are also needed. Every student should receive a mid-rotation evaluation, with the chance to discuss his/her progress with the attendings and residents. Learning objectives should be suggested and the emphasis should be on ways in which students may improve their knowledge and performance during the clerkship. Likewise, students' evaluations of clerkships should be used to improve rotations. The group noted students' need for an orientation on techniques and "how to, where is" information for beginning clerks. Students have created such courses at a number of schools (e.g., Kentucky, Temple). Fourth-year students, nurses and others can be recruited as teachers.

The group also listed specific concerns regarding medical student/patient interactions with which students need extra help: dealing with terminal patients, patient concerns about quality of life, seeing the unique and human qualities of each patient. Other concerns included less scut work and less student abuse and the need for rap sessions with nurses.

G. Career Counselling

Dr. Mark Schmalz (formerly U. of Minnesota) reported the following prioritized goals from his group: identification of a specific person in the medical school administration as the organizer, maintainer of information, and advisor; identification of individuals in each department responsible for information in that specialty; a clearly stated sequence of events to help students optimize timing in making career decisions, beginning in the first year.

He summarized the following characteristics of an ideal career counselling system as agreed upon by the group:

- First-year students encouraged to begin process of self- and specialty-evaluation; availability of personality evaluation aides during first- and second-year.
- Integrate a spectrum of counsellors, including residents, fourth-year students, program directors, community physicians and especially newly Board certified physicians.
- Incorporation of discussion of individual students' potential and personal abilities into career counselling process; emphasize expanding potentials of students and assure confidentiality and lack of bias of counselling.
- Appoint administrator with priority responsibilities for maintaining and upgrading career counselling system, including assisting students with the Match, collecting updated information on research projects and externships, etc.
- Provide special assistance for late deciding and unmatched students.
- Feedback system from students on their progress and on accuracy and value of information they used.

- Opportunities for students to explore career options early: e.g., time in second-year for voluntary preceptorships, rounds with staff, research opportunities, etc.
- Involve community physicians by inviting them to give guest lectures, brown-bag lunches, etc.
- Collect data on residency selection, e.g., personal qualities and backgrounds of students who got into "X" program, and encourage cooperation among students applying in a given field about application decisions.

Dr. Schmalz listed the following recommendations to OSR members on increasing positive forces and decreasing negative ones:

- Be a spokesperson for the need to develop an organized system.
- Emphasize to faculty and administration that an improved counselling system will fulfill better the school's missions because students will make better decisions.
- Involve members from all classes to gain support for improved career counselling.
- Stimulate open forum discussions of the process of specialty selection and the constraints students increasingly face.
- Provide incentives to clinical departments for faculty to become involved in counselling students.

H. Social Responsibilities

Ms. Carol Mangione (California-San Francisco) noted that the group leaders divided this topic into five categories of issues: 1) increasing the political awareness and social involvement of medical doctors and students; 2) students' and physicians' role in the allocation of scarce resources for health care; 3) the status and presence in the curriculum of primary care and preventive medicine; 4) increasing students' and physicians' understanding and appreciation of patients' rights, expectations and wishes and changing health care workers' attitudes in these areas; and 5) medical schools' support of "unconventional medical practice", e.g., third world medicine, medical care for rural underserved areas, and charity care. She summarized the positive and negative forces identified under each category:

1) Political awareness and social involvement:

- (+) -- Departmental and medical support of efforts to incorporate these topics into curriculum.
 - Presence of combined M.D.-Ph.D. or M.D.-M.P.H. programs with stable funding targeted at this specific area.
- (-) -- Core courses that incorporate these topics are not taken seriously by medical students; are often poorly attended, and given much lower priority than the "hard" sciences such as biochemistry.
 - Students and residents often focus more on "facts" than on the patients themselves.
 - Students and residents often have negative feelings toward the patients they treat, particularly the indigent population who are referred to with derogatory names.

2) Primary care and preventive medicine:

- (+) -- Medical school efforts to give departments of Family, Community, or General Medicine the status, prestige, and economic stability of some of the more established departments.

- Efforts to strengthen teaching in the ambulatory setting for medical students and residents.
- In terms of lifestyle choice, primary care may be viewed as more desirable than specialties that are more demanding (such as surgery).
- (-) -- Primary care physicians earn considerably less money than subspecialists.
- There are very few primary care role models in academic medicine, and the academicians who are instructors place little or no value on competent generalists.

3) Allocation of resources:

- (+) -- Physician participation in the decision-making process and physician recognition that s/he is the best advocate for patients.
- (-) -- Corporatization of medicine with profit motives.
- Government officials making allocation decisions.
- Unknown definition of what is adequate or sufficient care; i.e., should all people have access to all technologies.
- Economic pressures forcing health care into a two-tier system.
- Conceptualization of health care as a commercial product that patients will "shop around" for.

4) Patient/Doctor Communication:

- (+) -- Teaching communication skills in medical school.
- Increasing use of "living wills".
- Increasing patient awareness of medicine (consumerism).
- (-) -- Lack of emphasis on human values during medical school.

5) Unconventional medical practice:

- (+) -- Presence of a stable, well-funded National Health Service Corp with employment possibilities in underserved rural, urban, and third world locations.
- (-) -- Doctors are less likely to work where it is not economically profitable.
- Physicians have increasing educational debts.

Ms. Mangione said that the group suggested the following specific areas that the OSR may wish to address:

- (1) Encouragement of students to contact Congressmen about economic issues that will affect patients, such as funding cuts for Medicare;
- (2) Provide educational materials to students that address the importance of political awareness and social involvement;
- (3) Support the GPEP statements that deal specifically with:
 - (a) Evaluation of social responsibility as part of the admission criteria (specifically in terms of past life experiences); and
 - (b) Encouraging students not to matriculate directly from four intense years of premed. into medical school, but rather to diversify themselves with experiences such as participation in the Peace Corps, etc.
- (4) Encourage schools to offer community service electives.

OSR REPORT ON GPEP

The following draft of the spring issue of OSR Report is presented to the Board for review and comment. It is divided into four short sections:

- I. What Needs Changing? (includes GPEP recommendations)
- II. Where to Begin?
- III. Focusing Energies
- IV. What is a Realistic Goal?

The last two sections are unfinished and Board members' ideas are needed for completing them.

TITLE: "PHYSICIANS FOR THE TWENTY-FIRST CENTURY"

CHAIRPERSON'S PERSPECTIVES

GPEP (pronounced "gee-pep") is the study published last fall by the Association of American Medical Colleges on the General Professional Education of the Physician and College Preparation for Medicine. As AAMC's student voice, OSR is the strongest champion of this study and thus we devote an entire issue of our main publication to assisting individual medical students to take advantage of the GPEP momentum. During the course of this three-year study, the deans and faculty at all 143 U.S. and Canadian medical schools were urged to conduct self-studies in response to a series of charges. At some schools, students took the lead in engineering faculty and students into the same room to examine hard questions about medical education. All told, 83 U.S. medical schools, 24 colleges and over 20 professorial societies communicated their views to the GPEP Panel in public hearings and written reports. One of the ways that we know that a stir has been created and the field, fertilized, is the demand for copies of the Report. Subsequent to the initial distribution last September of 8,300, requests for an additional 48,700 have been received!

What can all of this activity mean to you? In the space of this brief overview, our goal is to stimulate you to take an inventory of your personal and professional directions and goals vis-a-vis your educational environment. You may be dissatisfied with important areas but remain willing to put up with them because you see no other way to become an M.D. You may be stuck in some uncomfortable, barely conscious compromises as a result. We suggest that you need to hold onto a humanistic view of your struggle to become a physician but in order to do so, you must look at your strengths and weaknesses and the strengths and weaknesses of your school and see where adjustments are required. First of all, this is a personal exercise. The next step is working together with other students, deans and faculty to prioritize and work toward changes. To close our eyes to problems with our education is ultimately to cheat ourselves.

Reading the following pages will spur you out of a passive mode and into a more exciting and responsible one and hopefully give you some great ideas. Contact the OSR representative and the other student leaders at your school to discuss them. Also any member of the OSR Administrative Board (see page 3) would be happy to offer any possible help or resources. Best Wishes.

Ricardo Sanchez

OSR Chairperson

WHAT NEEDS CHANGING?

The AAMC's decision to mount the GPEP study originated in the perception that the general education of physicians is inadequate (and will become more so) in preparing them to respond to the health needs of this country. In his introduction to the Panel Report, its Chairman, Dr. Steven Muller, lists numerous pressures to which medical educators must accommodate. These include: 1) rapid advances in biomedical knowledge and technology which are increasingly complex and powerful and the use of which requires a high degree of specialization; 2) patients' increasing need and demand for advice from physicians and other health professionals about how to stay healthy and how to use special medical services; and 3) the heavy influence which agencies paying for medical services, e.g., Medicare, exert on the environment of medical education.

The GPEP Report offers a series of conclusions about improvements needed in the present system. Its recommendations are summarized below:

A) Purposes of a General Professional Education

1. Faculties should emphasize the development of skills, values, and attitudes by students and limit the amount of information that students are expected to memorize.
2. The level of knowledge and skills that students must attain to enter graduate medical education should be described more clearly.
3. The education of students must be adapted to changing demographics and the modifications occurring in the health care system.
4. Students' education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease.

B) Baccalaureate Education

1. The baccalaureate education of every student should encompass broad study in the natural and the social sciences and in the humanities.
2. Whenever possible, the courses required for admission should be part of the core courses that all college students take, and medical school admissions committees' practice of recommending additional courses beyond those required for admission should cease.
3. The pursuit of scholarly endeavor and the development of effective writing skills should be integral features of baccalaureate education.
4. Medical school admissions committees should use criteria that appraise students' abilities to learn independently, to acquire analytical skills, to develop the values essential for members of a caring profession, and to contribute to society and should use the Medical College Admission Test only to identify students who qualify for consideration for admission.
5. Communication between medical school and college faculties about selection criteria should be improved.

C) Acquiring Learning Skills

1. Medical faculties should adopt evaluation methods to identify: (a) those students who have the ability to learn independently and provide opportunities for their further development of this skill; and (b) those students who lack the intrinsic self-confidence to thrive in an environment requiring independent learning and challenge them to develop this ability.

2. Attainable educational objectives should be set and students provided with sufficient unscheduled time to pursue those objectives.
3. Medical faculties should examine the number of lecture hours they now schedule and consider major reductions in this passive form of learning.
4. Faculties should offer educational experiences that require students to be active learners and problem solvers.
5. In programs emphasizing the development of independent learning and problem-solving skills, the evaluation of students' performance should be based in large measure on faculty members' subjective judgments of students' analytical skills rather than their ability to recall information.
6. Medical schools should designate an academic unit for institutional leadership in the application of information sciences and computer technology to physician education.

D) Clinical Education

1. Faculties should specify the clinical knowledge, skills, values, and attitudes that students should develop.
2. In conjunction with deans, department chairmen, and teaching hospital executives, faculties should develop strategies to provide settings appropriate for required clerkships.
3. Those responsible for the clinical education of medical students should have adequate preparation and the necessary time to guide and supervise medical students during their clerkships.
4. Faculties should develop explicit criteria for the systematic evaluation of students' clinical performance and share evaluations with students to reinforce the strengths of their performance, identify any deficiencies, and plan strategies with them for needed improvement.
5. Faculties should encourage students to concentrate their elective programs on the advancement of their general professional education rather than on the pursuit of a residency position.
6. Where appropriate, basic science and clinical education should be integrated to enhance the learning of key scientific principles and to promote their application to clinical problem solving.

E) Enhancing Faculty Involvement

1. Medical school deans should designate an interdisciplinary organization of faculty members to formulate a comprehensive educational program for medical students and to select the instructional and evaluation methods to be used.
2. This educational program should have a defined budget that provides the resources needed for its conduct.
3. Faculty members should have the time and opportunity to establish a mentor relationship with individual students.
4. Medical schools should establish programs to assist members of the faculty to expand their teaching capabilities beyond their specialized fields to encompass as much of the full range of the general professional education of students as is possible.
5. Medical faculties should provide support and guidance to enhance the personal development of each medical student.
6. By their own attitudes and actions, deans and department chairmen should elevate the status of the education of medical students to assure faculty members that their contributions to this endeavor will receive appropriate recognition.

Whatever your reactions, these recommendations are best considered in the context of the full GPEP Report. Although it is not lengthy, space limitations prevent its reprinting here; students

are urged to seek a copy (1). A major benefit of examining the whole Report, especially in conjunction with the Reports of the three Working Groups--Essential Knowledge, Fundamental Skills, and Personal Qualities, Values and Attitudes--is the perspective gained about the most persistent problems in medical education. It is easy to point to all the less-than-optimal conditions and methods but quite another to understand why changing the medical school curricula has been likened to moving a cemetery.

When taking stock of medical education, a particularly important feature to keep in mind is the high priority that most medical faculty members give to research, patient care and the training of residents and graduate students. This prioritizing frequently results in their not giving medical students their best efforts. Faculty typically receive few visible rewards, e.g., promotion, for devoting their energies to undergraduate teaching. Were faculty to receive academic recognition for teaching excellence on par with that forthcoming for research results, more could "afford" to realign their priorities. Another pervasive de-motivator of faculty is that small group teaching is labor-intensive and requires skills much different from those necessary to transmit specialized factual information in a lecture. Few faculty have ever received any guidance in teaching methods. For these reasons, in any way possible, students need to encourage faculty to become willing to improve their skills. Achieving a learning partnership is the goal, stellar but reachable.

WHERE TO BEGIN?

An appreciation of your schools' history, mission and present political realities are not spontaneous products of matriculation and tuition payments. But background on the directions the institution is moving in (ask the dean for a presentation?) is essential to students who want to work to improve it. An active student council and reliable mechanisms by which students communicate with each other also greatly assist students' ability to contribute to their school's development. At schools lacking a strong student council, students committed to achieving change can inspire new life into one and can meet and divide tasks; perhaps one class more than others will rise to the occasion. Some students could concentrate on literature searches in areas of particular interest, some with community health affairs, some with dean's office liaison, some with networking with students and other schools. Medical student organizations in addition to OSR (e.g., AMA-MSS, AMSA, Student National Medical Association) offer students unique opportunities to form networks and exchange information about promising and disturbing developments at schools across the country. Students active in such organizations also develop skills in brainstorming, group process and facilitation of communication within groups. Some may have participated in

leadership development programs and can share with other students what they have learned. Picking up non-verbal cues, using humor, facilitating discussions, and conflict resolution are skills which any medical student can acquire with assistance (2) and which all practicing physicians need.

But nothing fancy is involved with students taking a constructive interest in the process of their education and in the present and future well-being of their school. Each medical school class has its own distinct personality and unique resource which can be tapped. Chances are, if a class meeting is called and the leader/facilitator encourages everyone to examine personal educational goals in relation to the GPEP recommendations and to their school's state-of-the-art, a wish-list will emerge. Such an agenda is not for presentation to the dean but to energize individuals and groups of students to see what they can do to improve their education.

FOCUSING ENERGIES: IDEAS FOR ACTION

The following suggestions and examples originated in students' brains and have been put into action at at least one school. Two general categories are offered. The first pertains to working primarily with groups outside the medical center; while its focus extends beyond the GPEP recommendations, the suggestions are very germane to students' lives. The second focuses on the educational program.

Reaching Out

A. Community Outreach: Medical students can do much to benefit their communities, and by extension, their schools and themselves. What is required is energy, creativity, willingness to work in groups and a few savvy organizers with good contacts. Students can work with public agencies to organize health fairs. Another idea is to join with nurses in staffing a van which periodically carries basic and preventive health care information into underserved parts of the state. With the dean's consent, students can invite broader involvement of public figures and community leaders in student-sponsored activities.

B. Relationships with Elected Officials: With the cooperation of the dean, students can create a one-day open-house for legislators, designed to help them better understand what a medical school does, its role in the community, and the service aspirations of medical students. Many legislators seem convinced that, because medicine is a high paying profession and because the country no longer faces a physician shortage, government should stop subsidizing financial aid for medical students. Students must take the lead in educating the public about the crucial role of financial aid programs; so, while the officials are on campus, arrange interviews with needy and socially responsible students. Students can also arrange to see their representatives individually and write them letters when votes on legislation on key programs are pending.

C. Raising Money: Students have been known to install video games in lounges with proceeds going to a scholarship fund. Alumni telethons can generate loan funds. Students can sponsor a "Run for Health" and put the registration fee to good use (and at the same time staff a "blood pressure" table). They can organize and/or perform in benefits, seeking tax-deductable contributions from faculty. Students can create an active parents' association which can help raise money and/or donate funds, for instance, for microscopes. These kinds of activities are good publicity which may in turn assist in producing support from local hospitals, medical auxiliaries, and medical societies which may donate, for example, textbooks or other resources.

Looking In

A. Generating Interest in Change: Start by asking department chairmen if they have read the GPEP Report (all were mailed a copy) and if they would be willing to discuss the recommendations. In conjunction with the dean's office, try organizing an open forum with speakers and a panel to air the school's priorities on educating physicians for the 21st Century; the purpose would be to spur a renewed commitment to education, not to fire controversies. Luring a large number of participants would take a lot of imagination and footwork, and evidence of student interest at this level is crucial. Another idea which requires a lot of work but which is an excellent motivator of students is for the student council to put on a convention for students, with workshops on topics not typically covered in the curriculum, e.g., third-world medicine, social responsibilities, leadership training. Plans at Miami are for such a convention to become annual, with all four years able to participate and funds from drug companies helping to underwrite the costs of speakers and a mixer. Last year's theme was "Creativity in Medicine".

B. Motivating Faculty: Is there increasing awareness at your school of the importance of rewarding faculty who devote their time to teaching medical students? Is the faculty selection and promotion process under review? Would letters to, for instance, the president of the university or the board of directors about the impact of the present reward system help? Intrinsic rewards are important too. Excessively grade- and test-oriented students and those looking for the "easiest" way to learn ("just tell me what I have to know") convince faculty that there is no point in improving their teaching and evaluation methods. The problem-based and small group learning modes place just as much responsibility on the learner as on the teacher. Faculty/student retreats can elucidate some of the conflicts and stumbling blocks to progress in these areas. But perhaps nothing beats frequent positive reinforcement of teachers who are trying to introduce improvements.

C. Improving the Transition to Clinical Education: Since initial experiences with patients are so formative and since many schools' Introduction to Clinical Medicine courses are so inadequate, students especially need to marshal their energies in this area. Discussions about what keeps the introductory course from working well and students' need for more supervision can lead to an agenda of issues to be addressed with faculty and deans. The student council can even design a curriculum to present, with ideas on obtaining necessary resources. Students at some schools have designed "survival manuals" or handbooks, e.g., Temple's "So You Want To Be A Scut Monkey?" adopting a very practical and light-hearted approach to the needs of third-year students; AMSA also has published "Survival Manual: A Guide to the Clinical Years." Students also quickly come to recognize the role of psychosocial factors in illness and the importance of social interaction skills and a high level of ethical sensitivity. Some develop fears about technological aspects wiping out the human dimension of patient care. These areas deserve emphasis, and students can work with faculty in seeing that they are more frequently addressed in the clinical setting. Students can also request that the residents who work with them be provided clearly defined educational goals and sessions on improving their teaching skills. Other ideas are support groups on handling stresses of clinical education, including presentations on self-care and impairment prevention (3).

D. Evaluation: A recurring theme of the GPEP Report is the unfortunate influence of evaluation methods, such as the National Boards, on students' approach to learning. One OSR member writes: "Over-reliance on multiple-choice examinations has removed the ability of the faculty to promote thinking and reduced preclinical education to the point where it can be taken by correspondence (and is by many in our school via note services)." Evaluation methods are needed that stress the importance of independent learning and problem-solving rather than recognition and recall. Of course, these are much harder to design and more time-consuming to use. In clinical education, evaluation would improve if attendings and residents spent more time than is usually the case observing and counselling clerks. But so simplistic an observation only scratches the surface of improvements that are desirable; AAMC has summarized changes that are needed and is developing a guide containing self-assessment materials for use by clinical faculty (4).

These are harder areas for students to effect changes in. Students can, however, question the role of the National Boards at their schools and work to assure that this licensing examination does not exert too great an influence. Since some preclinical faculty fear a devaluation of the basic sciences in medical education if schools stop requiring passage of National Boards, Part I, this issue provokes strong feelings. Also many faculty appear to gauge the strength of their departments on their students' performance on the Boards. When it comes to grades, students at some schools, e.g., Cincinnati, have successfully fought the reinstatement of letter grades. Another important, often

neglected type of evaluation is students' evaluation of courses and faculty; University of Miami has recently strengthened its use of student evaluations of the clinical clerkships.

WHAT IS A REALISTIC GOAL?

In setting priorities for professional growth and in examining your education, what are realistic goals? And what does becoming the finest possible physician entail during this era of burgeoning scientific knowledge and shrinking resources for education? These are personal questions, but medical students' answers have broad implications for the quality of health care available in this country. Attaining an educational system that is better than the present one at shaping self-directed learners and excellent communications will take the efforts of everyone involved. Persistent patience is needed--and keeping the eye focused on the human dimensions of medical care. Society in general is so specialized and medicine is increasingly perceived by many as a technology such that students may be tempted to focus mainly on the technology.

Skepticism about the ability to make important changes is infectious--but so is faith. And faculty and deans may be more amenable to the changes suggested by GPEP than students in the prolonged adolescence of medical school might think. But if the students, the most immediate beneficiaries of an improved educational system, do not come forward, silence is interpreted as approval of the status quo and its regressive influences. Numerous national and local magazines and newspapers have published articles about GPEP. Interest within the profession, at the schools and at large is wide. As the Director of the American College of Surgeons writes: "It behooves every member of the profession and especially those active in medical education to read, ponder, and act on this landmark study" (5). Who is more actively involved in medical education than the student?

NOTES

1. Most schools appointed a GPEP coordinator who may have a number of copies of the GPEP Report which could be placed on "reserve" in the student lounge or another central place. Some schools requested hundreds of copies; Ms. Barbara Roos at AAMC (202/828-0553) retains records on who received these. The most complete resource is the November 1984, Part 2, issue of the Journal of Medical Education, containing not only the GPEP Report but also reports from the Working Groups and very useful appendixes.
2. There is quite a lot of literature on group process and communication within groups available at most libraries, e.g., David W. Johnson's Joining Together: Group Theory and Group Skills. In paperback, try E. Schindler-Rainman's Taking Your Meetings out of the Doldrums.
3. Some hospitals and state medical societies have committees on physician impairment that may want to provide presentations. The Center for Professional Well-Being in North Carolina is an even better resource (919/489-9167). A ground-breaking program at the University of Tennessee is AIMS (Aid for the Impaired Medical Student) which relies on students' looking out for each other and assures confidentiality of intervention and treatment. Another kind of pro-active approach is being tried at the University of Louisville, i.e., a four-day Health Awareness Workshop preceding the beginning of classes; Stanford offers an elective with similar content, e.g., exercise, relaxation, time management, nutrition.
4. An earlier stage of the AAMC Project on the Self-Assessment of Clinical Evaluation Systems produced a very useful overview titled "The Evaluation of Clerks: Perceptions of Clinical Faculty" (available from Dr. Xenia Tonesk at AAMC (202/828-0561).
5. C. Rollins Hanlon, "Directors' Memo", ACS Bulletin, December 1984.

OSR "CHALLENGES" PAPER

Last year, the three AAMC Councils produced very thoughtful papers examining their roles and directions: "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals: A Discussion Paper" (April 1984); "Future Challenges for the Council of Academic Societies: A Discussion Paper" (October 1984); "Issues for Consideration by the Council of Deans" (August 1984). At the December AAMC Officers Retreat, it was decided that staff undertake a synthesis of these three documents in order to present a potential global picture of areas of concensus and divergence. At this juncture, then, it is appropriate for OSR to contribute students' perspectives. The following draft addresses the first two sections noted in the outline on page one: A) Role of OSR in AAMC and B) Role of OSR Members at the Schools. At the time of the meeting, a draft of the last two sections will be available--C) Recurring Issues and D) Aspirations for AAMC Future Directions. Board members are asked to review and comment on what follows and to bring ideas for the last two sections.

CHALLENGES IDENTIFIED BY THE ORGANIZATION OF STUDENT REPRESENTATIVES

Background

In keeping with the forward-looking self-examinations recently conducted by the Councils of Deans, Academic Societies and Teaching Hospitals, the OSR also submits a summary of issues important from its perspective. The timing of this report and the majority of OSR members' relative unfamiliarity with the AAMC preclude its discussion by the membership. But the OSR Administrative Board has committed to and approved the document and submit it with the hope that the deans will find it useful as part of the on-going examination of AAMC's structure. The paper is divided as follows:

- A) Role of OSR in AAMC
- B) Role of OSR Members at the Schools
- C) Recurring Issues Raised by OSR
- D) Aspirations for AAMC Future Directions

A) ROLE OF OSR IN AAMC

In 1968 the AAMC Assembly passed a resolution calling for development of mechanisms for student participation in the affairs of the AAMC. Two years later the Assembly adopted an addition to the Bylaws creating the OSR. The first meeting of representatives occurred at the 1971 AAMC Annual Meeting. At this time the students adopted and the COD approved "OSR Rules and Regulations" which state the purpose of OSR: "1) to provide a means by which medical student views on matters

of concern to the Association may find expression; 2) to provide a mechanism for medical student participation in the governance of the affairs of the Association; 3) to provide a mechanism for the interchange of ideas and perceptions among medical students and between them and others concerned with medical education; and 4) to provide a vehicle for the student members' action on issues and ideas that affect the multi-faceted aspects of health care."

The OSR is a "sub-councillor" to the COD, with the OSR chairperson and chairperson-elect reporting OSR actions and describing its activities at COD Administrative Board meetings. OSR has two voting members on the Executive Council and 12 on the Assembly. Opportunities for informal sharing with members of the other Councils occur during the quarterly meetings when the OSR Administrative Board joins the other Boards for luncheons, receptions and programs. Another way in which the OSR has input into the affairs of the AAMC is through membership on AAMC committees. In addition to these mechanisms, opportunities for communication between OSR and GSA and sometimes GME occur at regional spring meetings. Also the OSR chairperson is a member of the GSA Steering Committee. Thus, adequate channels exist for OSR to communicate student perspectives to the officers of the Councils and GSA and to convey its views on all issues on the Executive Council Agenda.

Limitations to OSR's effectiveness are inherent in the differences between students and those with line responsibilities for the functioning of an educational institution. Lacking practical administrative experience and the historical perspective which naturally accrues, students cannot bring to the deliberation of many

issues in academic medicine as high a level of expertise as officers of the other Councils. But the students elected to the OSR Board have sought exposure to and recognize their stake in these issues and these students, with the guidance of materials and reports from AAMC staff, do achieve a broad level of understanding of them. At times, because they are not protective of any particular domain or argument, students can contribute in particularly creative and socially responsible ways.

A related hindrance in the OSR Board's participation is that each year usually seven of its eleven members are new to the Board, in contrast to the three-year terms of members of the other Boards. Only the person elected to the office of chairperson-elect serves a three-year term. Occasionally a student will run for one of the other positions and be elected two years in a row. While achieving greater continuity of service on the Board would be desirable, no feasible method is available if the flexibility of the current election procedures are to be retained.

B. ROLE OF OSR MEMBERS AT THEIR SCHOOLS

The "OSR Rules and Regulations" state that "members of the OSR shall be . . . selected from the student body . . . by a process appropriate to the governance of that institution." The "OSR certification form" which deans are annually requested to sign and return to AAMC asks for a brief description of the selection process. The activity levels and structure of student governments vary a lot from school to school, thus so does the selection process for the OSR member. Quite a combination of methods are used from screening of candidates by the student council with appointment by the dean to selection by a student executive committee to election by one class or

by total student body. In order to establish continuity of OSR representation from year to year and to stabilize the role of OSR at the schools, very desirable goals in terms of OSR effectiveness at all levels, schools are periodically encouraged to examine what can be done to achieve these goals. Particularly helpful are procedures allowing: 1) recruitment of freshmen for the position; 2) extended, i.e., more than one-year terms; and 3) selection of an alternate or "junior" as well as official OSR member who attends meetings for a year before becoming the school's official representative. Because these ideas can only be suggested to schools and because OSR is only one of a number of student organizations, many schools still limit the tenure of an OSR member to one year and do not assure prior OSR-exposure. Sharing of materials and advice between the departing and arriving representative does facilitate continuity and this appears to be occurring more frequently than in the past.

While the OSR does not compete with other medical student organizations for members, it usually does compete for funds to underwrite travel to meetings. The American Medical Student Association, the AMA-Medical Student Section, and other more specialized groups, in addition to OSR, usually share a budget created by the dean, student affairs office, or student government. Therefore, support for OSR members to travel to AAMC meetings varies quite a bit from year to year. Twenty schools with certified OSR members did not send a student to the 1984 Annual Meeting; fifteen is a more usual number. When students do not attend, it is not known whether funding was primarily the reason or if examination schedules or inability to receive time-off from a rotation were larger factors.

The role of the OSR member at the medical school begins as an information channel. OSR members are urged to share with their student council or government, if not with the whole student body, reports of AAMC/OSR activities. How representatives go about this depends to a great extent on local interest and on the organization of the student government. The most frequently used methods of transmitting information are placing items in the student newspaper and giving reports at student government or class meetings. Other methods include in-person announcements to classes, bulletin board postings in the student lounge area, and establishment of an OSR file in the student affairs office or library. Some OSR members also staff an OSR table at Freshmen Orientation, informing incoming students about a number of issues, including OSR activities.

In a more directive mode, OSR members are occasionally asked by the AAMC to generate letters in support of an AAMC position; and in the recent past many have worked hard and in laudable cooperation with other medical student groups to produce mail to Congress. Students are also periodically urged and prepared with background materials and guidelines to visit their elected officials at home or in Washington. Such efforts are conducted in conjunction with deans and financial aid officers.

Another role that the OSR representative is urged to play is generator of student input to the LCME accreditation and school self-study process. Shortly after student representation was achieved on the LCME, a student guide to the accreditation process was prepared; an updated version of this handbook is distributed to OSR members at schools with upcoming site visits. OSR members also are responsible

for the distribution to each student of OSR Report which is published twice each year by AAMC. OSR members, deans and others comment on the success of this publication in assisting medical students across the country to begin giving serious consideration to areas not usually covered in their curricula, e.g., physician manpower scenario, ethical responsibilities of medical students, residency selection process, avoiding impairment, and cost containment.

OCTOBER 22 - 23rd LCME MEETING

ACCREDITATION OF MEDICAL SCHOOLS

Six medical schools received full accreditation, with two schools in each of the three year, four year, and five year categories. All were required to submit interim reports on progress concerning specific areas. Voting was unanimous. One school was placed on probation by majority vote with only one dissenting vote. This school must show improvement by December 1984 or accreditation will be withdrawn. General areas of concern resulting in accreditation of a short- or intermediate-term included but were not limited to:

1. Financial stability
2. Administrative strength and efficiency
3. Size and quality of faculty
4. Curriculum
5. Strength of residency programs
6. Size and quality of physical plant
7. Minority recruitment
8. Student satisfaction with courses and with support systems
9. Student quality as assessed by MCAT and NBME scores
10. Quantity of research activity.

STANDARDS OF ACCREDITATION

Draft #11 of the LCME Standards of Accreditation was discussed and approved. This draft subsequently faced public hearings at the AAMC Chicago meeting on 10/30 and will be presented at the AMA meeting in December in Honolulu. Anticipated areas of debate at the public hearings include whether or not family practice should be placed as a core clinical clerkship along with psychiatry, pediatrics, surgery, internal medicine, neurology, and obstetrics & gynecology.

Of note: Standards of accreditation are needed to firm up the evaluation process. There is growing sentiment approving the use of outcome measures to evaluate institutions of higher education. Current LCME standards emphasize process measures. Apparent consensus among LCME members prefers using good judgement to evaluate the complexities of medical education rather than a computerized construct of quantitative measures. The LCME is, however, using some outcome data for its deliberations. Trends in NBME scores and in fiscal data will be considered, after analysis by a statistician, at later meetings.

INTERIM REPORTS

Nine reports were accepted unconditionally. One report was accepted with the proviso that there be no increase in the number of students. One was accepted pending a limited site visit planned for May 1986.

RANDOM OBSERVATIONS

There is one woman and one black member currently on the LCME. Students, as you know, are non-voting members. This decision was upheld at a recent LCME meeting. My co-student member, Catherine Willner and I are working out strategies on this issue. Student opinions are encouraged and, indeed, sought after by almost all LCME members. My comments at the meeting were well received and my suggestions acted upon. Catherine Willner is a smart, articulate woman with much political savvy who will represent student views well.

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If I can be of further service to the members of OSR please let me know.

Respectfully Submitted:

Peggy B. Hasley

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November 7, 1984