Among all the reasons given for conducting an interview as part of the medical school admissions evaluation, there is little mention of its use to determine that a school values personal interaction between human beings. In addition, there is also little said that the admissions process is not just a mechanical analysis of paper credentials and accomplishments, but rather a judgement of one's qualities as a human being and a future colleague. The process is also one that can provide institutions with an opportunity to place a human touch on a stressful, high stakes decision process. It also can demonstrate compassion for applicants, especially for those who have had temporary performance deficits due to illness, deaths in the family, or other problems.

The Association of American Medical Colleges (AAMC) has called for more emphasis on compelling personal characteristics in selecting medical students. A number of compelling personal characteristics are examined and some other practical alternatives are offered. Among these are the perceptions of others about the medical school if it were to reduce reliance on academic credentials. For example, mean undergraduate grade point averages and MCAT scores are used in determining the "best" medical schools by the U.S. News and World Report. However, setting a high threshold in MCAT scores, GPA, and USMLE performance may also damage efforts to identify students with prized personal characteristics.

Faculty believe only the best and brightest by academic measures should be admitted to medical schools. Poor outcomes of one or two students can be put in perspective by pointing out the good outcomes with 30 other students. If faculty members are willing to take risks of using a threshold approach for screening applicants and then admitting them on the basis of compelling personal characteristics, such attributes could be considered. AAMC President Jordan Cohen, M.D., suggests that undergraduate MCAT scores and GPAs should be only threshold measures used only after screening applicants with an assessment of their personal characteristics. He goes further to argue that admissions committees may find many instances where truly compelling personal characteristics "may overwhelm one or two isolated blemishes in the academic record."

Hospitals Resisting Computerization

Both major party candidates for the 2004 U.S. presidential race have called for computerization to reduce the 98,000 deaths said to be due to doctor, nurse, and hospital error. However, only a few dozen medical centers have made use of computer patient safety systems. Reported errors are indicated to be due to such activities as illegible handwriting, wrong drug prescriptions, improper dosages, or failure of physicians not knowing what another doctor ordered.

The Institute of Medicine (IOM) indicated in 1999 that by the end of the current decade most handwritten clinical data should be eliminated. However, IOM health care financing and quality expert, Janet Corrigan, indicates that many hospitals and doctors are cautious about the new technology, stating that computerized systems may never repay their cost. They also fear that current technology will be outmoded or may cost much less in a few years. Doctors also worry that using computers to write prescriptions and order tests will detract from time spent with their patients.

In Los Angeles' Cedars-Sinai Medical Center, for example, doctors rebelled last year because the computerized system installed was too great a distraction from medical activities. This was in spite of the fact that two-thirds of the 870-bed hospital complex already had its system installed. As a result, the system was withdrawn. However, 300 of the 4,900 non-governmental U.S. hospitals have already installed computerized systems in response to the IOM report. This year, it is expected that an additional 118 hospitals will comply with the IOM standard referred to as the Leapfrog Group.

Seattle's Boeing, a major employer in the area, indicated that beginning July 1, 2004, it would pay 100 percent of patients' bills only at hospitals that meet Leapfrog's goals. Other hospitals in its large network will require employees to pay five percent of charges. The American Hospital Association reported that an average hospital will have to pay $7.9 million to install a system. The Joint Commission on Accreditation of Healthcare Organizations plans to publicize those hospitals that use practices it defines as safe while not formally endorsing computerized systems.

(In Freudenheim, M. "Many hospitals resist computerized patient care." New York Times; April 6, 2004.)

Innovative Responses to Reduced Medical Resident Work Hours

With the regulations established by the Accreditation Council of Graduate Medical Education (ACGME) governing the working hours of residents, some surgical programs are employing nurse practitioners or physician assistants to assist in compliance.

Among 180 attendees at the 2003 Residency Coordinators/Administrators Workshop for Surgery and Surgical Specialties, 46 returned a survey. The survey attempted to determine what type of administrative procedures departments are using to support resident activities and limit work hours. In addition, it tried to determine the level of acceptance of work-hour regulations by residents and faculty.

The most common way of complying with duty-hour regulations was hiring physician assistants or nurse practitioners (30 percent) and the use of internet-based software applications to track the work of residents. These changes appeared to be less acceptable to senior faculty and senior residents compared to their junior counterparts. It is believed that hesitance to change senior residents and senior faculty was possibly because they were accustomed to an alternative system. It was hypothesized that this may improve with time.

Geriatric Vertical Curriculum Assessment

Geriatric content in the medical school curriculum is being reported as being on the increase. This creates a challenge of expanding content without lengthening the already packed program. Using a vertical curriculum has been employed as a method to address this challenge. Vertical curricula are those that longitudinally incorporate content into existing courses throughout the four-year curriculum. They are further defined by a set of educational objectives.

Methods to assess curriculum content in geriatrics currently include direct faculty observation, test-question analysis, student reports, and the self-report of the course director. The availability of learning objectives allows for the monitoring of the vertical curriculum in geriatrics. The American Geriatrics Society (AGS) developed core competencies for the geriatric curriculum in medical schools that includes attitudes, knowledge, and skills. A 123-item assessment tool was established by the authors requesting the topic, time allocated, date, and the name of lecturers in geriatrics. The nine categories included in the analysis of the vertical curriculum were:

- Attitude
- Knowledge Related to Basic Service
- Knowledge Related to Clinical Practice
  - Common Geriatric Syndromes
  - Diseases and Disorders
- Knowledge of Psychosocial Issues
- Knowledge of Prevention
- Knowledge of Ethical Issues in Geriatric Care
- Knowledge of Health Care Financing
- Knowledge of Cultural Aging
- Skills

(Fleazer G.P.; Liken M.; Hirth V.A.; Johnson D.; Lucas A.; Egbert J.; Boland M.A.; Wieland D. "Assessing geriatrics content in undergraduate medical education: Two approaches." Gerontology and Geriatrics Education. 24 (3); pp. 1-8; 2004.)

Future of Primary Care in Danger

While students come to medical school wanting to be someone’s doctor, by the time they leave medical school training, they have changed their minds. So says Lisa Sanders, M.D., a 1996 graduate of Yale’s medical school. She indicated that even Yale, a school with a reputation for super specialization, had made its mark in primary care. There were the Primary Care Club and the Primary Care dinners, where speakers were invited to talk about the future of primary care medicine. These speakers talked about the important role primary care was to play in health care in America. This influenced Dr. Sanders to enter a primary care residency and then to join Yale’s primary care program faculty.

She now fears that primary care is in danger with applications for such training plummeting. When Dr. Sanders applied for her residency, there were almost a 1,000 graduates who were applicants for 30 positions. Today this has dropped to just more than 500. Over the past decade, the number of applicants for primary care residencies has dropped by more than a third. Dr. Sanders questions if the idea of the personal physician is out of date. Patients are increasingly choosing to visit the emergency room and specialists directly.

(Sanders L. "The End of Primary Care." New York Times Magazine; April 18, 2004.)
Among all the reasons given for conducting an interview as part of the medical school admissions evaluation, there is little mention of its use to determine that a school values personal interaction between human beings. In addition, there is also little said that the admissions process is not just a mechanical analysis of paper credentials and accomplishments, but rather a judgement of one's qualities as a human being and a future colleague. The process is also one that can provide institutions with an opportunity to place a human touch on a stressful, high stakes decision process. It also can demonstrate compassion for applicants, especially for those who have had temporary performance deficits due to illness, deaths in the family, or other problems.

The Association of American Medical Colleges (AAMC) has called for more emphasis on compelling personal characteristics in selecting medical students. A number of compelling personal characteristics are examined and some other practical alternatives are offered. Among these are the perceptions of others about the medical school if it were to reduce reliance on academic credentials. For example, mean undergraduate grade point averages and MCAT scores are used in determining the "best" medical schools by the U.S. News and World Report. However, setting a high threshold in MCAT scores, GPA, and USMLE performance may also damage efforts to identify students with prized personal characteristics.

Faculty believe only the best and brightest by academic measures should be admitted to medical schools. Poor outcomes of one or two students can be put in perspective by pointing out the good outcomes with 30 other students. If faculty members are willing to take risks of using a threshold approach for screening applicants and then admitting them on the basis of compelling personal characteristics, such attributes could be considered. AAMC President Jordan Cohen, M.D., suggests that undergraduate MCAT scores and GPAs should be only threshold measures used only after screening applicants with an assessment of their personal characteristics. He goes further to argue that admissions committees may find many instances where truly compelling personal characteristics "may overwhelm one or two isolated blemishes in the academic record."