

The Front Line

A newsletter for preceptors of the
UNC-CH School of Medicine

The University of North Carolina at Chapel Hill - Office of Educational Development

Volume 6 Fall 2000

Mayer Society To Induct Preceptors

This year for the first time, the Eugene S. Mayer Community Service Honor Society at the School of Medicine will induct preceptors as members. The society was established in 1994 to recognize medical students for community service. The first step in expanding the membership opens it to preceptors who work with first- and second-year students and who have made important contributions through service activities in their communities.

The induction of newly selected members will be the culmination of the medical school's Community Service Day on Saturday, February 17. Earlier in the day, student inductees will present a poster session of their work, and three audiovisual presentations of their community service projects will be given by students selected by the board of the Mayer Society. The guest speaker for the induction luncheon had not been announced at press time.

Preceptors coming to Chapel Hill for Community Service Day are welcome to attend the Lawrence Zollicoffer Lecture and Banquet the previous day. This annual event, named in honor of the School of Medicine's fourth African-American graduate, is designed to commemorate more than 30 years of

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Grant to Help Address Minority Clinician Shortage

The Health Careers Opportunity Program of the U.S. Bureau of Health Professions has awarded UNC a five-year, \$2.36 million grant to conduct activities to increase the number of minority and disadvantaged students entering the health professions with the ultimate aim of improving access and quality of health care for disadvantaged North Carolinians.

The UNC-CH Health Careers Opportunities Program (HCOP) is a collaborative effort of the Office of Educational Development in the School of Medicine and the following partners: the School of Dentistry; North Carolina Health Careers Access Program; the Student National Medical Association chapter; the undergraduate campuses of ECSU, FSU, NC A&T, NCCU, UNC-CH, and UNC-P; the Chapel Hill-Carrboro, Durham, and Orange County public school systems; and the state's nine regional AHECs.

Studies have found that health professionals who are members of minority groups are more likely to practice in underserved areas and to care for disadvantaged patients. The shortage of practitioners from minority and disadvantaged backgrounds contributes to the inability of vulnerable populations to access adequate health care. Despite significant increases in the numbers of disadvantaged students gaining admission to the state's health professions schools over the past three decades, the latest reports of Health Professional Shortage Areas show that North Carolina remains behind the national average in almost every major health manpower category. Although one quarter of the state's population is made up of minorities, only 4% of the state's physicians are African-American, 0.86% are Hispanic, and 0.2% are Native American.

The UNC-CH HCOP partnership will work to identify, recruit, and support qualified minority and disadvantaged students interested in health

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Briana Webster develops skills in
Research Apprenticeship Program.

Profile of the Class of 2004

The Class of 2004 at the UNC-Chapel Hill School of Medicine comes with impressive credentials. Average MCAT scores for the entering class are 10.23 in physical science, 10.49 in biological science, and 10.08 in verbal reasoning. Undergraduate grade point averages are 3.53 for biology and chemistry and 3.62 in all other courses. Biology was the most popular undergraduate major (pursued by 62 of the 160 class members), followed by chemistry, psychology, and biochemistry. Twenty-six other majors are also represented.

Offers of admission were made to 175 of the 750 North Carolina applicants and 45 of the 1924 out-of-state applicants. Of those, 140 North Carolinians and 20 out-of-state students accepted and enrolled. Repeating a pattern seen in the past, the largest number of new students (43) come from UNC-Chapel Hill, followed by Duke (15) and N.C. State (8). The remainder of the class attended a total of 68 other undergraduate institutions.

The entering class is composed of 84 men and 76 women, and the racial/ethnic distribution is 111 white, 22 African-American, 21 Asian-American, 2 Hispanic, 2 Native American, and 2 other ethnicity. The age range of new students (based on age at application) is 18 to 47, with an average age of 23.3. Thirteen members of the class hold master's degrees, and two have earned a doctorate prior to enrolling in medical school.



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Conferences and Continuing Education

JANUARY

18-19

Challenges in Geriatric Practice: 12th Annual Conference. The Friday Center, Chapel Hill. (Contact Dail White, 919-962-2118.)

FEBRUARY

17

Community Service Day and Mayer Society Induction (students and preceptors). UNC Campus. (Contact Suzanne Marchionini, 919-966-6405.)

23-24

7th Annual Community Faculty Workshop. Greenville Hilton, and Monroe AHEC Conference Center, Greenville. (Contact Katherine McGinnis or Mary Esther Sabados, 252-816-3082.)

MARCH

7-9

25th Annual Internal Medicine Conference. The Friday Center, Chapel Hill. (Contact Dail White, 919-962-2118.)

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minority presence in the medical school, to increase awareness of minority health issues, and to introduce students to dynamic minority role models in the field of medicine. L. D. Britt, M.D., Brickhouse Professor and Chairman of the Department of Surgery at Eastern Virginia Medical School, will deliver the 2001 Zollicoffer Lecture.

For more information or to register for any portion of the weekend, preceptors may call Suzanne Marchionini in the Office of Student Affairs, 919-966-6405.

The White Coat: Apron, Satchel, Badge

First instituted at the UNC School of Medicine in 1996, the White Coat Ceremony for first-year medical students has become a fall tradition, the culmination of activities of the annual Family Day. The ceremony is meant to emphasize the importance of physicians' caring *about* their patients as well as *for* them. After the keynote address, students receive their first white coats and recite an oath of commitment to the values of medicine.

Keynote speaker at the fifth annual ceremony in September was Stewart Rogers, M.D., member of the AHEC faculty in internal medicine at Moses Cone Hospital in Greensboro and 1973 graduate of UNC School of Medicine. The comments below were excerpted from his address.

The white coat is an **apron**, a **satchel**, and a **badge**. Like cooks and blacksmiths, we have a messy job, and we need an apron to keep the stains off our street clothes. Fluids and feelings, blood and tears, are part of our business, and our work is up close and very personal, but we need to stay clean and calm—for the next patient, for our families, for our peace of mind. We have to worry, after all, about our own blood and our own tears, and we assume a white coat of detachment and equanimity for professional distance—work space for our techniques of healing and a defense against “burn-out.” At the same time, we cannot heal without empathy; the distress of our patients must echo somewhere in our own experience, our reading, our imagination, or we will fail to understand and our response will be misdirected or fall short. So the white coat is an apron, not a suit of armor, and you'll appreciate the design—it opens over your heart.

The coat is white, of course, to show the stains or, rather, to back-

light your purity. Never forget that the worst stains spill from your own character: from neglect, impatience, or greed. These spots are best seen at night when you take off the coat—that's why it's white on the inside.

The white coat is also a **satchel**.



Students and faculty line up for White Coat Ceremony.

**"This coat will
fit better and
last longer if you
do not wear it
all the time."**

You will soon find and appreciate the large pockets that, for most modern doctors, have replaced the black bag. You won't have much to place in those pockets today, but one of your principal tasks in training will be to load them with the tools and manuals that are most useful when you see your patients. The tools, in general, enhance your senses; the manuals annex and enlarge your memory. I've noticed, in myself and others, that patient care decisions are largely determined by the tools, skills, knowledge, and attitudes that

we have selected to carry with us as we work. For the next few years, you will rotate through many disciplines, and the contents of your coat pockets will be dictated by others and will have short half-lives, but gradually you will focus, dig in somewhere, and load your own pockets. There will be no shortage of advice about what is most important to have about you, but today is my turn, and I have three suggestions—not in any way exhaustive or even prioritized, but ones that are sometimes overlooked.

My first suggestion is simple **gratitude**. Your tuition at this school covers a small fraction of the cost of your medical education. Most of the rest is paid for you, directly or indirectly, by taxpayers, including millions of low-wage workers who comprise the large majority of the uninsured. You are already several weeks into a career debt to these people; stick a reminder somewhere in your white coat today and get it out when you set the access to your future practice.

A second resource for your coat pocket is a proper appreciation for the **social history** of your patients. We are not veterinarians—our patients are fellow humans with much shared experience that can be used to build trust and mutual respect. Often social circumstances will suggest clinical risks and exposures or may have a large impact on the patient's attitudes toward questioning and medical care. Finally, in most settings, implementing your care plan requires mental, social, and financial resources that may well be deficient, and a biologically sound plan may founder on social limitations. Can your patient even afford what you prescribe? Don't you think you should ask?

My last suggestion concerns the neurological exam and specifically what is called "**mental status**." This

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Challenging Cases

Challenging Cases is a regular feature in *The Front Line* intended to assist you in your role as a preceptor. It needs preceptor input in two areas. First, the editor is seeking suggestions for cases to be considered in future issues. If you have encountered a “challenging” situation with a student (or course director or university administrator) during your precepting, please consider sharing it through this feature as a teaching/learning tool. Fictional scenarios—cases that one might encounter—are also acceptable. Second, volunteers are also sought who are willing to serve as commentators on the general precepting issues the cases present.

If you will help in either of these ways, please contact Katherine Savage, newsletter editor, at UNC-Chapel Hill, Campus Box 7530, Chapel Hill, NC 27599-7530.

Case

“You have just observed a fourth-year student complete a history and physical on a schizophrenic man who needed an update on a disability form. The patient is a heavy smoker, and his appearance was somewhat disheveled. During the visit, the student was hostile and abrupt to the patient, avoided eye contact, and didn’t listen to his complaints. The student tells you that he never wants to see a patient like this again, and hates filling out forms. How do you respond?”

Isaac Miller, III, M.D., Halifax Medical Specialists, Roanoke Rapids: I would approach this problem in both a constructive and firm manner. An extended concern would be the relationship of the student to patients in the past like the one in this case.

The student should be made aware that we participate in a privileged profession that includes trust, humility, and unselfishness in the help and

“The student should be made aware that we participate in a privileged profession that includes trust, humility, and unselfishness in the help and care of all individuals.”

care of all individuals. Any individual considering or training to become a part of medicine should well understand that there will be many patients and situations that are personally undesirable; however, our commitment to help and care supersedes any attitudes of disrespect, dishonesty, or ethical/moral indiscretions.

There are many avenues of approach that facilitate and encourage satisfaction in the patient and physician relationship in meeting the necessary goals of the contract. I would probably encourage role playing between myself and the student to illustrate my point and assist the student in sensing the hostility and disrespect that he showed to the patient.

As a preceptor, it becomes extremely important to address these concerns as soon as possible in order that reoccurrences or future misunderstandings will not be allowed to develop. It may also be helpful to investigate with the student any personal background or circumstance that may precipitate such behavior and attitude towards patients of various backgrounds and problems. If a fundamental problem is discovered, necessary corrective action would be in order, seeking appropriate resources.

Timothy Carey, M.D., Professor of Medicine and Director of Sheps Center for Health Services Research, UNC-CH: Like many challenging cases in precepting situations, making lemonade out of the “lemon” of a disability determination problem is a learning opportunity for everyone. Filling out forms for patients is essentially always a nonproductive-feeling activity. However, the patient’s ability to keep a roof over his head and food on the table is dependent on these forms being filled out on a periodic basis. In this sense, the physician functions as a gatekeeper to medical disability benefits.

The history of government-supplied disability is an old and not particularly honorable one. Historically, Western societies have divided poor individuals who do not have gainful employment into “wor-

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Challenging Cases

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thy poor” and “non-worthy poor.” The non-worthy poor would receive only subsistence governmental assistance (if that). The “worthy poor” might receive additional benefits including housing, better food, etc. Over the centuries, society’s definition of “worthy poor” has varied substantially and has variously included individuals who are physically ill, sometimes the mentally ill, sometimes substance abusers, and frequently women and children. For obvious reasons, it has been a social and political construct as to who is or is not considered “worthy.”

“The student may be falling into the trap of considering the patient 'not worthy' of the disability benefits and, therefore, interpreting the presentation as a waste of his time.”

The patient described has a serious psychiatric illness but no visible stigmata of a medical illness. In addition, his schizophrenia may be poorly controlled, leading to his disheveled appearance, poor eye contact, etc. The student may be falling into the trap of considering the patient “not worthy” of the disability benefits and, therefore, interpreting the presentation as a waste of his time.

Two minutes spent with the learner to place the visit in both a medical and a social context prior to sending him into the room would absolutely be time well-spent in this situation. In addition, providing the student with a reading regarding the role of sociability programs in the medical office, in addition to the role of the medical certification of work disability, might be helpful. One useful reference might be “The Role of the Primary Physician in Disability Determination for Social Security Insurance and Worker Compensation” by Carey and Hadler in *Annals of Internal Medicine*, vol. 104, 1986.

Working with the student to explain why the patient has appeared in the office and how the request for “filling out forms” fits in with supporting this individual in a non-institutionalized environment, and describing some simple methods by which to reduce physician frustration, are always helpful. Working with the patient to drop off the forms a day or two prior to the visit and using nursing or administrative personnel to fill in nonclinical data (number of visits in the past year, recent hospitalizations, etc.) can save quite a bit of time.

The White Coat

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dimension of clinical inquiry, uniquely human, largely determines the experience of illness yet is rarely emphasized in physician reports; when mentioned at all, it is often reduced to those aspects that we share with other livestock like alertness and agitation. I seldom hear the mental faculties fully described. I almost never hear of a patient’s Creativity, Conscience, Humor, Kindness, Generosity, or Courage. Are these clinical issues? Perhaps not, but some thoughts in these directions might enhance your sensitivity to suffering and to the meanings and goals of your work.

Finally, the white coat is a **badge**, a hallpass in the medical center and a token of prerogative in society. Its meanings are many: some are trivial or pretentious, others are practical or even noble.

It can say, “I burned up the MCAT.”

Or it can say, “I’m here to help.”

It says, “Don’t slow me down.”

Or it says, “You are the only person who matters right now.”

It says, “If you were more like me, you wouldn’t have that problem.”

Or it says, “Let’s see if my strength can serve your need.

Next time our roles may be reversed.”

These are some of the uses and some of the meanings of the white coat that you are about to receive. There is also a warning, in fine print, that some of you may forget to read: “This coat will fit better and last longer if you do not wear it all the time.” Remarkable as it is, your white coat will not exhaust all your talents or meet all your needs. So hang it up sometimes, even during medical school. Walk over to this beautiful campus, go to the gym, take in a concert or play, call up a friend, read a book. Wear your *old* coats and, from time to time, go out and shop for a new one. And when you do wear your white coat: As my father always said when I got new clothes, “Wear it in good health.”

Sexual Harassment in Medical Education

Marco A. Aleman, M.D., Department of Medicine, UNC-CH

Sexual harassment is a type of medical abuse that usurps the rights and trust of those students subjected to it, negatively influencing their academic and professional advancement in a manner unrelated to their scholastic or clinical performance. This type of abuse of medical students may occur in any stage of their education but is more likely to occur in the clinical years. It affects a greater proportion of women than men and is usually perpetrated by those in power positions, i.e., supervising attending faculty and/or resident physicians. Students perceive specialties where the number of women is small (e.g., surgery) to be more hostile to women versus the specialties of pediatrics, obstetrics-gynecology or psychiatry, where the number of women is higher.

A recent AAMC Graduation Questionnaire found that harassment diminishes both the victims' level of confidence regarding mastery of clinical skills and their level of satisfaction with supervising attending faculty and residents and the quality of their medical education. Unfortunately the effects of sexual harassment extend be-

“Microinequities’ include language that minimizes women, treatment of women as invisible, negative perceptions of women’s abilities based on gender, and elimination of women from informal networks.”

yond the classroom and clinical educational environment. One longitudinal study of medical students, which adjusted for preexisting psychopathology, showed that those students with one or more episodes of abuse are more likely to have subsequent problems with depression or alcohol abuse. Women who experience sexual harassment and sexual discrimination report a variety of stress-related symptoms: sleep disturbances, headaches, loss of appetite, chronic fatigue, anxiety, depression, and feelings of alienation, anger, fear, humiliation, or vulnerability. Additionally, sexual harassment may harm professional working relationships and is likely to jeopardize patient care.

Sexual harassment occurs when there are repeated and unwanted sexual behaviors or the creation of a hostile environment in the work place (or, in our case, the academic learning environment). The first definition is “quid pro quo” or “bargain” harassment. Here, “academic consequences are explicitly or implicitly tied to a student’s compliance with, or rejection of, unwanted sexual demands.”* For example, a student’s course grade is dependent on her response to a sexual proposition by a supervising resident or attending physician. The second definition is “environmental” or “hostile environment” harassment. It is more difficult to understand and may include exposition of pornography or an environment burdened with sexual language, gestures, or innuendo.

There are also gender-based behaviors, “microinequities,” that although not actionable within the law, still contribute to a hostile environment. These include language that minimizes women (e.g., calling your receptionists “girls”), treatment of women as invisible (e.g., not offering as many procedures to a woman medical student), negative perceptions of women’s abilities based on gender, and elimination of women from informal networks.

We as members of the medical education community are charged not only with the education of students, but are also responsible for the inculcation of the attitudes, behavior, skills, and values that are appropriate for a physician. We must promote professionalism at all times and model the behavior that would engender the trust, respect, and support of the entire medical community. It is only in this safe environment that a student can best learn not only the clinical skills but also the professional attitudes that are necessary to be a physician. We must promote a lack of tolerance of sexual harassment in every aspect of our practice (office, hospital, classroom) and work to create and promote guidelines for educating all of our colleagues regarding this matter. If we do not, we risk losing yet another generation of students who, after suffering sexual harassment, may go on to promote this behavior to their future students and residents.

*Nora LM. Sexual harassment in medical education: a review of the literature with comments from the law. *Acad Med* 71(1): 113S-118S, 1996.

Grant to Help Address Minority Clinician Shortage (continued from page 1)

careers at every stage of the educational pipeline. Program director will be Assistant Dean Larry Keith, Director of Special Programs and Associate Director of the Office of Educational Development, who is also Director of Recruitment for the medical school. He directs the nationally recognized Medical Education Development Program for college and post-college students that is the centerpiece of the project. Keith also directs two other programs that are key components of HCOP, the Health Professions Partnership Initiative (HPPI) and the Research Apprenticeship Program (RAP), both designed for pre-college students.

Established in 1996 with start-up funds from the Robert Wood Johnson Foundation and the schools of Medicine, Dentistry, and Nurs-



Larry Keith (left) hosts annual Recruitment Seminar on UNC campus.

ing, HPPI works with three local school systems to provide a continuum of information, experiences, and skills development for minority middle and high school students to increase their preparation for health professions education programs. Students with the potential to pursue health careers are identified and brought to the UNC-CH campus for summer programs.

Summer Experience I for rising 9th and 10th graders is designed to raise their awareness of the broad

range of health careers available and to give them information about the level of academic achievement required to successfully pursue a health professions education and career. The following year, students are invited to participate in Summer Experience II, where they work as research assistants on selected faculty research projects in nursing, dentistry, and medicine. The third phase of HPPI focuses on college planning and intensive career development.

For rising high school seniors, the next point in the School of Medicine's pipeline is the Research Apprenticeship Program (RAP). Each summer RAP brings 20 promising disadvantaged students from across the state to Chapel Hill for a seven-week residential program. Through hands-on experience in clinical and basic science laboratories, RAP students develop competence in scientific research, learn about biomedical science careers, and interact with faculty mentors. Additionally, academic enrichment activities, such as scientific writing seminars, enhance students' potential to pursue science at the college level.

The third program administered by Special Programs at the medical school is the Medical Education Development (MED) Program. MED focuses on disadvantaged students who are either admitted and preparing to enter the medical or dental school, or rising college seniors or postgraduates who plan to apply to medical or dental school. They are introduced to the rigors of the first-year medical and dental curricula through a nine-week,



Students compare notes at Health Professions Recruitment Seminar.

structured summer program that simulates as nearly as possible the first semester of professional education. The curriculum is built around a core of basic science content.

"MED [gives students] an opportunity to prove themselves and increase the likelihood of their admission to health professions schools."

MED students have the opportunity to become comfortable with the professional school environment and to form academic and social support networks with peers and upperclassmen. They also receive training in academic skills. The program provides unique information for assessing candidates who may not otherwise have optimal credentials for admission, thus giving them an opportunity to prove themselves and increase the likelihood of their admission to health professions schools.

Larry Keith hopes to combat the national trend of declining numbers of disadvantaged applicants by funneling more qualified students into the pipeline through the programs offered by his office and by the other members of the UNC-CH HCOP partnership.



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Information Please

From THINCnet to NC AHEC Digital Library: a new look and a new address

Last autumn we introduced you to THINCnet and the new electronic resource, MD Consult. Since then, many new and exciting electronic resources have been added to the site. The North Carolina AHEC Program received a generous grant from the Duke Endowment to help make these resources available to you. A redesign of the original THINCnet began early in 2000, and with these changes in design came a new electronic address and a new name: AHEC Digital Library <<http://library.ncahec.net/>>.

The Digital Library is a statewide electronic network of quality resources and services. It is designed to be the first-choice portal to the Internet for all NC health care professionals to support their clinical and educational needs. Although anyone may access the AHEC Digital Library as a guest, AHEC preceptors are eligible to use the licensed resources on the site. To access these resources, you will need an AHEC Digital Library user account that you may acquire by contacting your local AHEC librarian or ORPCE.

The redesign of the page begins with a help bar at the top of the page. Help includes links to each North Carolina AHEC and its library, health topics in the news, answers to frequently asked questions, email feedback for your suggestions and questions, and a site map that lists all resources in the Web page. The central focus of the page is the collection of electronic resources, grouped into three categories: Clinical Resources, Communication & Networking, and Continuing Education.

Clinical Resources gives you instant access to literature searching, full text journals and textbooks, drug information, treatment guidelines, disease/health topics, and patient education (see Summer 2000 issue of *The Front Line* for a description of patient education sites).

Communication & Networking links you to Web pages from North Carolina medical and other health-related schools and universities, state and national associations and their meetings, state health agencies and departments, grand rounds, and preceptor/faculty support.

Continuing Education provides listings of continuing education programs from Duke, East Carolina University, UNC-CH, Wake Forest, and the nine AHEC centers in the state, as well as online learning opportunities. Continuing education is also listed by health specialty. Information about AHEC Spanish Language and Cultural Competency resources/classes and other similar sites is listed.

Future improvements will include the ability to create your own collection of resources from the AHEC Digital Library: You will be able to choose the sites you use most often and group them as you wish. Feedback from users will continue to provide valuable guidance in adding new resources. The long-term goal of the AHEC Digital Library is to make this resource available to all health care professionals in North Carolina.

If you have any questions about your eligibility or need assistance logging in, please contact your AHEC librarian or Betsy Dain, ADL Resource Development Project Coordinator at HSL, UNC-CH, (919) 966-1213 or dain@email.unc.edu.