2014 AAMC Annual Meeting Digest

Prepared by the OSR Communications Team
Dear OSR,

Many thanks to everyone who attended the 2014 AAMC Annual Meeting! The OSR saw a lot of change at this conference – in the format and content of the conference, in our director, and with the new initiatives OSR is launching. Unsurprisingly, you met these changes with enthusiasm and forward thinking. The conversations I overheard were no longer about the role of the OSR, but instead about the actions we can take as OSR members. I encourage you to keep up this energy as you have conversations back at your home institutions about what you learned and new ideas to implement.

This is going to be a very exciting year for the OSR. The launch of Student Interest Groups (SIGs) will give all OSR members the opportunity to play a more active role throughout the year. I look forward to defining this new territory with you and to making the OSR an even more powerful voice for medical students nationwide.

Best wishes,

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5th year MD/PhD Student
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Find presentation information and materials here: [https://event.crowdcompass.com/aamc2014/](https://event.crowdcompass.com/aamc2014/)

For programming, click here: [https://www.aamc.org/meetings/annual/am2014/](https://www.aamc.org/meetings/annual/am2014/)

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Friday, November 7

OSR Plenary: AAMC Arnold P. Gold Foundation Humanism in Medicine Award Recognition & Luncheon

Cynthia Haq, MD
University of Wisconsin School of Medicine and Public Health

By Marcus Sinewe
The Gold Humanism in Medicine Award is presented annually at this luncheon and recognizes physicians and educators who have contributed to the human condition in medicine. Dr. Cynthia Haq of the Wisconsin School of Medicine and Public Health is this year’s awardee. Dr. Haq challenged students to consider what they wanted to bring to the medical practice and what qualities would define the spirit of the doctor they wanted to be. She discussed how she balanced having three children and a demanding medical practice. She told stories about her time in Pakistan, Afghanistan, Ethiopia, and Uganda, and she shared the many ways taking care of people there changed her. A key point she learned in doing medical outreach was that lasting impact came through empowering and teaching local healthcare workers to carry out the same work once she was gone. She also discussed how seeing the healthcare system fail on her trips led her to work towards health system change and providing healthcare in countries of need. She believes that everyone in the world deserves a chance to live a healthy life and deserves access to basic healthcare. This common thread has been the energy source for her career and her tireless work to reach the underprivileged. Her final comments reminded students that being a good doctor means being a good person, and to take care of yourself and your loved ones since a physician’s skills are needed over the long-term. “We have power, privilege, and capacity to be instruments of healing and compassion.” She ended by challenging medical students, “What is it that you plan to do with your one wild and precious life?”

RESOURCES
About Dr. Haq
The panel discussion provided an update on the USMLE and other National Board of Medical Examiners (NBME) resources. The USMLE will be administered for the 20th time this year, with 2,600,000 individual tests completed up to this point. It was shown that the USMLE has now impacted 40% of the physicians practicing in the United States. In January, the Step 1 minimum passing score went up from 188 to 192, while in July the Step 2 CK minimum passing score went from 203 to 209. A priority for this group has been providing new and better feedback for students on the Step 2 CS exam. In instances of remediation for Step 2 CS takers, it still seems the best option is informational materials to improve score. Score interpretation guides have recently been added to the USMLE website, which can help students better understand their strengths and weaknesses. The recent change in the Step 3 Exam is that it is now a two-day test, but will contain roughly the same number of questions. The first day will have all multiple-choice questions and the second day will have multiple-choice questions along with computerized patient scenarios. New content coming to exams includes physical exam competencies and more multi-media integration in the test (breath sounds, etc.). To celebrate the 100th anniversary of the NBME, the organization launched a new website (NBME100.org).

**TAKEAWAYS**

- Many changes are occurring in all the different exams administered by the NBME.
- New score interpretation guides for the Step exams are available on the USMLE website.
- Minimum scores have recently changed for the Step 1 (188 to 192) and the Step 2 CK (203 to 209).

**RESOURCES**

- www.NBME100.org
- USMLE Transcripts and Understanding Your Score
By Kate Carroll

ERAS

The 2015 ERAS Season

- ERAS apologized for the delay in the September 15th application opening. The portal opened in the morning with serious system issues. ERAS worked with IT partners to try and fix it, but had to close the program in order to address the issues at hand. Twenty five hundred applicants applied on the first day, which was less than previous years, but the number of applicants increased to past levels by the next day. ERAS is working with IT to avoid this problem in the future.
- ERAS received feedback that an opening date of April 15th was too early for applicants and administrators.
- ERAS also received feedback about standardized letters of evaluation and recommendation, which are being asked for by more programs outside of the ERAS system. ERAS is implementing tools to manage letter of recommendation quality assurance, especially in the dean’s work station, and held two webinar training sessions for users. A watermark was added to letters of recommendations that will include the name of the author and when it was logged in.
- Applicants will now be required to create usernames and passwords. An additional message center was added to allow applicants to communicate with programs using a web-based system.

ERAS and SOAP

- Students will have needed to apply to one ACGME program or pay a fee to participate in the SOAP in 2015.
- Thirty-five applications will be available from Monday to Wednesday and ten from Wednesday to Thursday. Applicants will only see tracks they are eligible to apply for, and applications will open at 1pm on the Monday of Match Week.
- SOAP specific resources will be available on website for applicants and medical schools.
- An applicant document tracking system will be available.

The 2016 ERAS Season

- Letters of Recommendation policy change: letters used to be between the author and the program, but because of software requirements at the time of implementation, ERAS asked medical schools to upload letters to the ERAS system instead of authors. With modernization of the system, ERAS is going to allow authors to upload letters directly to programs via the Letter of Recommendation Portal.
  - Potential concerns about this change include evaluating the strength of an application, reviewing resource availability and how ERAS can help communication between administration and authors, and speaking with programs so that they know about the change.
- Modernization project: ERAS is working on new infrastructure that is easier to use, more reliable and more intuitive, secure, and allows for web-based application for medical schools (in addition to applicants). It will be mobile friendly (scale to device), and ADTS is being removed.
  - ERAS will be making decisions based on input from medical schools.
  - Some of the topics to be addressed include granting system access to students, document processing, advising on tactical and strategic issues (screens that facilitate this), and an effective way for applicants to create a virtual packet for each program with data and supporting documentation.
- Expected Enhancements:
NRMP
The question addressed by this session was, is the Match really becoming more competitive? And, the answer, from NRMPs perspective, is not for US allopathic seniors. There were 29,671 positions offered in the Main Residency Match in 2014, the majority of which were PGY-1 positions, and 28,490 of these positions were filled, making for a fill rate of 96%. US active allopathic seniors accounted for just over 17,000 applicants, and had a PGY-1 match rate of 94.4%. The historical average match rate for this group is 93-94%. The remaining residency positions were filled by active osteopathic students, International Medical Graduates (IMGs), and active previous graduates of US allopathic medical schools.

Of note to US active allopathic seniors are the following trends:
- 80.8% of the active US allopathic seniors matched in one of their top three choices.
- The number of unmatched US allopathic senior students declined this year by 500.
- There were more unmatched seniors than PGY-1 positions in the 2014 SOAP, but the number of students without positions at the conclusion of the SOAP declined to 412.

Programs responded to the Biannual Program Survey and provided the following information:
- The most important factors in choosing students to interview are Step 1 scores, Step 2 scores, the MSPE, and evidence of professionalism and ethics.
- The MSPE has become much more relevant to programs after being moved to October 1st.
- Slightly more programs have stated that they have a target score. Programs also report that failure on the first attempt is a significant barrier to getting an interview.
- Half of the programs are requiring Step 2 and now have a target score.
- Very few programs have increased their rejection rates since 2012.
- Factors that go into ranking applicants include interactions with faculty, interpersonal skills, interaction with house staff, and feedback from current residents.

The bottom line is that the US active allopathic senior match rate has remained at 94% since 2005. Only three specialties had lower match rates in 2014 compared to 2012 – Dermatology, Otolaryngology, OB/GYN.

While these data are encouraging for US allopathic medical students, the information presented in this session does not address the question of whether the number of residency positions is enough to meet healthcare demand in the future.

Match Week 2016
The number of positions in the Match is running ahead of the same time last year. The goal for this year is to allow unmatched applicants more time to process options before submitting SOAP applications. NRMP surveyed program directors and institution officials that participate in the Main Residency Match, and found that most programs start downloading applications as soon as they are available on Monday. They begin reviewing them instantly, and finalize a first round preference list as early as Monday afternoon. In 2016, there will be a scheduled change to the Monday of Match week: at 10:30AM schools will receive the list of unmatched seniors, at 11:00AM applicants and programs will be informed and unfilled positions will be posted on the internet, ERAS will open at 2:00PM, and programs may begin receiving applications at 3:00PM, which will provide 1 extra hour on each end.

RESOURCES
2014 Main Residency Match Data
2014 NMRP Program Directory Survey
Saturday, November 8th

Opening Plenary Session: Communicating Science, Advancing Medicine

Alan Alda
Actor, Director, Writer
Advisory Board Member, Alan Alda Center for Communicating Science

By Kate Carroll

This year’s opening plenary was delivered by Alan Alda, an actor best known for portraying surgeon Hawkeye Pierce on M*A*S*H and New York Times bestselling author of Never Have Your Dog Stuffed and Things I Overheard While Talking to Myself. Alda has also written a book called Radiance on Marie Curie and hosted the television programs Scientific American Frontiers, The Human Spark, and Brains on Trial with Alan Alda. Recently, he founded the Alan Alda Center for Communicating Science at Stony Brook University.

“I want to tell you about the night that changed my life,” Alda began. He was in Chile filming Scientific American Frontiers. They were at 8,000 miles in elevation and he was sitting on a blue vinyl bench waiting for lighting to finish, when he experienced excruciating pain in his gut. He was taken down the mountain to a small town where the surgeon explained to him in layman’s term that part of his colon had died and what procedure he needed. Alda responded, “Oh you’re going to do an end-to-end anastomosis,” which he had learned about on M*A*S*H. This, Alda said, was an example of good communication, because the surgeon’s demeanor and clarity gave him the peace of mind to choose the life-saving operation.

On the other side of the spectrum, Alda told a story of bad communication. A rock had broken Alda’s front tooth when he was 12 years old. A dentist removed the root and nerve, but at 50 his tooth began to turn blue. He went to see a dental surgeon who told him there was a risk of “tethering” with the procedure. Alda did not know what this meant nor was it explained to him. During the procedure the surgeon snipped his frenulum labii superioris, which caused Alda to lose the ability to smile. As an actor, this was quite problematic. When he smiled people told him he was sneering. When he told his dentist, the dentist was immediately defensive.

Good communication is essential for patient care. While patients are more likely to take their medication and divulge information if they feel listened to, studies have shown the average time before physicians interrupt their patients is between 18 and 23 seconds. Good communication also leads to fewer lawsuits.

Clarity and empathy, Alda said, are the two foundational tenets of communication. During Scientific American Frontiers, he developed a means of talking about science that was based on improvisation. He actively listened to scientists and when he was not following them, he would ask questions. They responded to him as a person and he found that on this show scientists became fellow human beings, who were smart, curious, and funny.

Due to Alda’s work with the Alan Alda Center for Communicating Science, every medical student at Stonybrook receives 10 hours of instruction on communicating. The class is based on improving both empathy and clarity in students’ communication. To encourage empathy, the Center teaches improvisation, so that students make contact with other people. As inhibition falls away, students are able to be truly empathic.

RESOURCES
Alan Alda Center for Communicating Science
The Community Health Needs Assessment: From Legislation to Implementation

Philip Alberti, PhD
Senior Director, Health Equity Research and Policy
AAMC

Ivy Baer, JD, MPH
Senior Director and Regulatory Counsel
AAMC

Victor Carrillo, MPA
Director, Community Health Development & Research
New York Presbyterian Hospital

By Kate Carroll

The Community Health Needs Assessment (CHNA) became a federal issue when the Affordable Care Act was passed because it included a provision that requires not-for-profit hospitals to conduct a CHNA every three years in order to maintain tax-exempt status. The IRS has been slow to get out final information on what the requirements are, so in the meantime the AAMC has been collecting information on what is being done.

The session reported the results of a survey administered to 270 AAMC member hospitals asking what they have done to meet CHNA requirements. Seventy-six completed surveys were returned, with 113 CHNA documents. The results showed the following:

- There is more potential benefit if you weave residents and medical students into the process, but fewer than half aimed to use CHNA data in medical education.
- 80% of individuals with primary responsibility for carrying out the CHNA were part of or reported to the hospital/health system leadership team. Senior leadership was well represented in the process, while researchers, educators, and learners were the least likely to play a significant role.
- Two-thirds hired a vendor or contractor to help in efforts.
- Regulation requires that hospitals collaborate with public health experts and members of the community. The survey found that half of respondents collaborated with local schools of public health and 77% of respondents collected data using multiple methodologies.
- The top 10 CHNA prioritized needs included access to medical care, access to mental health care, obesity, and social determinants of health – education, hunger, and poverty.

Victor Carrillo then gave a presentation on the CHNA at New York Presbyterian Hospital as an example of best practices. NYP began with a community resource inventory and identified what conditions are sending people to the hospital, what healthcare resources are available to the community, such as pharmacies, dental care and farmers’ markets. NYP also reached out to the community and asked community partners what they were seeing firsthand. They combined this data with the community resource inventory to build the CHNA. They found food deserts in Harlem and northern Manhattan neighborhoods and worked with the city and community organizations to develop a farmers’ market. They also found small grants to help bodega owners keep shelf space available for fresh fruits and vegetables.

NYP’s research efforts also identified a high incidence of obesity, diabetes, asthma, congestive heart failure, and mental health issues. To address this, NYP has partnered with the community and residency programs to build programs in medical homes. The three-year outcome data has seen a 30% reduction of Emergency Department utilization in that population, and a 28.5% reduction in inpatient use. Additional programs that have come out of the CHNA are Choosing Healthy and Active Lifestyles for Kids (CHALK) and WIN for Health, which was initially built to address childhood asthma, but has expanded to address diabetes and obesity. The result of these programs is a 54% reduction in ED visits, 67% reduction in hospitalizations and a 64% reduction in HbA1c scores.

The impact of the CHNA has extended beyond immediate healthcare. NYP has engaged academic researchers and shared information to further research efforts, worked with 23 local organizations on protocols to help them use data in the CHNA, and worked on cultural competency for residency training.
ERAS Update: Launching the Web-Based PDWS (Program Director’s Work Station)

By Allison Hunter

This session detailed the trials and tribulations, the AAMC’s reactionary measures, and the best next steps for improvement as it relates to the new web-based Program Director’s Workstation (PDWS) as a component of the Electronic Residency Application Service (ERAS).

Major technical and support challenges with the PDWS were acknowledged in this presentation, including PDWS login and access issues, storage problems, and system outages. Each of these issues stemmed from a high volume of users, the selectivity of multiple filters for a large number of applicants, and the capacity to save this data and generate bulk printing jobs. Collectively, all of the aforementioned problems led to crashes; however, once problems became evident, IT worked diligently to address each issue in order to find solutions.

New changes that are being implemented in response to these problems include:

- Phone triage during peak time is moving away from voicemail and transitioning to email in order to more quickly address concerns.
- Enhancement of Communication Tools, including:
  - Web-updates upon login to the AAMC site with a copy of the message sent to ERAS contacts (primary and secondary) to ensure it reaches the most people very quickly.
  - PDWS Support forum with FAQs, including tips for “work-arounds” or change in work flow for known issues.
  - Listserv to disseminate information with the development of a digest to consolidate updates for a single day for easier usability.

The next steps in the process include fixing infrastructure problems to accommodate the large number of users; upgrading technology for better quality and efficiency; improving file storage to maintain files for longer and to reduce time-outs; improving power functionality to accommodate highly selective filters and export options; and finally reviewing the support plan. The new support plan will refine trouble-shooting, allow for more practice opportunities, and provide adequate support during pre-launch and peak usage time. Collectively, a review of the current season’s data and the lessons learned from past experiences will help to avoid future problems.

TAKEAWAYS

- Launch of the web-based ERAS-PDWS system presented many challenges that are acknowledged by the AAMC with plans for improvement to make the process easier and more streamlined for the future.
- Major changes include technology updates, improved tech support, and practice opportunities that will help to make the ERAS-PDWS more user friendly.

RESOURCES
ERAS for Programs
The New Era of AAMC Student Surveys

By Marcus Sinewe
This session provided a panel discussion with an introduction and update to the different questionnaires used before, during, and after medical school training. The surveys included the Post-MCAT Student Questionnaire (PMQ), Matriculating Student Questionnaire (MSQ), Medical School Year Two Questionnaire (Y2Q), and the Medical School Graduation Questionnaire (GQ). Currently, there is 80% participation in the GQ and 75% participation in the MSQ. The goals of the survey group are relevance, timeliness, quality, and continuity of the surveys. The new focus on the PMQ is to flesh out questions on work/volunteering, preparedness, and influences on the decision to pursue medicine. The questionnaires that are used throughout medical school are beginning to incorporate sexual orientation, gender, quality of life, time use, mentoring, and many other relevant topics to life in the medical education system. The panel discussion ended with a heavy discussion on how to get more second year students to be involved in the new Y2Q. The suggestion of some sort of incentive for students to do the service may be advantageous. The Y2Q first round of results will not be available until the second set of M2 students have taken it.

TAKEAWAYS
- The AAMC uses many different surveys to gain the opinions of medical students, before, during, and after their education.
- These surveys allow for benchmarking at schools and for areas of weakness to be noted.
- The surveys are continually evolving.
- Students have a vested interest in completing surveys, as they are really an impetus for change in medical education.
Tackling the Shortage of GME Slots: Solutions Within Reach

Moderator: Atul Grover, PhD
Chief Public Policy Officer
AAMC

Karen Sanders
Deputy Chief Officer for Academic Affiliations
Veterans Health Administration

Speakers:
Michelle (Shelley) Nuss, MD
Campus Associate Dean of GME and DIO
University of Georgia

Karen Sanders
Deputy Chief Officer for Academic Affiliations
Veterans Health Administration

Lori Mihalich-Levin, JD
Director, Hospital and GME Payment Policies
AAMC

Rick Bossard
Government Relations Officer
University of Michigan Health System

By Kate Carroll

There are several opportunities for addressing the shortage of GME slots, including beginning residency training programs or rotations at hospitals that have never trained residents before and want to begin residency programs, and hospitals that do not want a residency program but are willing to take rotations. Medicare GME payment is available to these types of programs. Direct GME payments are paid per resident full time employee up to a certain cap. If a new teaching hospital sets up a residency program, they must establish a per resident amount (PRA), which is based on their Medicare share (the percentage of patients that are Medicare patients), and the number of residents. Indirect medical education payments will partially compensate for higher patient care costs due to the presence of teaching programs, patient complexity, etc. This compensation depends on a formula using intern and resident to bed ratio. Establishing the PRA uses the lower of first year actual costs or a weighted PRA for the geographic area. The final amount is based on a 5-year window, after which the PRA and cap are permanent. The definition of a new residency-training program is fairly strict. It requires a new program director, new teaching staff and new residents. If the program does not meet these requirements, it will not be granted GME payment.

Creating New Residency Programs in Georgia

Dr. Nuss described her experience building a teaching hospital in Georgia, a state that is very short on physicians. Georgia has increased its medical student spots, and enrollment is up by 57% however, GME has only expanded by 31%. When she arrived to address the issue, only 16 hospitals in Georgia participated in GME. Some of the considerations for new hospitals are sustainable funding, distribution of the programs, and what specialties they will focus on. The challenges that new hospitals face are: hospital readiness, medical staff perceptions and willingness, strategic planning, mission changing decisions, transformation to community teaching hospital, and financial constraints. Dr. Nuss said start-up costs are probably $2-8M, and hospitals will not receive any Medicare payment until the first resident is on duty.

They proposed 400 new resident positions and a funding model to help cover costs. They required that hospitals focus on primary care and general surgery and match the funding 1:1. The governor supported the initiative and approved funding in 2013. There are now six additional ACGME accredited sponsoring institutions. State appropriations will increase from $1.2M in 2013 to $5.275M in 2016.

Politics of GME in Michigan

Michigan has a very mature GME program, but recently they have had to fight to keep it moving forward. In 2011, the governor targeted GME for a 40% budget reduction. UMHS took the lead and led a grassroots effort to rally the full restoration of the $164M budget. Their strategy involved identifying champions in the legislature, using hospital CEOs and CFOs as messengers, and rallying house officers to apply gentle but relentless pressure on political officials.

Opportunities for Residency Rotations in the VA

The VA is the largest single provider of health professions education in the US and is in partnership with both allopathic and osteopathic schools. Most consist of the VA as a partnering site – less than 1% of VA GME is actually
sponsored by the VA. The VA hosts 40,000 medical residents annually, which is 30% of total medical residents. They receive $10,500 FTE funding for residents and collaborate with over 2400 ACGME accredited programs. The VACAA Choice Act was signed in 2014 and expands VA GME by 1500 positions over five years. They have very specific priorities for the funding allocation – facilities in areas with physician shortages, no prior GME, rural locations, a high concentration of veterans, and HPSAs. The programs they will fund will be primary care, mental health and new affiliations. They have put out requests for positions in VA hospitals and received many applications. The VA will pay stipend and benefit costs for the time at the VA only, usually through the OAA funded disbursement agreement.

RESOURCES
AAMC Physician Workforce Data Book
www.AAMCAction.org
Institute of Medicine Report

Provider-Patient Communication from the Patient Perspective

Moderator:
Andreas Theodorou, MD
Chief Medical Officer
University of Arizona Medical Center

Diane Stollenwerk, MPP
Co-Founder
Patient Voice Institute

Speakers:
Adrienne Boissy, MD, MA
Editor in Chief, Journal of Patient Experience
Neurological Institute Experience Officer, Cleveland Clinic Foundation

Paul Haidet, MD
Dir. of Medical Education Research and Professor of Medicine, Humanities and Public Health Sciences
The Pennsylvania State University College of Medicine

Sumita Khatri, MD
Asthma Center, Cleveland Clinic Respiratory Institute
Cleveland Clinic Foundation

By Marcus Sinewe

This panel-based discussion focused on the different methods successful healthcare systems have been utilizing to provide better patient-physician communication. There is a lot of learned helplessness within the healthcare system. How do we turn frustration into constructive engagement? Research has shown that what patients want is safety, compassionate human interaction, continuity of care, access to meaningful information, and partnering with their clinicians. E-patient Dave spoke about the shift in medical culture from “compliance” to partnerships with patients. One example of this is how the medical record can be a shared working document. Another is how the BMJ is allowing patients to peer review research papers on their own illness, which represents a perspective shift to seeing patients as intellectual partners.

Dr. Andy Theodorou discussed the instruction both UGME and GME students receive at the University of Arizona Medical Center. Students learn that communication across professional cultures presents new challenges and they gain a perspective on how everyone contributes to the healthcare team. They created a video for use among hospital administrators highlighting the patient partnership. At Penn State University, they have developed a course called “Jazz and the Art of Patient Communication,” where students are taught how the same tempo, words and key can still convey different information, said Dr. Paul Haidet. Drs. Boissy and Khatri described their experience at the Cleveland Clinic working with attendings, faculty, and staff on the patient-provider centered approach. The new program – Foundations of Healthcare Communication Course – is required for onboarding all new staff.
Aligning School Competencies to the Physician Competency Reference Set for the Curriculum Inventory

Terri Cameron  
Director of Curriculum Management  
AAMC

Colleen O’Connor Grochowski, PhD  
Duke University

Hugh Stoddard, MEd, PhD,  
Emory

Bonnie Granat, PhD  
SUNY Downstate

Vicki Park, PhD  
University of Tennessee

Jennifer Christner, MD  
SUNY Upstate

By AJ Blood

The Curriculum Inventory and Reports is an international repository of medical school curriculum competencies, content, pedagogy, structure, and policies. The data comes from annual collection each academic year, and an annual survey submitted by the LCME (LCME Annual Questionnaire Part II). The Physician Competency Reference Set (PCRS) compares healthcare profession competency sets to create a set of “core” competencies for aggregate reporting in MedAPs and MedEdPORTAL. The complete list of competencies was published in August 2013 in Academic medicine. The final list outlined eight domains with 58 competencies.

Hugh Stoddard described how he tries to make sense of what he termed, the “Tower of Edu-Babel.” Despite all the different terms and descriptions, he said you could distill it all down to “expectations” in the curriculum inventory. The PCRS is an aggregation of frameworks, covers multiple domains, and offers a general consensus statement. It is not a blueprint for assessment, an outline of required curriculum, or a performance standard. Then representatives from various schools gave examples of how they have incorporated the PCRS into their curriculums, what kind of value it provides, and some of the obstacles or deficiencies they have encountered.

For example, Dr. Grochowski explained how Duke University has mapped their curriculum to the PCRS. Duke has 233 overarching school of medicine objectives, with 36 goals in 12 categories. They go through these goals and renew them every 3 years or so. Duke reviewed their goals and objectives to determine whether they reflect the content of the new documents and to determine what was missing. They found that most of the objectives mapped to at least one PCRS, all basic science objects mapped to PCRS 2.2, some basic science objectives mapped to just one or two more of the PCRS, and that the Curriculum Committee members liked the PCRS. They have adopted the PCRS as the program objectives/competencies and have kept the mapping of old objectives onto the PCRS. They have found that the 58 goals from PCRS are more manageable then the 233 they had before this.

TAKEAWAYS

- This system seems to be a good way to standardize expectations
- Experiences are more difficult to document and analyze in the 3rd and 4th years
- Challenges still exist but schools should look to this to compare themselves to one another

RESOURCES

https://www.aamc.org/initiatives/cir/about/348808/aboutspcrs.html  
www.aamc.org/cir
Crafting a Sustainable Future for Clinical Faculty & Organizations of the Academic Health Enterprise

**Moderator:**
Angela Sharkey, MD  
Assoc. Dean, Faculty Affairs and Professional Development  
Professor of Pediatrics  
Saint Louis University School of Medicine

**Speakers:**
Amy Sebring, MPP  
Senior Associate Dean, Finance and Administration  
Virginia Commonwealth University School of Medicine

Vincent Pellegrini Jr., MD  
John A. Siegling Professor and Chair of Orthopaedics, Medical University of South Carolina  
Director, Musculoskeletal Service Line  
Medical University Hospital Authority

Marian Limacher, MD  
Sr. Assoc. Dean, Faculty Affairs and Professional Development  
University of Florida College of Medicine

Julie Freischlag, MD  
Vice Chancellor, Human Health Sciences; Dean  
University of California Davis School of Medicine

Theresa Brennan, MD, FACC  
Chief Medical Officer  
University of Iowa Roy J. and Lucille A. Carver College of Medicine

Susan Pollart, MD, MS  
Ruth E. Murdaugh Prof. of Family Medicine  
Sr. Assoc. Dean of Faculty Affairs & Faculty Development  
University of Virginia School of Medicine

**By Alyssa Blood**

Increasing faculty turnover, faculty engagement, and faculty retention in the changing economic climate is a pressing challenge. Academic institutions are struggling financially to attract the 'best and the brightest' due to the increasing financial appeal of private practice, coupled with ever increasing expectations of physicians practicing at academic centers.

Many feel that their careers are no longer progressing, that their ability to teach and do research is being minimized, and are attracted to the more relaxed and lucrative private practice climate. With increased pressures associated with productivity, teaching, and lack of research funding, physicians are becoming less attracted to academic medicine. The advent of electronic health records, longer hours, and pressures to increase productivity by decreasing patient encounter time are also driving physicians away.

It is now the responsibility of health care leadership to create climates of excellence that physicians are attracted to in order to improve retention, as there are significant financial and productivity costs associated with high physician turnover.

Research has found that leadership turnover has been implicated in physician turnover. The percentage of time in clinic did not seem to affect the rate of those wanting to leave, while lack of satisfaction of the distribution of time (e.g. too much time in clinic, teaching, research, administrative roles, etc.) was predictive of intent to leave.

Proposed solutions include creating a unique niche for new faculty training that equips physicians with specific values, involving co-workers and departments in hiring decisions to foster cohesive work climates, mentoring systems in which senior faculty play a supportive and advisory role, clear definitions of tenure and achievable milestones, and face-to-face annual reviews with the department chair.
How Pivio Can Help Students Become Doctors – AAMC & NBME New Career Documentation Platform

Joshua Jacobs, MD
Senior Director, Electronic Portfolios
AAMC

By Regina Kwon
Pivio is searching for its purpose. This online portfolio service, created by the AAMC and NBME, allows students, residents, and physicians to collate their medical education and certification data. It also proposes to guide students through the processes of applying to medical school and residency.

Through next year Pivio pricing remains at $100 per year for medical students and undergraduates, $125 per year for residents and fellows, and $250 per year for physicians. The cost of Pivio is a significant obstacle to uptake; it is inflexible because Pivio must pay the company whose technology underlies the service per-user fees. At this session, the service opened itself to discussion about its market focus.

This session began with a walkthrough of Pivio, and then moved on to table discussions between faculty, administrators, and students about how it might be used by different constituents. Dr. Jacobs, the presenter, stated that one possibility would be subsidies by medical schools in exchange for access to student performance and competency-achievement data past graduation.

RESOURCES
http://www.pivio.org
Leadership Plenary

Lorris Betz, MD, PhD  
Chair, AAMC Board of Directors  
Senior Vice President Emeritus of Health Services,  
University of Utah

Darrell G. Kirch, MD  
President and CEO  
AAMC

By AJ Blood

Small changes can be as important as big, institutional changes. It takes courage and resilience to cause real and sustained change. The theme of this talk was the courage it takes to change our behavior with teams, students, and patients and the resilience to sustain our community as we change the healthcare environment.

Courage: Dr. Lorris Betz

Dr. Betz began by describing the epidemic of bad behavior in medicine and how this issue has been brought to the forefront of our profession. Screaming, disrespectful behavior is prevalent in all institutions. Of 840 respondents to a survey, 70% stated that they see this behavior every month and 11% said that every day they see doctors “behaving badly”. About 60% of medical trainees reported experiencing some form of harassment during their training. Mistreatment is embedded in medicine; it can be found in actions as simple as referring to patients by their disease and refusing to do a mandatory safety time-out in the O.R.

Since the 1990s, there has been no change in the incidence of students reporting mistreatment. Dr. Betz argued that this is because we have treated only behavioral symptoms, and not the root cultural cause. Students experience humiliation, shame, and self-doubt during their training, and then come into a position of power where they propagate the cycle. Dr. Betz urged the audience to stop being defeatist about changing medical culture.

He gave an example of cultural shift at the University of Utah. There was a need to improve the patient experience. The hospital made data more transparent by publishing patient comments and creating an online 5-star ranking system for physicians. The percentage of surveyed patients who responded that they would recommend the hospital rose from 27% to 66%. Physician rankings, quality, and safety all improved, as did employee satisfaction, and malpractice and healthcare costs decreased. Student mistreatment decreased, as well. To change culture takes the courage of leaders, faculty, and staff to work together. It requires a zero-tolerance policy for not reporting failures. Dr. Betz closed by imploring the medical community to act now.

Resilience: Dr. Darrell Kirch

Healthcare faces many challenges these days. Funding sources have halted students face very high tuition rates, and the it is unclear whether there will be enough residency positions to train the number of physicians needed to care for the population. The individuals within the profession are suffering. A study on burnout, in which 7,000 physicians were surveyed, found that nearly 46% of doctors reported at least one symptom of burnout. Sixty percent of ER doctors reported burnout, which was the highest of all specialties. Forty percent of doctors screened positive for depressive symptoms and 7% of doctors admitted suicidal ideation in the last year. An opinion piece in the New York Times by Pranay Sinha, a resident at Yale-New Haven Hospital, entitled “Why Do Doctors Commit Suicide?” told the story of two residents in NYC who had recently committed suicide. While being a physician can be gratifying, noble, and stimulating, Dr. Kirch noted that many of our colleagues are in genuine distress.

Given the current climate and how quickly things in medicine change, how can we keep up? The answer, according to Dr. Kirch, is resilience – a quality demonstrated by many in the medical profession for many years. Medicine has a history of stepping up to challenges. The fear of Ebola has become widespread, but so was the fear of AIDS in the 1980s. Just as we did then, we can step up and treat this disease. What makes medical professionals move forward in the face of doubt and failure? A quality shared by doctors and all people in the healthcare field – resilience – the willingness to work on a problem despite difficulty and challenges.

Dr. Kirch has seen many examples of resilience. He told the story of a neurologist who was denied funding three times in a row. When others may have given up, this physician showed resilience and on the fourth attempt
received funding. Another example is how Vanderbilt Medical Center was able to overcome a $25M deficit by reducing operating costs and forming new connections and ties to the community and is now in a stronger financial position.

He ended by acknowledging that we all face obstacles, but he challenged the audience to tap into their resilience and rise above these obstacles, to keep overcoming fear and coming up with cures, and to always be there for our patients.

**TAKEAWAYS**

- The medical profession is a strong community. While the current challenges it faces may seem new and different, history suggests that they are very similar to those faced in the past.
- Physicians can and will overcome these difficulties because a common thread amongst doctors is resilience and because our patients and colleagues need us.

**RESOURCES**

*JAMA Article on Physician Burnout*
By AJ Blood

The prevailing epistemological model on leadership emphasizes a third person approach. One learns leadership by being taught another’s knowledge. It suggests that knowing is the foundation of leadership, and leadership is anchored in theories and explanations. In this paradigm, barriers to effective leadership are external – the competitive environment, shifting industry trends.

But a new model of leadership is emerging that emphasizes first person learning. This model postulates that it is impossible to act like a leader if you are not being a leader. The foundation of leadership is not knowing, but being. Therefore leadership classes fall short of creating leaders, because they only teach students what they need to know, and not how to be. The barriers to effective leadership are no longer external, but rather internal and interpersonal. This definition of leadership suggests that there are many different ways to be a leader, and that one’s effectiveness as a leader is not about specific traits but rather how one responds to a situation and solves problems. A good analogy to explain this is that of the baseball player. One of the speakers told the story of being a junior faculty member and meeting Hank Williams. He asked Williams how he hits a ball flying at him at 100mph, to which Williams replied, “I don’t know how I hit a baseball, the ball just shows up as hittable.” Being a leader means that you possess the mastery of a situation such that when a problem shows up you can reframe that problem as “hittable”.

The House of Leadership is a new structural framework for exercising leadership. It is built on awareness, integrity, authenticity, and commitment. Awareness requires that one pays attention to their inner voice. Instead of reacting to situations, awareness gives us the power to take a step back and form an informed response. Integrity is the internal characteristic that we develop as we become leaders. It means sticking to one’s word and always acknowledging when we have to break it. Authenticity is remaining true to oneself amidst responsibilities that are not of one’s own creation, which is a frequent reality for leaders. The final tenet is commitment to a future that is bigger than you are.

TAKEAWAYS

- Leadership is more important in practice than in theory, we need to give people the opportunities to take leadership roles for them to learn what works and what does not work for them to effectively lead.
- While characteristics can be similar, depending on the context the best leaders can be very different people and a great leader in one situation may not translate well to another situation.
- Outcomes are important, people need to be more concrete about what they are going to do, how they are going to do it, and how they are going to measure whether they are successful or not.
How Empowered, Engaged Patients Are Changing What’s Possible in Medicine

Dave deBronkart (aka e-Patient Dave)  
Author, Let Patients Help: A Patient Engagement Handbook  
Co-founder and Co-chair, Society for Participatory Medicine

Robert J. Laskowski, MD, MBA  
President and Chief Executive Officer  
Christiana Care Health System

By Kate Carroll

Patient Dave is many things, but at this session he spoke as an advocate for patient engagement. He spent a long career working in high tech marketing and wrote the world’s fastest software for typesetting business cards. He describes himself as a data geek who is fascinated by trends and carefully follows them. Medicine, he said, does not yet have the kind of high quality workflows that other industries have. His experience provided him with a unique perspective when he learned in 2007 that he had Stage IV Renal Cell Carcinoma. Through a patient support and information group he discovered online, he learned about the treatment – high dose IL-2 – that would ultimately save him. Since his recovery, Dave has devoted himself to advocating for patients. In 2008, he began blogging about ePatients. One year later the Boston Globe wrote an article about participatory medicine and talked about his work. He took this on full-time in 2010 and has gone on to speak at conferences and give a Ted Talk.

Dave stressed the importance of involving patients in their medical care. It is fairly impossible to keep completely up to date in medicine. Information is like nutrients – if it arrives it enables a healthier response. Patients can connect to information and each other and subsequently to providers. “Woe unto someone who tries to operate in a field without realizing that a fundamental change has happened and patients are now nutrients!” Dave said. He described the Open Notes study, in which patients were allowed to see unedited physician notes. Both patients and doctors wanted to continue this method after the study.

RESOURCES  
Dave’s Ted Talk – “Let Patients Help”  
Twitter Handle: @ePatientDave  
Email Address: dave@epatientdave.com
Literary Spotlight: Breaking Ground

Honorable Louis W. Sullivan, MD
President Emeritus, Morehouse School of Medicine
Former Secretary, U.S. Department of Health and Human Services
Author, Breaking Ground: My Life in Medicine

By Allison Hunter

In this session, Dr. Sullivan discusses his recent memoir, “Breaking Ground: My Life in Medicine,” which characterizes his life, beginning with his roots in Atlanta, Georgia, and later the family’s move to Blakely, Georgia, where his father established the first African American funeral home while serving as a community activist. His father founded the first chapter for the NAACP in the area, helping to register African American voters.

Dr. Sullivan left Blakely to pursue a quality primary education, ultimately graduating from Atlanta’s Booker T. Washington high school as Class Salutatorian. He went on to attend Morehouse College, where he was inspired and motivated by exceptional faculty and leadership, including his role model Dr. Benjamin Mays. He graduated magna cum laude in 1954 and was subsequently accepted into medical school at Boston University School of Medicine as the only African American student in the class and the first Morehouse alumnus. His time in Boston served as Dr. Sullivan’s first experience living in a non-segregated environment. In 1958, he graduated from medical school and was accepted to Cornell for an internal medicine residency. He went on to do a research fellowship in pathology at Massachusetts General Hospital and a research fellowship in hematology at Harvard.

Dr. Sullivan was instrumental in the development of Morehouse College’s medical school, ultimately helping the medical school to become independent from the college as the Morehouse School of Medicine. Morehouse invited their first class in 1972, and he served as the founding dean and director of the Medical Education Program.

Dr. Sullivan accepted the position of U.S Secretary of Health and Human Services under President George H.W. Bush’s administration with goals to increase diversity in race, gender, and socioeconomic background. His major campaigns included women's health and research, anti-tobacco and smoke-free campaigns, development of a new FDA food label, and initiatives to improve health based on behavior and prevention. He also helped to establish the Medical Education for South African Blacks (MESAB) organization to provide scholarships for more than 10,000 students to become health professionals.

TAKEAWAYS

- Dr. Sullivan’s personal and professional achievements were shaped by his roots in the Jim Crow South, his experiences and mentors while at Morehouse College, and his medical education in the Northeast. These experiences laid the foundation for his many roles as a physician, leader in health policy, minority health advocate, and ultimately educator and author.
- Instrumental in the founding of the Morehouse School of Medicine, serving as founding dean and director of Medical Education.
- U.S. Secretary of Health and Human Services under President George H.W. Bush, fostering initiatives that championed diversity in race, gender, and socioeconomic background, while improving the health and health based behavior for all Americans.

RESOURCES

Breaking Ground: My Life in Medicine
VSAS: A Conversation about the Visiting Student Process

Melissa Donner  
Director, VSAS  
AAMC

By Allison Hunter
The Visiting Student Application Service (VSAS) is an online application service provided through the AAMC that helps medical students apply for clinical rotations at other medical schools within the United States. This session provided an overview of the visiting student process, including the goals of visiting rotations, institutional “best practices,” and ways to streamline the VSAS system.

Based on voluntary survey data, student goals included the following: path to residency (84%), audition, letters of recommendation, finding a good fit, the educational experience (10%), to be close to family and friends, required, other. Most commonly, the Program Directors’ goals included introducing potential residents to the program, using the rotation as an audition, and other.

Ideas proposed to improve the VSAS process include:
- Improved standardization: application requirements, submission and decision dates, and rotation dates
- Eliminate redundancy
- Decrease the number of requirements
- Eliminate incomplete applications and provide updates on filled electives in to prevent students from applying to filled electives
- Speed up process to hear back more quickly and with more time to plan

TAKEAWAYS
VSAS plans for the future improvement to include the following:
- Standardizing the immunization form for all host institutions
- Increasing the number of participating institutions that adopt the Uniform Clinical Training Affiliation Agreement
- Decreasing the time spent applying

RESOURCES
Visiting Student Application Service (VSAS)
Disruptive innovators, a term originally coined by Clayton Christensen, is a process by which a product or service takes root in simple applications at the bottom of a market and then transforms the market as we know it. Examples of disruptive innovation in medical education include Entrustable Professional Activities, three-year MD programs, universal curricula, student-assembled content for Step 1 preparation, and commercial products such as First Aid and Pathoma. Dan London presented the results of a survey sent out to determine if students felt their core curriculum set them up to succeed on Step 1 and what they used to study. 74% students did not believe their core curriculum prepared them for Step 1, and thought that they were getting 85% of material on Step 1 from the curriculum. Most students supplemented this material with review books and question banks.

Dr. Ben-Ari then discussed the development of the Integrated Case Studies, which Keck School of Medicine began to address this discrepancy between curriculum and Step 1 preparation. It is a seven-week course that promotes clinical reasoning skills in MS2s and provides a better transition from classroom to clinical immersion. The course uses First Aid as its required text. Each week is devoted to a symptom — headaches, abdominal pain, dizziness, fatigue, shortness of breath, fever, and finally emergencies. They have found mean Step 1 scores have improved by 8% since implementation and the course is now an accepted part of the curriculum.

The session then provided ample time for discussion amongst attendees about what has the most potential to disrupt the preclinical education experience. Audience members voted that a universal curriculum, fast-tracked pathways, and competency-based evaluations posed the most disruptive potential.
Oath Taking in Academic Medicine: Expanding the Commitment to Ethics within the Profession

By AJ Blood

The first documented use of an oath was in 1804 at University of Mount Pilliar in France. Since then it has had a cyclical presence in medical schools. In the mid-19th century oaths were popular, however by the turn of the 20th century oath taking was not common in medical schools. It started to rise again in the 1950s, and by the 1970s over 90% of medical schools were using oaths again.

There are some commonalities amongst the oaths that are used in allopathic and osteopathic schools. These include: respecting confidentiality, respecting teachers, serving all patients regardless of differences, placing interests of the patient (the public, the profession) ahead of self, passing knowledge on to the next generation, avoiding harm and injustice, humility in acknowledging limits and seeking help, advancing medical knowledge, continuing to expand one’s own knowledge, and serving public health (however poor and unable to pay).

While ceremony is important to the human experience and taking medical oaths is now part of assuming the normative identity of physician, oath taking has more than ceremonial value. It implies a social contract for the oath-taker, as a profession, and collectively across colleagues.

TAKEAWAYS

- Oaths are important both for historical and ceremonial purposes
- Oaths have different texts and meanings, many of which have changed over time including many schools which choose to allow each graduating class to write their own oath
- Schools have chosen to administer oaths at the white coat ceremony, the transition to clinical training, and at graduation from medical school
Academic Medicine Question of the Year: How Can Our GME System Prepare Trainees for Future Practice?

By Allison Hunter

This session poses the following question: how can our current training system prepare students for future medical practice in a health care system that is constantly evolving? This challenge is met with the reminder that our healthcare systems will require physicians to have an expanded set of competencies beyond those fostered by our current educational programs.

Ideas posed for better preparing our future physicians include developing interprofessional education to foster professional collaboration, training cost-conscious physicians who utilize value-based decision making, and improving institutional culture through vertical integration from medical student to attending.

Individual table discussions further developed ideas to help better prepare trainees:

- Team grand rounds with collaborative presentations
- Interprofessional collaboration: doctors rounding with other doctors or residents rounding with case managers and nurse practitioners
- Ambulatory care clinics that allow residents to experience continuity of care
- Choosing the right patients for the residents to see

Collectively, there are many challenges that await medical students and residents in future medical practice given the nature of our evolving healthcare system. Challenges to better training include funding, time restraints, and a culture that values what is available as opposed to what is necessary.

TAKEAWAYS

- Interprofessional education is important for future interprofessional collaboration and can be accomplished utilizing a team-based model often seen in primary care
- There is a big push to reduce healthcare costs by training physicians to be more cost conscious and to utilize value-based decision making
- An institutional culture that values respect and vertical integration from medical students to attendings is important to good teaching and success in a value-based care system
By Kate Carroll

What was at stake in this November’s election? It is no longer the economy, but the party in power still wound up suffering. Frommer’s analysis was that the Republicans put forth good, disciplined candidates, while the Democrats had more gaffes, however this was not an anomaly. Historical trends have shown that presidents lose seats in the six-year election. The party in power has never picked up Senate seats. The Democrats did slightly worse in the Senate compared to historical data and slightly better in the House. The only exception in this trend was in the sixth year of the Clinton administration.

Exit Polls (NBC) showed that the president had his lowest approval ratings of the term, but every president since Truman has had a lower approval rating than Obama’s current standing. Congress had a low approval rating as well, although it rose between pre-election and post-election polls. Only 20% of exit poll responders said that they trust the government.

The most important issues, according to American people, are the economy, health care, terrorism, and Ebola, while social issues were ranked much less important. Republicans were thought to better handle protecting the nation, the economy, and management of the government, while Democrats were favored for health care, same sex marriage, and immigration.

The future of healthcare funding is looking up. NIH is currently withholding 10% on all renewals, which happens whenever there is a continuing resolution. Funding has slowly been building back up from 2012 levels of $30.6B. We are winning the battle of the hearts of the nation for research funding – 80% of people think that federal support of research is a good thing, and only 4% believe that the federal government spends too much. Research is finding footing in Congress as well – the Pediatric Cancer Research Act was one of the only 184 laws to come out of Congress. The remaining challenge is that while everyone agrees that the NIH is a good body, Republicans will not increase the budget caps and Democrats will not take funding from any other programs. One big threat to research spending is that we are losing champions to retirement or flagging faith.

The priorities of the AAMC are to help academic centers figure out how to supplement grants. There is some hope for GME funding and positions, but fighting within healthcare ranks threatens our initiatives. The IOM called for a 34% average cut in GME per hospital and family physicians are recommending ending GME money for specialists.
Transformative Student Initiated Innovations in Medical Education

Moderator: Anu Atluru
Student, University of Texas Southwestern Medical Center Southwestern Medical School

By Allison Hunter and Catey Harwell
Duke Leadership Education and Development (LEAD) Program
Allison Webb, Duke University School of Medicine
The LEADership, Education, and Development (LEAD) Program is a formal student-led leadership curriculum created by medical students. The success of the 2012-2013 piloted version of the LEAD program was made fully available in the 2013-2014 first year medical students, and is planned to span all four years in a curriculum that involves team-building workshops, individual goal-setting, mentorship, leadership series, community projects, and finally a Capstone presentation on the leadership journey.

Quality Scholars Program
Lauren Groskaufmanis, Duke University School of Medicine
This program focuses on medical student driven quality improvement research and project development by way of an online curriculum and student-faculty mentorship pairings. Students complete online coursework and work with their faculty mentors to develop quality improvement projects. This project was first piloted in the spring of 2014 with five medical students and two faculty mentors and has since developed to include 15 medical students with an expanded scope to include interdisciplinary teams, supplemental curricular components with guest speakers, and facilitated student scholarship.

Students for a Better Healthcare System (SBHS)
Sean Maroongroge, Yale School of Medicine
Students for a Better Healthcare System (SBHS) is a student-initiated and organized community campaign that educates community members about healthcare reform and the Affordable Care Act. The intent is to improve health literacy in order to help everyday people obtain health insurance and learn how to navigate the healthcare system. Students deliver short PowerPoint presentations, print materials, and even an interactive map of primary care providers in the area to reduce barriers to access. So far, this project has reached more than 1,000 unique individuals with more than 50 presentations. This program and the associated materials are available to students interested in bringing SBHS to their own schools. SBHS.National@gmail.com

Student Designed International Ultrasound Projects
Yuanting Allison Zha, UC Irvine School of Medicine
This student initiative organizes international trips to teach and utilize ultrasound diagnostics in countries in which they would not otherwise be available. The trips focus on research, ultrasound education, and service. It relies entirely on student-driven curriculum development, grant and funding proposals, and the establishment of international contracts with transitional oversight from the Ultrasound Student Interest Group. To date, students have traveled to Romania, Turkey, Central America, India, Vietnam, Australia, and Tanzania to teach medical students and other medical professionals the fundamentals of ultrasound for anatomy, diagnostics, and research.

Columbia Human Rights Initiative
Erin Elbe, Columbia University College of Physicians & Surgeons
The Human Rights Initiative is a group of students and faculty that focuses on the development of events and initiatives that champion a human rights based approach to medicine. This group sponsors the Asylum Clinic, a medical clinic that provides free medical evaluations for individuals seeking asylum in the United States. The clinic is composed of a multi-disciplinary team of primary care providers, psychologists, social workers and legal professionals that provide services to ultimately become evidence as part of an asylum applicant’s legal case. Medical students are involved in physician recruitment, clinical administration, and the medical evaluation process. They are also active in writing the affidavit and may follow each case through the legal process to understand and witness final outcomes.
Does Money Matter? The Role of Financial Factors in Specialty Choice

Jay Youngclaus MS
Senior Education Analyst
AAMC

Marc Kahn MD, MBA
Senior Associate Dean for Admissions & Student Affairs
Tulane University School of Medicine

Natalie Cornay MD
Neurology Chief Resident, Northwestern Memorial Hospital

By AJ Blood

The first question addressed by this panel was whether financial concerns play an important role in specialty choice. Data is weak at best in linking debt to specialty choice (Acad. Med. 2005; 80:8-15). A study in 2005 using GQ found a weak relationship, but the effect was nullified by demographics. In 2006, a study of three medical schools over four years using real data found no relationship (Acad. Med. 2013; 88:16-25). Possible reasons for this are the financial incentives for primary care that are available and the importance of lifestyle. Physicians in any specialty earn high salaries: the estimated Net Present Value (NPV) of an MD degree is over $1 million, so unless you are paying $160,000/year in tuition per year, medical school is still financially gainful. Primary care is also financially viable for graduates with median levels of education debt.

The second question addressed was whether future remuneration drives specialty choice. The top six reasons from GQ data were personality fit, specialty content, role model influence, work/life balance, future family plans, and fellowship training options – financial gain was not amongst these reasons. Furthermore, data shows that half of first year attending physicians fall in the middle salary bracket of $181-270k, while about a quarter fall above and below that. Interestingly men and medical students graduating from private schools were more likely to go into higher paying specialties.

TAKEAWAYS

- Most medical students do not make a choice of specialty based on expected income
- Those students for whom income is rated as highly important are more likely to go into fields that have high incomes

RESOURCES

Debt Information Card
GHLO Collaborative Update

Jenny Samaan, PhD  
Founding Sr. Director  
AAMC-GHLO  

Donna Elliott, MD, EdD  
Student Affairs Dean  
Keck School of Medicine at USC

By Regina Kwon

Jenny Samaan, PhD, director of GHLO (Global Health Learning Opportunities), met with administrators to review this AAMC service and answer questions. GHLO recently released version 2.0 of its software. Also speaking were Dr. Donna Elliott, Dean of Student Affairs at Keck School of Medicine at USC, and Ahmad Nagy, a medical student from Egypt.

GHLO is a collaborative effort that medical schools and teaching hospitals can join as a host or a home institution or both. By joining, these institutions agree to specific procedural and legal standards, receive privileges to accept foreign students (host) or send students to foreign electives (home), and gain access to resources and tools that support global training programs.

Dr. Elliott shared the story of Keck becoming a GHLO institution. She described a complicated, one-to-many affiliation management problem. Although some exchange agreements remain, the majority have been transferred to GHLO. Keck maintains a single affinity agreement with GHLO and students can use a single application to apply to a wide range of electives.

Next, the audience heard from Ahmad Nagy, a sixth-year medical student from Egypt who experienced applying for and attending electives both before and after GHLO.

The session closed with Q&A. Please see the Resources section below for a link to the questions asked.

RESOURCES:
https://www.aamc.org/services/ghlo/
View Q&A notes online
Learner Mistreatment: From Fractured Perspectives to Unified Approach

Moderator: Sam Dail
Student, The Brody School of Medicine

Speakers:
David Acosta MD, FAAFP
Associate Vice Chancellor, Diversity and Inclusion
University of California Davis Health System

Sofia Noori
Student, University of California, San Francisco, School of Medicine

David Berg PhD
Clinical Professor of Psychiatry, Yale SOM

David Bracken
Student, University of Texas Medical School at Houston

Lauren Rafka
Student, Albany Medical College

By Sofia Noori, Kate Carroll

The “thing that hurts the learning experience most here and that results in a sense of mistreatment here is more a sense of disempowerment and disenfranchisement and vulnerability and inability to respond to an unjust evaluation or a resident who’s just an ********.” This quote is from an anonymous MS4, and paints a picture of medical education that was a recurrent subject at the AAMC Annual Meeting. Medical education is plagued by a culture of disrespect, and this panel urged that it is time to move in a new direction. Mistreatment begins very early in our educational system. At this point, some students have been primed to expect mistreatment and believe that it is needed to build resilience and character.

The panel discussed ways in which we can address and ameliorate learner mistreatment. Restorative justice is a model of healing that brings the victim, perpetrator, and community together with a facilitator to begin having meaningful dialogue about the incident. They identify the impact on the victim and others and review what harm was done. Finally, together they address what can be done to rebuild trust and restore community. It is based on four principles: 1) inclusive decision-making, 2) active accountability of the perpetrator, 3) repairing harm, and 4) rebuilding trust. The model invites participation by all parties and emphasizes restoration of the relationship, rather than judgment, sanctions, and punishment.

One example of restorative justice is the restorative justice community circle. This model brings together a trained facilitator, community representative, the person responsible, support for the person responsible, support for the harmed party, the most affected harmed party, and less affected harmed parties. The group participates in four rounds of discussion that focus on setting the agenda, sharing feelings and identifying the harm, sharing ideas for resolution, and final comments. This model enables medical professionals to respond to any form of perceived mistreatment in professional manner. It allows for a high stakes conversation to take place without fear of retribution. It also teaches skills to the parties involved about how to respond in an open, nonjudgmental, humble way.

Some of the challenges medical schools face in addressing this problem are resistance to cultural change, the hierarchy of healthcare education, subjectivity in clerkship grades, the status of students as consumers of education or clients of the school, which renders them in a position of powerlessness, and the lack of transparency in reporting mistreatment.
Jordan J. Cohen Humanism in Medicine Lecture: Emotionally Intelligent Healthcare

Daniel Goleman, PhD
Psychologist and Author of Emotional Intelligence and Social Intelligence: The New Science of Human Relationships

By Allison Hunter

In this session, Dr. Goleman details why empathy and the human capacities are critical to high performance in the healthcare arena. Physiologically, the limbic system and emotional centers of the brain are responsible for the translation of feelings, such as safety or threat, into memory. Therefore, understanding the social neuroscience behind the constant emotional interaction and exchange have implications in the modern patient-physician interactions, such as engaging the patient and keeping the focus on the interaction as opposed to the computer screen and other technology forms in the workplace. Without this careful attention, the physician cannot empathize or show compassion, which is critical in the practice of medicine.

The emotional intelligence framework is based on self-awareness, social awareness, self-management, and relationship management. Often times, social awareness has shown to be a challenge for students. Specifically, social awareness involves three kinds of empathy: cognitive empathy, social brain empathy (building rapport), and empathetic concern (taking time to hear all the patient’s questions). Teaching one type of empathy does not necessarily help with the other. However, Emotional intelligence (EI) can be learned and developed. One way to accomplish this is through the Emotional and Social Competency Inventory (ESCI), developed by Dr. Goleman and Richard Boyatzis of Case Western. This evaluation tool helps to establish an individual’s baseline intelligence in an effort to understand and develop these abilities. Admittedly, bad habits are hard to break and require mindfulness and a willingness to understand that the process may be uncomfortable as new neural pathways are developed and strengthened.

TAKEAWAYS

- Emotional intelligence (EI) is important in the patient-physician relationship
- EI, unlike IQ, can be taught, such as through the Emotional and Social Competency Inventory. It can be further developed with the right amount of instruction and breaking bad habits.