

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 7 Fall 2001

Class of 2005

The School of Medicine Class of 2005 has an enrollment of 85 women (53%) and 75 men (47%). It is an ethnically diverse class. Of the 160 students, 116 (73%) are white non-Hispanic, 21 are African-American, 10 are Asian-American, two are Hispanic, two are American Indian, and nine are of other ethnicities.

Although 58 first-year students were born in North Carolina, 142 resided in the state at the time of application to medical school. The largest number of students—58—graduated from UNC at Chapel Hill. Twenty-one graduated from Duke, seven from North Carolina State University, and two from Wake Forest University. The most popular undergraduate major was biology, pursued by one third of the new class (58 students). Other popular majors were chemistry (18 students), psychology (12), and biochemistry (8). Nineteen students completed double majors. The average undergraduate GPA for the class as a whole was 3.64. Eleven members of the class hold advanced degrees.

The MCAT scores of the entering class were high: 10.48 on physical science, 10.53 on biological science, and 10.19 on verbal reasoning. This continues the upward trend in MCAT scores of admitted students.

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What Do Preceptors Expect Students to Know?

What do preceptors expect students to know and be able to do when they start a community-based rotation? Do they find the students they precept to be well-prepared, or do they think that additional background would be helpful?

Dr. Cornelius Cathcart of Henderson Pediatrics is a long-time preceptor of fourth-year students in the Ambulatory Care Selective (ACS). He expects students to come in with the skills to evaluate and work with patients so that they can focus on the finer points of the history and physical. The majority of ACS students he has precepted have been well-prepared, with a good basic fund of knowledge.

Sometimes a student who does not want to be in pediatrics does not take advantage of the opportunity to learn as much as possible on the rotation. But Dr. Cathcart has found that ACS students come with a knowledge of what the rotation is supposed to be and with ideas already in place about what they want to get out of it. Thus he is able to start working with them right away to achieve their goals. When he has worked with students from other programs, he has often had to spend a great deal of time assessing them and helping them decide what they want from the experience. He finds that students who already have a clear idea of what they want benefit the most.

Dr. Cathcart, who also precepts family nurse practitioner and first-year medical students, noted that if rotations in the community were a little longer, they would allow for more of a continuity experience. He suggested that to prepare students better for community practice, the curriculum should incorporate some understanding of the business side of practice.

Dr. James Parsons of Eden Internal Medicine precepts UNC students in the Medicine Clerkship and in Introduction to Clinical Medicine (ICM). The first week they come to his practice, Dr. Parsons hopes to get first-year ICM students beyond simply shadowing so that they develop some



Dr. Cornelius Cathcart responds to interview questions.

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Connolly Named Clerkship Director



Dr. Connolly

AnnaMarie Connolly, M.D., has been named director of the third-year clerkship in Obstetrics and Gynecology. The six-week clerkship offers rotations at AHEC sites in Asheville, Charlotte, Wilmington, and Raleigh, as well as at the newly opened Women's Hospital at UNC in Chapel Hill.

Dr. Connolly is a cum laude graduate of Mount Holyoke College, where she received the Abby Howe Turner Award for Excellence in Biological Science. She received her Doctor of Medicine degree from Tufts University School of Medicine and completed her residency and a fellowship in

urogynecology and reconstructive pelvic surgery at the University of North Carolina at Chapel Hill. During residency, she conducted research on trauma in pregnancy. She spent several years in private practice and joined the faculty of UNC in 1999 as an assistant professor of obstetrics and gynecology.

Dr. Connolly's responsibilities for medical student education include not only directing the clerkship but also directing the Reproductive Biology course required of all second-year students. She has also served on the course faculty of Introduction to Clinical Medicine as a tutor. Her professional affiliations include membership in the American Urogynecologic Society, International Continence Society, Sigma Xi scientific research society, and Alpha Omega Alpha medical honor society. She is a fellow of the American College of Obstetrics and Gynecology.

As co-director of the Teaching Scholars Program in the School of Medicine, she works with faculty and staff from the Office of

Educational Development to promote expertise in medical education through a faculty development program for a select group of UNC faculty nominated by their departments.

Conferences and Continuing Education

JANUARY

17-18

Challenges in Geriatric Practice: 13th Annual Conference. The Friday Center, Chapel Hill. (Contact Deirdre Boyer, 919-962-2118.)

26

Mountain AHEC Preceptor Development Program. Bridge Building, Asheville. (Contact Norma Beaty, 828-771-3433.)

FEBRUARY

14

Cardiovascular Issues in Women. The Friday Center, Chapel Hill. (Contact Ken Taylor, 919-962-2118.)

16

Community Service Day. Carolina Inn, Chapel Hill. (Contact Suzanne Marchionini, 919-966-6405.)

16

Pain, Addiction, and the Law. The Friday Center, Chapel Hill. (Contact Deirdre Boyer, 919-962-2118.)

22-23

8th Annual Community Faculty Workshop. Greenville Hilton and Monroe AHEC Conference Center, Greenville. (Contact Mary Esther Sabados, 252-816-3082.)



OFFICE OF EDUCATIONAL DEVELOPMENT

The Front Line is published by
The Office of Educational Development, School of Medicine,
University of North Carolina at Chapel Hill, CB #7530,
MacNider Building, Chapel Hill, NC 27599.

Phone: (919) 966-3641

<http://www.med.unc.edu/oed/frontline/>

EditorKatherine Savage, M.A.

Katherine_Savage@med.unc.edu

Editorial Advisory Board:

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HIPAA Regulations and the Community Physician Preceptor

by Donald C. Spencer, M.D., M.B.A.

Clinical Associate Professor of Family Medicine; Director, UNC Family Practice Center

What is important about HIPAA? What does the precepting physician working with medical students need to know? On the light side, you should resist all impulses to think of the hippopotamus and spell the abbreviation for the law incorrectly with two P's instead of one. The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, is a large body of law with aspects that will affect not only patient care, but teaching and research as well. To begin thinking about the law, you should understand the history and intent of the regulations, the basic structure of the relevant sections of the law, and three basic "getting started" principles.

While most physicians think about privacy regulations when they hear the acronym HIPAA, the law is much broader than privacy alone. As the full name implies, the law grew out of a need for health insurance standards after the Clinton health plan failed to pass in the early 1990's. The intent was to improve health insurance availability, decrease health insurance fraud and abuse, and simplify administrative aspects of health insurance.

This last section of the law is called **Administrative Simplification** and contains the regulations of current interest to physicians. The health care industry pushed for the aspects of the law that would simplify the maze of insurance forms and varying standards. This current confusion increases the cost of administrative overhead and confounds physicians and patients alike. While these aspects were largely applauded by the health care industry, they came at a price. The privacy and security sections of the law were meant to address public concerns even as standardization and computerization of protected health information (PHI) benefited the industry.

The Department of Health and Human Services (DHHS) has made a financial estimate that the cost of implementation of HIPAA will be \$17.6 billion over 10 years, which largely relates to the higher privacy and security standards. However, DHHS is also quick to point out that the financial savings of administrative simplification through insurance-related, computerized standards will be \$29.9 billion. While the government notes this large net positive benefit, critics say that the costs will be "up front" for the industry while the financial benefits are more distant and uncertain. Aspects of the law have been so controversial that DHHS received 52,000 public comments during an extended comment period after publication of the initial regulations in November 1999 and then received an additional 11,000 in April 2001 after the new Republican administration came to Washington.

The structure of the Administrative Simplification section of HIPAA is divided into four basic parts: Electronic Transactions & Codes, National Identifiers, Security, and Privacy. The law covers a health care entity (provider, health plan, or health care clearinghouse) that transmits any health information in electronic form. Since most doctors submit at least some of their insurance claims electronically, they would come under applicability of the law whether they had a com-

plete electronic medical record or not. For those who are then a covered entity, the law applies to all health information whether it is transmitted orally, on paper, or by computer. The DHHS regulations for Transactions & Codes were finalized in August of 2000 and will become effective in October 2002. The Privacy regulations were finalized on April 14, 2001 and will become effective on April 14, 2003. The DHHS regulations for the remaining two sections are still in proposed but not final form.

The regulations as published in the Federal Register can be daunting to read. However, physicians should not be overwhelmed or allow themselves to be dazed into unpreparedness. The civil and monetary penalties for intentional breaches of the Privacy section as enforced by the HHS Office for Civil Rights range up to 10 years in prison and \$250,000. In the words of William Braithwaite, DHHS's senior advisor for health information policy, "Don't whine about it; get started." To ease the road toward compliance, there are several principles that providers should find helpful.

The first principle is that the regulations are meant to be flexible and scalable to the size and resources of the covered entity. A solo practitioner will not be expected to develop the same HIPAA plan that would be expected of an academic health center. They are also meant to be "reasonable." A Guidance issued by DHHS on July 6, 2001 further defines this. It states that reasonable efforts must be made to prevent uses and disclosures not permitted by the regulations, but that doesn't mean a guarantee of the privacy of health information from any and all potential risks. For example, DHHS specifically denied that providers would have to retrofit walls in exam rooms to make them soundproof or cease the use of sign-in sheets in waiting rooms.

The second principle is that this is not just a "computer" issue to be solved with new technology. The Privacy and Security regulations involve administrative and physical as well as technical components. Administrative components involve arranging for agreements with business associates so that companies who provide you services will also ensure the privacy and security of your practice's health information. Policies and procedures are important components of a HIPAA plan.

- Does your plan include orienting a medical student to the confidentiality aspects of your practice?
- Have you come up with your practice's plan for whether patient identifiable information should be kept on a PDA (personal digital assistant or Palm-like device)?
- Does your plan train employees not to share computer passwords and notify them of consequences if they do?
- Do you have a notification for patients of their privacy rights?
- Is the physical security of your chart room defined?
- Have you designated a Privacy Officer in your hospital or practice?

All these questions emphasize that compliance with HIPAA

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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 assign the third-year clerkship student you are precepting to use the Web to do some research on treatment options for asthma. The student returns to you with information that you consider to be of poor quality. What will you teach this student about evaluating information on the Web?”

William C. Miller, M.D., Ph.D., M.P.H., Assistant Professor of Medicine and Epidemiology: When many of us were in medical school, we spent many, many nights (and days) reading and learning about the diseases we encountered in our patients on the ward. Our tools were relatively simple: a few key textbooks, our class notes, and journal articles. Often, we didn’t consider the source of the information too carefully—who wouldn’t trust the author of a chapter in Harrison’s or Cecil’s textbooks of medicine? Today’s students still spend much of their time investigating, learning, digesting this material, but they have additional tools at their fingertips. Without leaving their cubicle on the ward, they can search the Internet and discover a wealth of information related to their disease of the day. But what is the quality of that information?

The medical information on the Internet is vast and varied. I can sit at my computer in my home and access Medline easily and efficiently. I can also search on a topic with one of a number of Internet search engines. But digesting the information found by such a search can be daunting. A quick search of “asthma treatment” on a popular search engine found over 300,000 Web sites. Obviously, it is a nearly impossible task to sort through all of those sites to find the ones with the most relevant information. So, what do we tell our students?

My primary message would be to evaluate the source of the information critically. Now, with a great deal more knowledge than I had in medical school (at least in some areas!), I am much more skeptical about many sources of information. I even view my trusted textbooks from medical school with a bit of skepticism. Nearly always, my first question is, “What is the source of the information?” As I read the textbook, I am frequently flipping back to the references to identify the sources. Much of what we do in medicine is based on few data, but if I’m going to make a decision about treatment options, I want to know, at the least, whether I’m basing that decision on good data or weak data. So understanding the source of the information is important, whether it be from a textbook or a Web site.

I would strongly encourage the student to go directly to the medical literature. We have no better source of information than published reports of medical research. A third-year medical student has had an entire course in clinical epidemiology, which provides the basic skills necessary for interpreting the quality of published medical research. Unfortunately, these skills fade when not used regularly, and many students read the literature relatively passively and without questioning. I would encourage the student to hone these skills, because they will serve him/her well in the future. Our field is one of continued learning, and being able to teach oneself is an absolutely critical skill to cultivate.

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I would also encourage the student to consider the source of the Web-based information carefully. Quality information will be referenced in a manner similar to a textbook. If you don’t know where the data came from, don’t trust the data. Similarly, some weight should be given to the source of the Web site. In my search for asthma treatment, one of the first Web sites listed was from JAMA that included a series of links to articles and guidelines on asthma therapy. It seems reasonable to expect that “name brand” Web sites will be more likely to include information of reasonable quality.

The Internet provides quick and easy access to a tremendous amount of information. The Web will be a great tool for the next generation of physicians. But only if they learn how to digest the information—just as they would any other source of medical information.

Evaluating Online Information

[The following information is used with permission of the UNC-CH Health Sciences Library. See www.hsl.unc.edu/lm/eval/Nuts.htm]

Anyone can publish on the Web. There is no quality control such as that provided by librarians who select items for their collection. This gives you the opportunity to do the quality control yourself, which can be empowering. But it makes it important for you to develop skills in evaluating information. To evaluate online information, the Health Sciences Library has developed the following criteria.

Credibility How credible is the source? Consider:

- Credentials: academic background, institutional affiliation, or previously published work.
 - Arguments: Are arguments for the author's point of view logical and well-reasoned?
 - Documentation: Are facts and arguments supported by references to existing scholarly literature by reputable authors?
- A source may have excellent credentials and yet be of limited value. In some cases, a source with less impressive credentials may turn out to be highly valuable.

Bias

- Does the source seem to have a hidden agenda or rigidly narrow point of view?
- Does the source distort other points of view, or dismiss them out of hand?
- Does the source accept advertising? If so, does the advertising appear to bias the information?
- Is there a conflict of interest? Does the source stand to profit financially from a particular point of view?

Although financial motivations can cause information to be biased, keep in mind that many corporate sites are excellent sources of free, valuable information. Just remember to look at the information in context.

Accuracy

- Does the author give supporting documentation of the facts presented?
- Is the cited documentation reputable?
- Does the information contradict other reliable sources?

You may choose to overlook a minor discrepancy or factual error in an otherwise valuable source. But if you notice such a mistake, it makes sense to be somewhat skeptical. There may be other errors or omissions that you don't notice but that undermine the quality of the information.

Currency

- Is the information current?

The Web page should state the name of its author (or institution) and the date it was last modified. Of course, the fact that a page was recently modified doesn't guarantee that the information it contains is up-to-date. Currency may be extremely important for topics that are changing on a daily basis; for other topics, currency may be less of an issue.

Relevance

- Is the information relevant to your topic? This may vary depending on the stage you are in:
- During your initial search, explore broadly so that you

won't exclude anything that you may later decide is important.

- As you refine your search, your topic will probably become narrower and fewer items will be relevant.
- When you identify your key sources, you will have more stringent requirements, and even fewer items will be relevant.

Significance

- Is the information significant?

The content is not valuable to you unless it is significant. The information may be trivial. Or it may be common knowledge. Or it may be too general and not include enough detail about the subject you are researching.

Intended Audience

- Is the information designed for an audience with needs similar to your own?

For example, a site intended for health care consumers may cover the same subject matter as a site for post-doctoral medical researchers, but the needs of the two audiences are different.

Usability

A Web site that is easy to use is more fun and inviting. This encourages us to explore and to learn. A site that is very difficult to use may not be worth the trouble. However, you may come across a site that is not well-designed but that has valuable information.

HIPAA Regulations

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will not be simply a computer fix. HIPAA does not answer many of these questions but expects your practice to provide the administrative plan to control privacy and security risks to a reasonable degree.

The last principle to emphasize is that the physician must become involved in a leadership role for a successful HIPAA implementation. "Hiring out" to consultants does not abrogate your responsibilities under the law. Learning details about the law is an important first step. Allow time for your office manager to network and go to HIPAA educational meetings. Take advantage of information in medical journals, through professional organizations, or on the Internet. Become involved in your community hospital's efforts toward HIPAA compliance, as your involvement benefits not only your hospital but your practice as well.

A useful resource in our state is the non-profit North Carolina Healthcare Information and Communications Alliance (NCHICA). Its Web site (www.nchica.org) has links to DHHS HIPAA documents as well as notices about workshops and meetings on the topic. JAMA has recently published an article on the Privacy section of HIPAA (Gostin LO. National health information privacy. *JAMA* 2001; 285(23): 3015-3021). A practical article in *Family Practice Management* will help with the specifics of getting started (Kibbe DC. A problem-oriented approach to the HIPAA security standards. *Family Practice Management* 2001; 8(7): 37-43; also available at www.aafp.org/fpm).

Finally, don't hide your progress and struggles with adjusting to these new regulations from your learners. Medical students are eager to learn what the "real world" is like. And the coming real world will involve HIPAA.

Medical School Building Projects Move Forward

Passage of the higher-education bond referendum in the November, 2000 state election has allowed a number of projects at the UNC-CH School of Medicine to move forward. New buildings and renovations at various stages—from initial concept to design phase to construction—have benefited from the commitment of North Carolina voters to meeting the universities' capital needs.

Medical school projects funded in whole or in part by the bond issue include:

- Phases I and II of the new Medical Biomolecular Research Building, slated for completion in March, 2003 (\$26,718,000 from state bond issue; \$30,045,500 from UNC bond issue; \$7,000,000 from state appropriation; \$1,000,000 from School of Medicine overhead receipts)
- Bioinformatics Building, projected completion date of September, 2002 (\$2,000,000 from state bond issue; \$33,677,000 from UNC bond issue)

Both the Medical Biomolecular Research Building and the Bioinformatics Building will play an integral part in UNC-CH's new Carolina Center for Genome Sciences, with both facilities housing genomics and related research.

- Burnett Womack Building, comprehensive modernization, projected completion by March, 2005 (\$24,848,000 from state bond issue)
- Community Health Building, projected completion by Summer, 2005 (\$18,340,000 from state bond issue)
- Medical Sciences Research Building, comprehensive modernization of classroom and meeting space, projected completion by Summer, 2005 (\$12,895,000 from state bond issue)
- Berryhill Hall, comprehensive modernization of classrooms and laboratories (\$10,700,000 from state bond issue)

In addition, projects funded from other sources are in the pipeline:

- Phase III of the Carolina Living and Learning Center, an outreach program in Chatham County for people with autism, scheduled for completion in December, 2001 (\$1,274,275 state appropriation; \$90,000 departmental fund)
- Glaxo/Medical Biomolecular Research Laboratories: re-roof, fire safety, emergency generator, cold room, glassware wash, equipment room, lab renovations; projected completion date of May, 2003 (\$900,000 National Institutes of Health grant; \$900,000 matching funds)

Funding through gifts and other sources is currently being sought for a planned 220,000-square-foot research building projected to cost \$65,000,000. It will be served by a new Mouse Facility costing approximately \$3,000,000.

What Do Preceptors Expect Students to Know? (continued from page 1)

comfort with meeting and talking to patients—the ability to walk into a room, introduce themselves to strangers, and ask questions. He feels that above all, it is important that the first week be a positive experience, so he does not push students beyond their comfort level, which varies with their age and self-confidence. When the students return later in the year for their second week, he is guided by their goals.

By the second year of ICM, Dr. Parsons' expectations are greater. Students are expected to be more involved in getting problem-focused histories and doing an exam to the extent that they are comfortable.

When a third-year clerkship student comes to his practice, he expects that student to have reasonably developed interview skills: to be able to establish rapport and obtain data. The student should be able to understand why the patient is there and to take a history. Dr. Parsons said that students he has precepted have ranged from limited to superb ability in history-taking. The student should be able to do a complete physical, assimilate and evaluate the information, and develop an idea of the appropriate treatment. The level at which the student is able to do these things depends on the student's clinical knowledge at that point. Dr. Parsons tries to get the clerkship student to say what he or she thinks is going on with the patient and to back up that opinion with evidence.

At each level, Dr. Parsons tries to make time to observe a complete student-patient interaction and give feedback. In filling out evaluations of student performance, Dr. Parsons has thought a lot about what additional preparation the students should have before coming to his practice, and he does not think they need additional background. Almost all have been well-prepared for interacting with patients—in fact, he finds them better prepared than he was at comparable stages. They have good skills in getting a history, and by the second year, their physical exam skills are good.

Saying that he does not know whether the better skills of current students are a reflection of more capable students entering medicine or of the nature of the coursework they have completed prior to their community-based rotations, Dr. Parsons stated that he felt that the Introduction to Clinical Medicine course is important and is a good use of students' time during the first two years of medical school. "As long as the student has a good preceptor experience, it's an opportunity to see early on what being a doctor is all about." He also noted that the university setting is different from the

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What Do Preceptors Expect Students to Know?

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community setting that most students will be entering as physicians, therefore the community experience is essential.

Raleigh pediatrician Terry Brenneman precepts medical and nurse practitioner students from first-year through residency levels. He does not expect much initially from first-year ICM students except verbal skills, professionalism, and enthusiasm. By the second year, their interviewing skills should include open-ended questioning with the ability to shift to narrower questions if the situation warrants, and they should be able to do a basic physical exam and give a differential diagnosis. He expects third-year students to have built on their second-year skills, with competence in performing complete physical exams and awareness of abnormalities.

Dr. Brenneman points out that the clinical expertise of students he precepts varies with the amount of experience they have had. One of the positive things about their preparation is that they all know the expectations of the rotations. He feels that the curriculum is doing a good job with first- and second-year medical students by exposing them to primary care practice through the Introduction to Clinical Medicine. He said that residents also need experience in community practice to get more frequent exposure to the kinds of cases they will see in the “real world” outside of teaching hospitals.

Preceptor Susan Snider of Blue Ridge Family Practice in Spruce Pine hosts students from Introduction to Clinical Medicine and the Ambulatory Care Selective. She expects first-year students to be open-minded and eager to learn about different kinds of practice in different settings. She gives them experience with Hospice by sending them on home visits with Hospice nurses. By second year, she expects them to have a sense of what the non-physician members of a health care team do and to be comfortable with that. Again, Hospice is useful for illustrating the interdisciplinary team approach.

Dr. Snider expects fourth-year students to be able to diagnose and know how to treat common problems. In her office, they can function somewhat independently in identifying the problem and formulating a plan before she follows up. When she send them into community settings—such as the health department for cross-cultural exposure—they go as observers.

All of Dr. Snider’s students have been bright, enthusiastic, and well-prepared, in her opinion. Some of her students have told her of classmates at other precepting sites who are expected to do things for which they have insufficient background. She feels that assigning first-year students to go to the hospital on their own to read patient charts is not a productive use of their time, because they don’t yet know how to interpret what they are reading.

In thinking about what additional training would better prepare students for eventual practice in the community, Dr. Snider noted that students often lack a sense of how the financial aspects of a practice work, such as dealing with third-party payers. Better training in documentation requirements is a related concern. She thinks that students need to think about using health resources wisely in terms of cost. Dr. Snider said she has been somewhat surprised that fourth-year students have not had more exposure to information on how hospitals and physicians are reimbursed, and the implications of that for what gets done—or not—so that the hospital does not go bankrupt.

Dr. Harvey Kohn, who practices obstetrics and gynecology in Laurinburg, currently precepts first-year ICM, third-year OB-GYN, and fourth-year ACS students. He believes that by third year, students should have a good idea of what they are finding as they perform physical exams. What he expects depends not only on the level of the students but also the time of the year that they come to him on rotation. They should be well-versed in the areas in which they have already had clerkships. If a student comes to his practice later in the year, he expects her or him to have done pelvic exams and to be aware of pregnancy-related and other female issues. Students should be ready to take considerably more responsibility by the time they reach third year. In general, Dr. Kohn finds the preparation of his students to be excellent.

A number of his students have had experience working in the community in free clinics and similar activities, giving them insight into the population and the community. Although this is an advantage, Dr. Kohn does not think that the curriculum should include this type of experience as a requirement. Those students for whom it is an interest will pursue it, he said.

Preceptors: What should the curriculum be doing that would better prepare students for practice in the community? Share your ideas with The Front Line, UNC-CH School of Medicine, Campus Box 7530, Chapel Hill, NC 27599-7530.



**OFFICE OF
EDUCATIONAL DEVELOPMENT**

School of Medicine
The University of North Carolina
CB# 7530
Chapel Hill, North Carolina 27599

<http://www.med.unc.edu/oed/frontline/>

Information Please



In past issues of *The Front Line*, we described the contents of three major sections of the NC AHEC Digital Library: Medical Literature Searching & Clinical Resources, Communication & Networking, and Continuing Education. In this issue we will focus on Centers of Excellence. Special collections, focusing on specific health care disciplines or important areas of interest, are highlighted in the AHEC Digital Library. **Nursing** resources and **Evidence-Based Medicine** Centers of Excellence are the first two special collections developed.

The **Nursing** Center of Excellence begins with a collection of *Clinical Resources*, including access to a nursing database, six full-text textbooks, and more than 100 journals. The next section is *Resources for Selected Specialties and Groups*, including nurse practitioners, school nursing, and public health nursing. *Networking and Communication* provides links to nursing associations, organizations, directories, and discussion groups. *Education and Careers* lists degree programs, CE, and credentialing resources.

The **Evidence-Based Medicine Education Center of Excellence** is a collection of resources that support teaching and learning Evidence-Based Medicine (EBM) for faculty, librarians, students, and other health care professionals. In addition to the learning and teaching EBM units, this site has a “What’s New in EBM” section that is updated monthly. The Research section contains a list of core EBM journal articles, many with links to abstracts. The Resources section is an evaluated, core list of EBM databases, full-text journals, and books. NC AHEC librarians and academic librarians who teach formal EBM programs formed a team to create and maintain this page.

These are the first Centers of Excellence in the ADL, and others will follow. Work is currently underway for a Mental Health collection and a Spanish health resources collection.

To take a look at the NC AHEC Digital Library (ADL), go to <<http://library.ncahec.net>> and register as guest. As a North Carolina AHEC preceptor, you can use the ADL to access the resources of your affiliated university. To set up your ADL account, contact your AHEC librarian. If you have suggestions for content, questions about eligibility or becoming an individual member, or general questions about ADL, please contact your local AHEC librarian or Betsy Dain, ADL Resource Development Project Coordinator, at HSL, UNC-CH, (919) 966-1213 or dain@email.unc.edu.