STATUS OF REDUCED-SCHEDULE RESIDENCY REMAINS IN DOUBT

The reduced-schedule residency is a relatively new concept in medicine. These programs have emerged during the last decade as an alternative to traditional residency programs for probably two reasons. First, the increased enrollment of women in medical school has almost certainly resulted in an increase in physician-student marriages. Secondly, recent social changes have created an atmosphere where physicians are trying to achieve a new balance between the personal, family, and professional aspects of their lives. It is no longer universally accepted that being a physician demands total denial of outside pleasures and interests.

There are two major types of reduced-schedule residencies. In one type (known as shared-scheduled positions) conventional part-time positions are offered, salaries are half the usual stipend, and the time required to reach board eligibility is proportionately increased. This type of program may be offered to an individual or to a pair of students. In the latter case, the couple shares time and patient responsibility and assures continuity of care.

The other type is based on alternating blocks of time away from the program. A two-year residency would become twice as long with the house officer performing his or her duties in perhaps three-month rotations with equivalent time off between blocks. Two people sharing such a residency would simply alternate responsibility.

Housestaff today seek these programs for a variety of reasons. Physician couples who have decided to share equally in the responsibilities of housekeeping and child rearing make up a small but important population. Another group is comprised of women physicians, committed to the profession but unwilling to defer child bearing and family responsibilities to the post-residency years. Still others seek these programs in order to pursue research interests, usually at the same institution.

Since their inception, reduced-schedule residencies have existed in a grey zone of semi-official acceptance. Institutions do not advertise such positions, and the NIRMP listing of approved residencies makes no special note of their existence at certain hospitals. The Liaison Committee on Graduate Medical Education (LCGME) does not have special guidelines to assure their quality. At a recent AAMC Executive Council meeting this issue was discussed and some members of the council argued that AAMC should not actively encourage institutions to offer reduced-schedule programs. They maintained that medicine was a full-time job requiring a full-time commitment. They argued that official endorsement of the concept would inevitably result in a population of under-motivated, part-time physicians. It was their feeling that the present status of these programs was adequate to deal, on a personal level, with the very few cases who demonstrate a genuine need for a reduced-schedule training program.

There will be more discussion of this issue before a decision is reached. OSR has consistently endorsed the concept, and we would like you to let us know your thoughts on this question by responding to the survey on page 3.

OSR OPINION SURVEY—Continued

6) Reduced-schedule residencies are compatible with high quality training.

7) Reduced-schedule residencies will promote the proliferation of poorly motivated and under-trained doctors.

8) Reduced-schedule programs should be developed openly, accredited by standard means, and listed as such by NIRMP.

9) This newsletter has served a useful function by providing new information.

10) Additional issues published three times per year would be useful.

OSR REPORT

Published by the Association of American Medical Colleges for the Organization of Student Representatives.

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Volume 1, Number 1 Spring 1977

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© Housestaff Status: Students or Employees?
© U.S. Students in Foreign Schools
© Can Student Input Influence Decisions at the National Level?
© Reduced-Schedule Residencies: Problem or Solution?

OSR National Chairperson: Thomas A. Rado, Ph.D.
OSR National Chairperson-Elect: Paul Scales

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HEARINGS HELD TO AMEND LABOR ACT

The right of housestaff to form collective bargaining units under the provisions and rules of the National Labor Relations Act (NLRA) has been hotly contested for the past few years. Last year, the issue came to the public eye after a series of strikes. At that time, housestaff at five hospitals asked the National Labor Relations Board (NLRB) to assert jurisdiction over them. The NLGB would have given housestaff the right to vote on whether or not they wanted to be represented by a union in contract negotiations with their hospitals.

The AAMC entered the case as amicus curiae (friend of the court) in support of the housestaff petition. AAMC, which represents

(Continued on page 3)

U.S. STUDENTS IN FOREIGN SCHOOLS: MANPOWER PROVISIONS STIR WIDESPREAD DEBATE

The new health manpower law (PL 94-484) contains a provision that in order to receive 1978-80 capitation grants, medical schools must accept into their M.D. programs a number of American students who have completed basic science studies at foreign medical schools.

This provision was hastily added to the law in conference, and it was initially popular with proponents of the theory that U.S. health care problems are due primarily to a physician shortage. It soon became apparent, however, that the issue is much more complicated. The law specifies that schools cannot reject these students for academic reasons if the students have passed Part I of the National Boards. Schools can only use non-academic criteria in justifying their failure to accept the required number of transfer students from foreign medical schools.

In this way, passage of NBME Part I is substituted for the school's usual application evaluation procedures. The dearth of manpower and medical schools feel that being forced to admit a specified number of students "around" the standard admission process is an unjustified threat to the autonomy of their institutions. Others feel that the law is discriminatory—that it allows rejected applicants who were wealthy enough to attend high-priced foreign schools access that their poorer counterparts did not have. It is also thought to be possible that students from foreign medical schools might take available third-year slots from students in U.S. two-year medical schools.

Since there is currently no reliable estimate of the actual number of students involved, it is not possible to predict the full effect of the new law. Because of this and because of great difficulties which undoubtedly accompany the verification and translation of documents, it is unlikely that the law can be implemented until academic year 1978-79. AAMC has testified in a Pennsylvania lawsuit brought to force earlier implementation of the law and has explained the problems which schools would face if forced to implement the transfer provisions on such short notice.

OSR has reviewed the provisions of PL 94-484 relating to U.S. students studying abroad; in general, we share the views of AAMC regarding these aspects of the law. We feel that this provision will be hard to implement, that it is somewhat discriminatory, and that it does not represent an unwarranted intrusion into the admissions process.

Some medical school deans have indicated that they may recommend that their schools refuse capitation rather than comply with this provision. OSR has consistently argued against this course of action. According to the law, students cease to qualify for the new Federal Program of Insured Loans for Health Professions Students when their schools become ineligible for capitation. Under these conditions, we feel that refusal of capitation would result in undue hardship for large numbers of medical students.

(Continued on page 3)
This issue of OSR Report marks the beginning of a major new direction for the Organization of Student Representatives (OSR) of the Association of American Medical Colleges (AAMC). OSR has made a decisive role in shaping medical education for over a century. The Association is a parent organization of every major committee charged with the evaluation, accreditation, and planning of medical education. In many cases, it has line-item veto power over the decisions of these committees. In effect, I would guess that the majority of the 60,000 medical students in this country are unaware of its existence.

The OSR, established in 1970, is the mechanism where-by student opinion is made known to AAMC. Today we have two votes on the AAMC Executive Council; we are invited to participate as members of various AAMC task forces, and we recommend student members to standing AAMC committees. Every accredited U.S. medical school is invited to elect a representative to OSR. OSR members receive a great deal of information about areas in which AAMC has interest. In general, they have been around the complexity of the problems facing a system which educates physicians, treats huge numbers of patients, and tries to respond to public needs and government demands.

In the past, the role of OSR has been to react rather than initiate. This has occurred because of the complexity of the issues and the lack of communication between OSR members and their medical student constituency. This newsletter is part of our effort to improve the situation.

In this issue we deal with three important topics. First, we want you to be aware of the issues behind proposed legislation which may alter the nature of the educational experience. They maintain that it is more expensive for a hospital to have a residency program than to hire an equivalent number of employee physicians. Finally, AAMC argued that the special relationship which presently exists between housestaff and their service chiefs is delicate and critical to the educational experience. They maintained that it would be irreparably damaged if a negotiation atmosphere, complete with shop stewards and formal bargaining, were to prevail.

Housestaff and medical student groups, including OSR, took an opposing view. Basically, we argued that housestaff perform vital services in the areas of patient care and undergraduate teaching. While it is true that housestaff learn new skills while performing service, OSR argued that this does not in itself classify them as students; in addition, the housestaff groups questioned the validity of hospital accounting practices which fail to distinguish between savings in patient or (community) dollars and savings in university hospital dollars. Housestaff groups maintain that immense patient costs would accrue if private physicians were called upon to perform all of the services presently provided by housestaff.

The NLRB ruled against the petitioning housestaff groups, but reserved the option of hearing other petitions in the same debtor. We asked OSR members to respond to this resolution via letters to the NMB. In the last weeks of the 94th Congress, Representative Frank Thompson (D-NJ) introduced a bill which would specifically amend the NLRA by defining interns, residents, and fellows as employees. Mr. Thompson has reintroduced his bill (H.R. 2222) in this session.

The most recent hearings on the Thompson Amendment were held in Washington on April 4. Testimony urging defeat of the amendment was offered by the president of AAMC and officers of the American Hospital Association, the American Medical Association, the American Medical Student Association, the American Society for Medical Education, and the AMA and the ADA testified in favor of the amendment. AAMC testimony held that the NLRA, originally designed for the industrial sector, was not applicable to "graduate medical students." AMSA and PNHSA urged speedy passage of the bill.

During the development of the AAMC position on H.R. 2222, OSR supported a compromise stance. It was our view that there are aspects of the housestaff experience which are amenable to collective bargaining—wages, hours, and working conditions. There are also aspects in which we feel that the roles and responsibilities of the group are different from other medical students. The role of classical academic mechanisms are probably more appropriate. It is entirely possible that AAMC is correct in proposing changes that are for the good of the country.

OSR continues to study the diverse responses generated by the Thompson Amendment. Our place to work is toward a solution which will provide assurance for the educational quality of housestaff programs and will also guarantee housestaff, as workers, the same rights which other segments of the labor force have already won.

OSR OPINION SURVEY

We would like you to take thirteen cents and a little of your time to let us know your thoughts on issues we have raised in this newsletter. Please tear this form out and send it to:

Diane Newman
Division of Student Programs
AAMC
One Dupont Circle, N.W.
Washington, D.C. 20036

For each of the statements below, please make a mark on the line between "0" (strongly agree) and "10" (strongly disagree). Note that the midpoint "5" may be used to indicate "no opinion."

1) The living standards of housestaff will improve significantly if permitted to unionize.

2) The educational quality of housestaff programs will decline if residents are given employee status.

3) I would like a union to represent my interests when I become a house officer.

4) The allocation of slots for U.S. students presently at foreign medical schools is a step towards solving the nation's health care needs.

5) The preferential treatment shown to American students in foreign medical schools discriminates against the remainder of rejected applicants and students in two-year schools.

6) The Thompson Amendment will provide assurance for the educational quality of housestaff programs.

7) The Thompson Amendment will provide for the educational quality of housestaff programs.

8) The Thompson Amendment will provide for the educational quality of housestaff programs.

9) The Thompson Amendment will provide for the educational quality of housestaff programs.

10) The Thompson Amendment will provide for the educational quality of housestaff programs.

(written comments continued on page following this page)
ACCREDITATION (Continued from page 2) may be granted for some portion of the maximum ten years with progress reports due at specified intervals. In recent years, two schools have been placed on probation until certain deficiencies were remedied while no school has been denied accreditation.

The accreditation of schools is conducted in several phases. The first, preparation of the institutional self-study site visit, the school conducts an institutional self-study, examining in detail all the phases of the school's operation—everything from curriculum to animal quarters. The results of the survey, taking a few thousand pages of documentation, are sent to the LCME. A site visit team is appointed which reviews the self-study document and visits the school for about four days, meeting with faculty, administrators, and students, and examining the facilities. A report of the visit and an accreditation recommendation are prepared by the team and circulated to all members of the AAMC's Executive Council and the AMA's Council on Medical Education (CME). The final accreditation decision is made by the LCME and ratified to satisfy certain licensure requirements by the parent bodies.

Student input into the accreditation process is at three levels. First, and most importantly, students should participate in all phases of the institutional self-study. This participation often provides students with a different perspective on the strengths and weaknesses of their schools and allows them to participate in the process. Second, due to lack of communication, students are not included in the institutional self-study process. This occurs, a formal request to the dean is usually all that is necessary to include students on the self-study committee. A new policy of the OSR will provide for a regular meet to discuss accreditation site visits with a copy of the OSR Accreditation Handbook well in advance of the site visit.

The second level of student participation occurs during the visit of the site team which is scheduled including all the team and representatives of the student body. Only students and site visitors are present at this meeting, and students should use this time to completely candid about their concerns. Site visit teams are extremely sensitive to the concerns of students and regard themselves in a sense as student advocates. Although students may be reluctant to speak up about their concerns for fear of having an adverse effect on the accreditation decision, they should keep in mind that an effective examination requires both honesty and candor. The accreditation process provides an opportunity for medical schools to look closely at all phases of their function and to identify problems and solutions. Students should participate in the process of medical education, and their participation in the identification and resolution of these problems—during the institutional self-study phase and during the site visit—is vital.

The third level of student participation in the accreditation process occurs at the national level. Site visit reports are routinely circulated to the parent councils, and the two students who sit on the LCME's Executive Council and the student on the AMA-CME have the opportunity to review and comment upon all site visit reports and recommendations. Their comments are submitted directly to the LCME along with comments from other members of the parent councils. In addition, the LCME recently asked both AAMC and AMA to appoint one student each to sit as non-voting members on the LCME. It is too early to tell what role the student LCME members will play on the committee, but the OSR and other medical student groups feel that achieving the long-term goal of attaining student representation on the very influential LCME is itself a victory for medical students.

CONGRESS PASSES BILL TO AMEND HEALTH MANPOWER ACT

In late December President Carter is expected to sign a bill which would amend the U.S. foreign medical student (USFMS) capitation provision of the 1976 health manpower law. As noted in the last issue of OSR Report, the original USFMS provision was highly controversial, and at least 14 schools had announced that they would refuse capitation rather than comply with the requirement that they admit, without regard to usual academic admissions criteria, a specified number of U.S. students who were studying medicine abroad prior to October 12, 1976.

If, as anticipated, the new law is signed by the President, it would require medical schools to increase their third-year enrollment by 5% in 1978 in order to receive capitation grants. Under the new law, schools would not receive credit for USFMS voluntarily enrolled in 1977, but a significant change is that schools would be able to use any normal academic criteria in selecting the students they wish to admit. Schools would receive credit towards the 5% enrollment increase not only for USFMS enrolled abroad prior to October 12, 1976 but also for transfers from two-year U.S. schools and for students in special Ph.D.-M.D. programs in the U.S. The pool of students who would be eligible for transfer under the new law has been estimated to be more than twice the number of places (about 800) which would be made available by this third-year enrollment increase.

OSR REPORT

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for the Organization of Student Representatives

Volume 1, Number 2
Winter 1977/78

In This Issue:

- Financial Aid for Medical Students
- Student Participation in Medical School Accreditation
- Congress Amends U.S. Foreign Medical Student Provisions
- OSR National Chairperson: Paul Scoles
- OSR National Chairperson-Elect: Peter Shields

OSR REPORT

Published by the Association of American Medical Colleges for the Organization of Student Representatives

Distributed free of charge to all U.S. medical students.

Editor: Diane Newman, AAMC Division of Student Programs, One Dupont Circle, N.W., Washington, D.C. 20036, (202) 466-5050

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FINANCIAL AID FOR MEDICAL STUDENTS: A SHIFT IN PUBLIC POLICY

The enactment of the health manpower law (PL 94-484) over a year ago represents a major shift in public policy with respect to the financing of medical students' education. However, the failure of the federal government to issue regulations to implement the new legislation during the past year has produced uncertainty for students and financial aid officers for this academic year.

Two underlying assumptions form the basis of student financing mechanisms in PL 94-484. First, student financial aid can be used as a lever to ensure the even distribution of physicians by specialty and by geographic practice location. Federal financial aid for medical students has been available in ever-increasing amounts—as both scholarships and loans with generous repayment provisions—since a U.S. doctor shortage was identified in the early 1960's. Since then, these student aid programs, in conjunction with various types of institutional incentives for increased sizes of medical school classes, have produced significant increases in absolute numbers of U.S. physicians. Nevertheless, legislators continue to hear from their constituents about severe shortages of medical personnel in rural and inner-city areas. Both the executive and legislative branch of government have therefore come to believe that merely increasing the number of doctors is not enough; mechanisms must also be designed to assure that physicians will serve the tax-paying public in the locations and specialties in which they are most needed. Hence, PL 94-484 created a new and ex-
## ISSUES, PLANS, AND DIRECTIONS FOR COMING YEAR

This year, as in the past, the OSR has identified several areas of particular concern to medical students, and members of the OSR Administrative Board have been designated to coordinate OSR efforts in each of these areas. If you are interested in any of these topics, contact either the individuals listed or OSR Chairperson Paul Scoles.

### Financial Aid

The crisis in financial aid for medical students is a subject of continuing concern to OSR and AAMC. Immediate-Past-Chairperson, Tom Rado, serves on the AAMC financial task force which is currently developing strategies for viable and satisfactory sources of funding for medical students. Fred Emmel and Clay Griffin are also very knowledgeable on the subject and will be coordinating our work in this area.

### Directory of Graduate Medical Education Programs

There is a consensus within OSR that students need a significant amount of additional objective information on available graduate medical training programs than is currently offered in the NIRM Directory. Administrative Board members Molly Osborne and Dan Miller are exploring with NIRM the feasibility of expanding the Directory to include additional data.

### Stress

Finding ways to identify and reduce non-productive stress in medical education has been an ongoing interest of OSR. At the recent Annual Meeting, the OSR approved a resolution on a related topic—the effects of sleep deprivation on the learning process—which they hope the public will support. For this year, Dennis Schultz and Paul Scoles will be working with other board members to develop a report on this subject with specific proposals for action.

### Graduate Medical Education

The OSR continues to be interested in housestaff affairs. With the legislation to grant housestaff the right to unionize under the National Labor Relations Board, our attention has shifted to more general concerns about graduate medical education and alternative forms of residency training. Cheryl Gutmann, a member of the AAMC Task Force on Graduate Medical Education, keeps the Administrative Board informed about all issues and developments relating to graduate medical education including NIRM.

### Legislation

It is a monumental task to keep track of the mountain of state and federal legislation relating to medical education. This year, Jim Maxwell will keep abreast of legislative developments at the state level, and Peter Shields will concentrate on national health legislation. Jim and Peter have assisted in this area by Fred Emmel, who is located in Washington.

### Other Issues

Other areas of continuing interest to OSR are:
- **Women in Medicine:** Molly Osborne
- **Minority Affairs:** Clay Griffin and Paul Scoles with the assistance of Winston Griner of the Student National Medical Association

### Student Participation in Medical School Accreditation

During the past several years, OSR has been actively engaged in an effort to increase medical student participation in the Accrediting process. The work of OSR in this area has been particularly successful, and it now can be said that formal mechanisms exist for students to be involved in every aspect of the accreditation process. In order to understand how students fit into the total picture of medical school accreditation, a little background information is essential. The group which is charged with the responsibility of accrediting medical schools is the Liaison Committee on Medical Education (LCME). Formed in 1942, its membership consists of six representatives from the AAMC, six representatives from AMA, and two public members. In addition, the Association of Canadian Medical Colleges is represented by an observer/participant who votes only on Canadian medical schools, and the Secretary of HBW designates one non-voting representative.

The LCME conducts periodic reviews of American and Canadian medical schools. Typically, the actions of the LCME can take ranges from denial of accreditation to full accreditation for ten years. Usually, the actions taken by the LCME fall somewhere in between, and accreditation

### OSR ADMINISTRATIVE BOARD

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### FINANCIAL AID (Continued from page 1)

Panded National Health Service Corps Scholarship program under which tuition, fees, and a monthly stipend are paid to recipient students, in exchange for their commitment to practice medicine in specified shortage areas. Those who control the federal purse strings have strongly endorsed this approach of straight-forwardly buying the physician services that the government perceives to be needed after it is available to make an appropriation for the NHSC Scholarship program for this fiscal year is $60 million, which would support roughly 4,680 medical student recipients. The availability of NHSC Scholarships to medical students who are utterly without financial resources of their own to obtain a medical education, but only if they are willing—for at least a portion of their medical education, and where and when they will practice medicine. However, the NHSC program is not, strictly speaking, a financial aid program since, as with Armed Forces Scholarships, need is not a legitimate selection criterion, other than the intention to serve in the health professions.

Since physicians have been among the most highly remunerated workers in our society, those who do not agree to repay the cost of their medical education by service in an underserved area should be willing and able to repay in dollars, plus full interest, whatever funds they borrow for medical school expenses. PL 94-484's new Federal Family Education Loan Program in Health Professions Schools permits students to borrow up to $10,000 per year and originally permitted the annual interest rate on loans under the program to be as high as 7%. Currently legislation before Congress and awaiting the President's signature would raise the maximum interest rate to 12% plus up to 2% for non-degree program students. Although repayment of principal does not begin until several months after completion of medical school and may continue for as long as 15 years, interest is payable throughout the life of the loan, including while the borrower is in school. A student who borrows $10,000 a year at 10% interest for four years of medical school will owe $4,000 in interest alone during the fourth year. What effects this debt level will have on the ability of students to graduate on time is a real concern.* If the Congress and awaiting the President's signature would raise the maximum interest rate to 12% plus up to 2% for non-degree program students. Although repayment of principal does not begin until several months after completion of medical school and may continue for as long as 15 years, interest is payable throughout the life of the loan, including while the borrower is in school. A student who borrows $10,000 a year at 10% interest for four years of medical school will owe $4,000 in interest alone during the fourth year. What effects this debt level will have on the ability of students to graduate on time is a real concern.*

The absence of regulations to define the details of these two approaches to medical student financing renders both programs inoperative for the current school year. Further, funds available under the previous-undergraduate school is manageable, particularly when the salaries of young physicians in post-graduate training are taken into consideration, remains to be seen.

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greater freedom of choice than would be possible without a matching program. Prior to the creation of NIRMP, students were being forced to reach decisions about programs before they had a chance to complete all of their interviews and to rationally consider all of their alternatives. Because of the uniform-timing structure of NIRMP, all participating students and hospitals have a designated period of time to sort out what they know about each other and to reach thoughtful conclusions. NIRMP does not make decisions; it is simply a "black box" which facilitates the decision-making process.

Another misconception about NIRMP involves how the algorithm works to match students to programs. All students participating in NIRMP should carefully review the detailed description of the algorithm and the step-by-step analysis of the actual matching process which is included in the NIRMP Directory. As the analysis in the Directory clearly indicates, it is to a student's advantage to rank order programs according to desirability and not according to perceived chances of getting into those programs. Students who maximally utilize the match rank "long shot" programs first with more realistic choices ranked lower on the list.

NIRMP RULES AND VIOLATIONS

In order for NIRMP to best serve its consumers—students, and hospitals, and programs—rules must be strictly adhered to by both parties. The fundamental principle for students to remember is that by participating in the match, they are entering into a binding, contractual agreement that they will apply only to programs registered with NIRMP and will accept the program to which they are matched. Naturally, hospitals must play by similar rules, and only cooperation from both sides will keep NIRMP a viable system.

Much has been reported in recent years about violations of NIRMP guidelines, and the most frequently publicized infractions have been the making of "deals" outside the match. Neither hospitals nor students may demand any sort of statement of intention from the other about how they will be ranked. No written or verbal agreements made prior to submission of the rank order lists are binding, and students would be ill-advised to regard them as such. Every year, a significant number of students who have listed only one choice on their rank order list (and who presumably have had a prior commitment from that hospital) have not matched.

Another common violation which occurs just prior to the release of the match results involves unmatched students and unfilled programs. Medical school student affairs deans often notify unmatched students of their status prior to the time of the general release of results. Likewise, it is a violation of NIRMP rules for program directors to make attempts to fill any unfilled positions before match results are released. The importance of uniform adherence to this rule is obvious. Premature action by some students puts other unmatched students at a very unfair disadvantage when attempting to locate a desirable position.

COUPLE MATCHING

NIRMP does have special provisions for students who wish to match together as a couple. Students who choose this option must complete a special form available in all deans' offices indicating whether they are seeking positions in the same hospital, the same community, the same metropolitan area, etc. The matching mechanism is more intricate for couple matching, and interested students should consult with their dean and/or contact the NIRMP office directly for a detailed description of the special considerations involved when two students match together.

The matching program has functioned well for the past 25 years by providing students the maximum amount of time possible to reach decisions about program choice while providing directors adequate time to plan their programs for the next year. Physicians who sought graduate training positions and the medical school administrators who counseled them in the pre-NIRMP era, will attest to the importance of maintaining the program through the mutual cooperation of both students and program directors.

To contact NIRMP: Write to 1603 Orrington Avenue, #1125, Evanston, Illinois 60201 or call 312-328-3440.
An Applicant's Evaluation of a Medical House Officer -

The LCGME document, "Essentials of Accredited Residency Programs" is distributed to students via the deans' offices. The 1977 edition with addenda for new programs can be purchased by the AMSA at no charge for AMSA members and for $1.00 for non-members.

Tabelle (Continued from page 1)

I. SELECTION OF SPECIALTY AND PROGRAM TYPE

During the SPRING OF THE THIRD YEAR, students should try to reach a decision about their preferred specialty in order to narrow down the range of programs of interest and to plan for their fourth year. At this time, many students arrange fourth-year electives at other schools as a means of gaining first-hand knowledge about programs at other institutions. Students facing this decision might wish to discuss with an advisor or with fellow classmates the possibility of taking the Meyers Briggs Type Indicator or the Medical Specialty Preference Inventory (MSPI). MSPI is a relatively new test currently being used by several schools to help students assess their interest in the various specialties. It is structured in such a way that it can be used by students individually or as a tool for counseling by deans' offices.

During this period, students should begin to think about program type (i.e., categorical, categorical*, and flexible). A categorical program is sponsored by one residency program with the content limited to the specialty area of the sponsoring program. A categorical* program is also sponsored and supervised by one residency program but may include experience in one or more additional specialty fields. Flexible programs are designed to provide a broad clinical first year and are sponsored and supervised jointly by two or more residency programs.

II. INFORMATION GATHERING

During the EARLY SUMMER FOLLOWING THE THIRD YEAR, students should begin to collect information about programs of interest by reviewing references listed in the Bibliography and writing letters of recommendation and potential conflicts with career goals and objectives and by listing specific questions they want to ask during interviews since certain types of information (e.g., the candid views of current housestaff about the program) can best be gained in the interview.

IV. INTERVIEWS

The next step in the process, which should occur in the SPRING OF THE FOURTH YEAR, is to schedule interviews with program directors. It is important to coordinate the interview schedule with the dean's office to avoid problems with the timing of letters of recommendation and potential conflicts with course work. Also during this period, students may need to follow-up on applications if some programs have not yet responded to their initial contact.

The AMSA Guide to the Appraisal and Selection of Housestaff Training Positions is particularly helpful in terms of maximizing the interview as a learning experience for students. Most students will find it helpful to begin preparing on paper the questions they wish to ask during interviews. It is also important to keep in mind that the interviews are not just for the students, but also an opportunity for students to learn about the housestaff training positions at the institution and the career goals and objectives of the program.

V. MATCHING

In MEDICAL SCHOOL, students will receive the NIRMP Directory, which lists all programs participating in the match. The Directory will also include a schedule of key dates for the match. Deadline dates vary slightly from year to year, but in general, the deadline for applications to programs is in early January with the student rank order list due at the NIRMP office by mid-January. The announcement of match results is usually occurs in mid-March. For additional information about the matching process, see the article on NIRMP.

NIRMP—WHAT YOU NEED TO KNOW ABOUT THE MATCH

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NARI
The National Association of Residents and Interns and Practicing Physicians (NARI) is a nonprofit membership association founded in 1959; since then, it has enrolled over 80,000 members. Dues are $12.50/year and are payable upon application for membership. In general, NARI's purpose is to offer members economic advice and assistance, group discount privileges, and insurance programs. Of greatest interest to medical students will be the $2600 Senior Student Loan Program. Associates Financial Services Corporation administers this program and requires that you furnish some form of life insurance. If you assign an existing policy, the annual interest rate for this loan is 16.9%. If you request Associates to provide credit life insurance, a nominal premium cost will be added to your monthly payments. With regard to the high interest rate, it is important to remember that this is not an educational loan. On their own, medical students with no collateral could probably not obtain a non-educational loan from a bank at even the highest of rates. In essence this program provides a unique service, especially to students who do not qualify for financial aid but who require extra funds for interview travel, moving, etc.

Another service NARI offers is the arrangement of seminars on money management, including discussions of setting up a medical practice and of financial traps to look out for. For more information on arranging a seminar at your campus and on NARI and its spectrum of offerings, call Dennis Freeman at their toll-free number (800/221-2166; inside N.Y.: 212/949-5960).

SUMMING UP
It is important to keep informed about the current status of legislation affecting student financing. One excellent source of information to consult is the Chronicle of Higher Education, published weekly and subscribed to by most libraries. The New Physician, a magazine published monthly by the American Medical Student Association, is also a good source of current information. Another readily available reference on financial aid programs is Medical School Admission Requirements, published annually by the Association of American Medical Colleges. The 1980-81 edition will be coming out in April and will contain an extensively revised section on financial information for medical students, including an up-dated bibliography.

Many benefits accrue from becoming educated about the financial aid scene—not the least of which is that you can write cogent letters to your Congressman expressing your concerns. Of course, the main benefit is that such knowledge, especially during these times of limited resources, is prerequisite to making sensible financial decisions. Though you may sometimes feel that much of the knowledge required is above your pay grade, you should try to acquire as much as possible. The effects of your financial decisions will be made for you—which you did not direct—by your financial aid officer or parents or indirectly, by Congress—you have a larger field of action than you might think and numerous difficult decisions ahead. The more you know about managing your personal finances and about how changes in the financial aid picture may affect you, the broader your field of action and the wiser your choices will be.

FOOTNOTES
1 Undergraduate Medical Education: Elements, Objectives, Costs—A Report by the Committee on the Financing of Medical Education, Association of American Medical Colleges, October 1973.
5 Forebearance: A Special arrangement whereby the lender may delay principal and/or student billed interest payments to relieve the borrower's financial hardship when repayment is due.
6 Default: Failure to meet financial obligations on maturity of notes or contractual agreements. Defaults are recorded on an individual's permanent credit record and that individual is subject to lawsuit.

FUTURE OSR MEETINGS
OSR Southern Regional Meeting March 22-24, Little Rock, Arkansas
OSR Western Regional Meeting April 21-24, Pacific Grove, California
OSR Central Regional Meeting May 3-5, Rochester, Minnesota
OSR Northeast Regional Meeting May 10-12, Boston, Massachusetts

OSR REPORT
Published by the Association of American Medical Colleges for The Organization of Student Representatives

OSR National Chairman: Peter Shields
OSR National Chairman-Elect: Dan Miller

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OSR Chairperson
Peter Shields

IN THE BEGINNING WAS FINANCIAL AID!
A word about the cost of a medical education is an appropriate introduction. Because medical schools not only train doctors but also produce research and provide patient care, separately estimating the institutional cost of one of these activities is a complex task, one which was undertaken by the AAMC in 1973 and by the Institute of Medicine in 1974. The results of the AAMC study show the institutional cost of an undergraduate medical education in the twelve schools studied to range between $16,000 and $26,000 per student per year in 1972 dollars, depending on the individual school being considered. In 1978, this means an average of $125,000 for the four years. Based on the AAMC estimate for full resource cost of $31,400 per student per year. Among other things, these figures reveal that even schools which charge over $10,000 per year in tuition must additionally rely upon many other sources of support in order to provide a quality program.

CHAIRMAN'S PERSPECTIVES
The OSR Administrative Board believes that the single most troublesome worry for all but the most fortunate of medical students is finances. Most of us, as students, have been dependent for most of our lives and have had to sit, in most cases quietly, watching tuition increases and financial aid become more difficult to find. There is every reason to believe that this situation will get worse before it gets better. One contribution the OSR can make in the face of this grim situation is to point out the sources of OSR Report on personal finances. In fact, this issue might well bear the label "Warning: May contain information you won't want to hear." Only if you believe that foresight is better than hindsight, will you want to read on.

Although this issue will probably be of greatest value to those students who have borrowed or soon will be borrowing money, it deserves a broader audience since it provides basic information on budgeting, banks, and the like, and since no one can predict what situations may arise which will require the borrowing of funds. This pecuniary primer begins with a brief discussion of the cost of a medical education and how medical students are currently financing that portion of this cost which is charged to them. The next sections are about borrowing money and contain a guide to budgeting, a sample chart for keeping track of loans, and a methodology by which you can estimate what portion of your salary during graduate education will need to be set aside for debt repayment. A final section should help you make sure you have covered all your financial bases. While we understand that the discussion of aspects of money management offered here cannot be exhaustive, we know that many students do not have ready access to these kinds of information and thus hope that this issue will provide a helpful introduction to the topic.

There are many other aspects of finances which we did not attempt to address here: sources of and recent developments in financial aid; the uncertain future of government support for medical education; predictions about the effect of a doctor oversupply on physicians' incomes. Medical students need to broaden their financial horizons beyond the next tuition increase and their source of information beyond their overworked financial aid officer. We hope that the information presented here will provide a prod in that direction, and we would greatly appreciate any comments you have on our efforts.
Since 1963, the federal government has been a major source of such support. A major objective of the government in providing financial assistance was to cure a perceived shortage of doctors by increasing the supply. Now that a nationwide oversupply of physicians is projected by 1980—with no guarantee that, allowed to choose freely, doctors will enter locations or specialties in short supply—there could be reason to believe that the character of government support is changing and that medical students are being asked to bear more of the burden in terms of tuition, service commitment and high interest loans.

The size of this burden has caught many medical students unprepared. Prior to entering medical school, they did not give much consideration to financing much thought, believing that acceptable alternatives would be available. It has come as a shock to many that there is no more "easy money"—a fact well-documented in the September 1978 issue of The New Physician. The most recent figures on how medical students are financing their education reveal that average annual expenses rose from $7,065 in 1975 to $8,500 in 1977 and that the proportion of students receiving scholarships dropped from 45% to 42%; of those receiving scholarships in 1978, 29% were National Health Service Corps or Armed Forces award recipients. In the last year alone, the proportion of students depending to some extent on loans increased from 50% to 56%. These percentages are not mutually exclusive, for most students who receive grants also rely on loans. This study also reports that the proportion of students with debts increased from 44% in 1968 to 73% in 1978; the average debt for senior students has climbed from $4,397 to $13,800 durintg this time period.

Times are changing, creating new demands on and expectations of the medical profession and physicians-in-training. Not only are medical students going to be learning more about hospital cost containment; in order to prevent disruption of their studies, medical students are also going to have to learn more about personal money management and how to handle the lion's share of financial hassles by accepting a service-obligated "scholarship" contract. To be sure, freedom from financial worry will not be the only reason students seek such contracts, but it is an understandably important consideration. However, here are some of the fears associated with these service programs: (1) there are not enough scholarships for people who need them; (2) the characteristics of the programs keep changing from the time students sign the contract, e.g., taxability of the monies; (3) there might not be enough spots or proper process to place physicians in shortage areas when they enter the service obligation via the NHSC; (4) accepting an obligation may interfere with career plans, and some students have opted to ignore the lion's share of financial hassles by accepting a service-obligated "scholarship" contract. To be sure, freedom from financial worry will not be the only reason students seek such contracts, but it is an understandably important consideration. However, here are some of the fears associated with these service programs: (1) there are not enough scholarships for people who need them; (2) the characteristics of the programs keep changing from the time students sign the contract, e.g., taxability of the monies; (3) there might not be enough spots or proper process to place physicians in shortage areas when they enter the service obligation via the NHSC; (4) accepting an obligation may interfere with career plans, and some students have opted to ignore the lion's share of financial hassles by accepting a service-obligated "scholarship" contract. To be sure, freedom from financial worry will not be the only reason students seek such contracts, but it is an understandably important consideration.

The first step is to obtain detailed descriptions of existing loan programs, so that you can decide which ones may be of use to you, and a glossary of financial terms (e.g., deferred interest, maturity date, etc.), the understanding of which is prerequisite to completing an application for a loan. An increasing number of financial aid officers are putting together financial aid handbooks which include these kinds of information. If you do not have access to such information, an excellent handbook has been developed at George Washington University. You may obtain a copy by writing to Mrs. Jean Hammer, Director of Financial Aid, George Washington University School of Medicine and Health Sciences, Washington, D.C. 20037.

The rest of this section is a guide to the more complicated and less common addressed aspects of borrowing money—budgeting, banking, and keeping track of your loans.
Budgeting

Many accepted this salutary habit long ago. Many find the thought so unpleasant that they have never really tried it. But, like it or not, budgeting is the first step in sensible financial management. On page 4 is a sample budget which might serve as a guide to the uninitiated in this art of predicting expenses and resources. Although your personal budget should be more detailed, your financial aid officer should share with you the institutionally prepared budgets so that you can compare amounts under such umbrella categories as housing, transportation and medical expenses. This comparison might reveal an extravagance you need to think twice about or a problem on the horizon best dealt with before the fact. Here are a few additional suggestions for designing a financial calendar:

1) Prepare a budget you can live within: underestimation can lead not only to a sense of failure followed by out-of-hand rejection of the whole process but also, and more importantly, to the jeopardy of your physical and mental health.

2) Trim your budget of luxury items: remember that when you are relying on loans every dollar you spend must be repaid with interest and that some pleasures are postponable until a paycheck can absorb the expense.

3) Use your budget as a decision-making tool: before signing a lease or buying a car, weigh all of the concomitant expenses, e.g., insurance, then consult your worksheets to determine the impact of your decision.

4) Create a well-organized file for your financial papers: get in the habit of writing down your expenses at the end of each week. Keeping track of errors and victories in planning will provide a useful guide for the future.

5) Open a savings account: even if you are able to add only occasional, small amounts, a savings account has three-advantages—interest accumulates; the total depletion of resources (a source of truly unproductive stress) is prevented; and the account may be useful as an indicator of reliability and foresight to a loan officer who needs proof of these two traits.

Getting to know your bank

It is a very good idea to establish an open, working relationship with a loan officer at your bank. Before you can hope to establish a relationship, you will need to consider the following facts: 1) Banks accept less of a return on educational loans than on virtually every other kind of investment; not only are the interest rates lower but collection and administrative costs are higher. Moreover, when students default on federally-insured loans, banks retain the notes on their books for months, without earning interest, because the government is often slow in paying these accounts. 2) Relationships of banks with their student borrowers are often strained because of the high default rate, minimal returns, and the fact that students tend to view bankers as bogeymen. Students do not realize that banks often participate in educational loan programs mainly because they believe in education and want to provide a community service. 3) Even though the educational loan business is a relatively new industry, lenders are already becoming very worried about the amount of debt they are saddling students with; thus, a reticence on their part to lend you funds should not automatically be construed as a kind of prejudice or distrust. The business of loan officers is money management. They are prepared to give you advice you may not know you need.

Keeping Track

Before signing a loan application or promissory note be sure to determine the following information: 1) the maximum amount that may be borrowed per academic year as well as the maximum aggregate amount; 2) the interest rate and whether the interest is deferred until after graduation, subsidized, or payable while you are in school; 3) whether the interest, if not deferred, is payable monthly, quarterly or annually; 4) whether the loan may be repaid at any time without penalty; 5) if repayment of the principal and/or interest can be deferred through residency training; 6) the grace period and the number of years allowed for repayment; 7) whether the loan can be forgiven for practice in a physician shortage area; and finally 8) what the required monthly payment will be during the repayment period. Additionally, try to help your financial aid officer help you by following directions on loan applications, allowing enough time for processing, and Keeping records of all transactions. Below is a chart titled "Record of Outstanding Loans"; you are encouraged to copy this chart or develop your own system for keeping track of loans.

<table>
<thead>
<tr>
<th>Name of Loan/Lender</th>
<th>Date Incurred</th>
<th>Amount Borrowed</th>
<th>Interest</th>
<th>Date Due</th>
<th>Grace Period</th>
<th>Repayment Period (years)</th>
<th>Minimum Monthly Payment</th>
<th>Student's Projected Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2.</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>3.</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>4.</td>
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<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
There are many sound reasons for keeping such a chart up-to-date. One of these is to prevent your “exit interview” with your financial aid officer around graduation time from becoming a shock treatment. At this interview, you and the aid officer will review your total financial obligations. It is the latter’s responsibility to ascertain if you understand repayment terms, the importance of keeping lenders informed of address changes, and the like. If you enter this interview prepared and informed, it will be an unparalleled opportunity for clearing up any doubts you have and for double-checking your records. If not, it will be an unpleasant collision between you and the financial world you are about to enter.

### Sample Budget

<table>
<thead>
<tr>
<th>Expenses from ______ to ______</th>
<th>Estimated</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Special</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition &amp; school fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Boards exam fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newspapers/journals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Books &amp; newspapers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortgage/Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groceries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus/subway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licenses/fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gas &amp; oil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bicycle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Medical/Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Dentist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses/contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Clothing/Personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaners/laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Amusement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacation fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Books/crafts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home owners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenses vs. Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Total Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus (+)/Deficit (-)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DEBT MANAGEMENT

The first step in debt management is a prospective one: know how much you owe in principal and interest at any given time. The next step is to calculate how the payments which will be required during the residency years will stack up against an estimated salary. Senior students who have not already done so and juniors who can estimate their debt upon graduation should not delay in referring to their chart of outstanding loans and creating a repayment schedule. While calculus is not prerequisite to such an exercise, a thorough understanding of repayment conditions for each type of loan is: required and minimum monthly payments, length of grace and interest deferral periods, and length of repayment period are important variables. For each type of loan a separate sheet will be required. Your goal is the creation of a schedule which resembles in format the example offered below. Finally, add each schedule into a master repayment calendar, from which you will be able to see at a glance your monthly and annual obligation to lenders.

**Example:** for the sake of simplicity, let us assume that the student has borrowed $10,000 per year in medical school at 10% simple interest. The student has been paying the interest on the loans while in school and repayment of principal will not begin until the student has

### REPAYMENT SCHEDULE

<table>
<thead>
<tr>
<th>Amount borrowed</th>
<th>Repayment Period: 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interest Payments</th>
<th>PER MONTH</th>
<th>PER YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Year of Residency</td>
<td>$333.33</td>
<td>$4000</td>
</tr>
<tr>
<td>2nd Year of Residency</td>
<td>$333.33</td>
<td>$4000</td>
</tr>
<tr>
<td>3rd Year of Residency</td>
<td>$333.33</td>
<td>$4000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal and Interest Payments</th>
<th>PER MONTH</th>
<th>PER YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Year in Practice</td>
<td>$666.67</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>2nd Year in Practice</td>
<td>$633.33</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>3rd Year in Practice</td>
<td>$600.00</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>4th Year in Practice</td>
<td>$566.67</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>5th Year in Practice</td>
<td>$533.33</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>6th Year in Practice</td>
<td>$500.00</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>7th Year in Practice</td>
<td>$466.67</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>8th Year in Practice</td>
<td>$433.33</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>9th Year in Practice</td>
<td>$400.00</td>
<td>$4000 Principal</td>
</tr>
<tr>
<td>10th Year in Practice</td>
<td>$366.67</td>
<td>$4000 Principal</td>
</tr>
</tbody>
</table>
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OSR REPORT

Published by the Association of American Medical Colleges for the Organization of Student Representatives.

The demands of medical school on our time and energies often seem to leave little of these two commodities for other endeavors. One of the more unfortunate results of our remaining submerged in day-to-day assignments is that we rarely get a glimpse of the big picture of what’s going on in health. While we all realize that health is big business (about 9% of the Gross National Product in 1978), our experience tells me that few medical students realize the extent to which: 1) health funding is a political process, and 2) the outcome of negotiations which are right now taking place on Capitol Hill will affect their immediate and future situations. It is easy to be confused and disappointed with the political process in this country, but a dismissal will not change the fact that in the coming year or two legislations will be passed which will affect you— as a medical student, resident, and practitioner. Laws don’t make themselves; they are the creation of elected officials who are responsive to their constituencies. To be sure, some Congressmen are already well-informed about the health issues on which the vote will be made, yet a greater number are not; and many individuals, including your dean and faculty, find it important to educate legislators about the effects that various Congressional actions may have. On some of these issues—and the best example is student financial assistance—medical students simultaneously expressing their concerns represent testimony which cannot be ignored. Learning about the health legislation arena should be viewed as integral to the medical education process; it represents yet another area with which you will need to be familiar in order to protect your interests and the interests of your patients. Now is the time to accept this responsibility and we hope this issue of OSR Report will help you to prepare for your first. First described are those items in President Carter’s FY 1980 budget which are crucial for you to know about, followed by an outline of the federal budget process. The second section reviews your memory on how a bill becomes a law. The last section lists the key congressional committees and contains suggestions on how to maximize your input into the legislative process. Obviously, this issue represents only an outline of the subject—the issues facing the health care industry and health professions education are enormously complex and the political process is a challenge to understand. But it is a place to start, and I and the other members of the OSR Administrative Board look forward to hearing your reactions to our efforts.

Chairman’s Perspectives

Financier’s Medical Education

The demands of medical school on our time and energies often seem to leave little of these two commodities for other endeavors. One of the more unfortunate results of our remaining submerged in day-to-day assignments is that we rarely get a glimpse of the big picture of what’s going on in health. While we all realize that health is big business (about 9% of the Gross National Product in 1978), our experience tells me that few medical students realize the extent to which: 1) health funding is a political process, and 2) the outcome of negotiations which are right now taking place on Capitol Hill will affect their immediate and future situations. It is easy to be confused and disappointed with the political process in this country, but a dismissal will not change the fact that in the coming year or two legislations will be passed which will affect you— as a medical student, resident, and practitioner. Laws don’t make themselves; they are the creation of elected officials who are responsive to their constituencies. To be sure, some Congressmen are already well-informed about the health issues on which the vote will be made, yet a greater number are not; and many individuals, including your dean and faculty, find it important to educate legislators about the effects that various Congressional actions may have. On some of these issues—and the best example is student financial assistance—medical students simultaneously expressing their concerns represent testimony which cannot be ignored. Learning about the health legislation arena should be viewed as integral to the medical education process; it represents yet another area with which you will need to be familiar in order to protect your interests and the interests of your patients. Now is the time to accept this responsibility and we hope this issue of OSR Report will help you to prepare for your first. First described are those items in President Carter’s FY 1980 budget which are crucial for you to know about, followed by an outline of the federal budget process. The second section reviews your memory on how a bill becomes a law. The last section lists the key congressional committees and contains suggestions on how to maximize your input into the legislative process. Obviously, this issue represents only an outline of the subject—the issues facing the health care industry and health professions education are enormously complex and the political process is a challenge to understand. But it is a place to start, and I and the other members of the OSR Administrative Board look forward to hearing your reactions to our efforts.
THE BUDGETARY AND LEGISLATIVE SCENARIO

The underlying theme of the play which is currently being enacted on Capitol Hill is the effort to restrain governmental spending in order to reduce the overall federal deficit and to curb inflation in response to increasing vocal and dissatisfied taxpayers. Easily recognizable subplots include the Carter Administration's determination to contain rising health care costs and the projected national oversupply of physicians. Thus, while deeply disturbed, the alert members of the health audience were not surprised by President Carter's Fiscal Year (FY) 1980 budget requests and FY 1979 rescission messages.

A rescission is an effort by the Administration to cut or eliminate funds which have already been appropriated by Congress for the current fiscal year; President Carter asked Congress to rescind nearly $168 million which had already been allotted to the Health Resources Administration for health professions education. The 1980 budget request is for a total budget authority, i.e., ceiling, of $57.6 billion for health programs, only 16% of which is for "controllables," i.e., non-Medicare or Medicaid expenditures. Programs aimed at reforming the health system (e.g., health maintenance organization development, conversion of unused hospital beds) appear to be what the President is most interested in expanding. However, it is evident that funding proposed for health professions education programs is far below what is needed to maintain the quality and diversity of the programs. This is how the funding picture is shaping up in the two areas which will have the greatest immediate impact on medical students—financial aid and capitation grants.

Financial Aid Programs

An introduction to current developments in student financial assistance must begin with the Health Professions Education Assistance Act of 1976 (PL 94-484). A comprehensive discussion of the student assistance elements of PL 94-484 is contained in the Report of the Health Profession Student Loan (HPSL) Programs, thereby eliminating new funding for the only need-based programs nationally available, and only need-based programs. However, it is evident that funding proposed for health professions education programs is far below what is needed to maintain the quality and diversity of the programs. This is how the funding picture is shaping up in the two areas which will have the greatest immediate impact on medical students—financial aid and capitation grants.

Worse yet is the news contained in the FY 1980 budget request. While the President failed to gain Congressional approval for a rescission of HPSL funds for FY 1979, his FY 1980 budget contains zero dollars for both the ENFS and HPSL Programs, thereby eliminating new funding for the only need-based programs nationally available, and only need-based programs. The HHSC Program to maintain the current number of medical student enrollees at approximately 430 (only seven percent of the total medical school enrollment).

Capitation Grants

The Comprehensive Health Manpower Act of 1971 formally established the capitation mechanism as the primary federal method of providing institutional support to U.S. medical schools. The funds are provided on the basis of enrollment, i.e., per capita, with eligibility determined by whether the school responds to federally-identified national health goals. Capitation awards have declined substantially since FY 1972 (from $2065 per medical student to $1370 in FY 1978) but the requirements for eligibility have not. For example, only last fall, schools admitted U.S. Foreign Medical Students with an implicit promise for continued capitation support.

Some Letter Writing Tips

All of the foregoing is preparation for the bottomline of your process: communicating your views to your legislators. The cardinal rule in writing Congressmen is: speak for yourself. They are not interested in "canned" messages or form letters (and can spot them); they want to know what you have to say. Here are some basic ground-rules to remember:

- type your letters if at all possible
- include your name, school and address—and your signature
- be courteous and brief
- verify your facts
- write to U.S. Senators and Representatives at their Washington offices using the following format and addresses:

   The Honorable Jane Doe
   U.S. House of Representatives
   Washington, D.C. 20515

   The Honorable Jane Doe
   U.S. Senate
   Washington, D.C. 20501

Dear Ms. Doe:

As you have probably gathered from the above descriptions of the budget and legislative process, the timing of your involvement is very important. If you enter the process when a bill has gone to conference, you may be less than influential because you may have missed your opportunity to influence the outcome. If you had expressed your opinion when the bill was in subcommittee. It is also important to have accurate information on the current status and potential impact of the bill about which you are writing. But the most important thing is that you do write to inform your Congressmen of your views. If this issue of OSR Report elicits only a few letters, each letter is valuable because the subcommittee must consider each letter individually. By virtue of this role, you are expected to speak out on education and health issues. Indeed, your silence will be interpreted as approval of whatever health legislation is promulgated. The time to get involved is now.

FOOTNOTES


3 You may subscribe to the AAMC's "Weekly Activities Report" by writing to Membership and Subscriptions, AAMC, One Dupont Circle, N.W., Washington, D.C. 20036. Subscription price: $15/year (45 issues).

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Oliver L. Dingell

Charles McC. Mathias, Jr., Md.

Herman "Jack" Schmitt, N.M.
This January, President Carter asked for a rescission of $58.7 million of the $120 million appropriated for FY 1979 for medicine, osteopathy and dentistry (MOD) schools. That Congress approved $24 million of the requested rescission came as a bitter disappointment to medical educators. This defeat augers ill for the outcome of the current debates over President Carter's FY 1980 budget which requests zero dollars for MOD capitation grants. Evidently, the rationale for this withdrawal of support is that there is no longer a national shortage of physicians. However, the costs associated with expanded enrollment, which schools accomplished in response to federal initiatives, are recurrent; they continue by virtue of commitment for new faculty, expanded physical facilities, etc. Reduction in capitation support will not only significantly reduce schools' flexibility in program planning and ability to meet commitments but will also likely cause tuitions to rise. As is shown above, current financial aid programs are woefully inadequate to assist students in bearing such increases.

A Word About the Budget Process

The size and complexity of the federal budget requires that a large part of the initial task of budgeting be delegated to the Executive Branch. Within 15 days after Congress convenes each year, the President submits a proposed federal budget, representing the culmination of a year of preparation by agency officials. Three different types of Congressional committees then begin their reviews. Budget committees decide how much money can be made available, given limitations on revenue, for all the functions of the government, e.g., defense, health. Authorizing committees, which describe what a particular program is intended to accomplish, establish absolute ceilings on the public monies to be spent on a program. Finally, appropriations committees then decide how much can be actually be spent for a specific program in a specific fiscal year or years within the limits set in the authorizing legislation.

The most important aspect of the workings of these committees for you to know about is that funds can be authorized at any level for a program but unless they are also appropriated at a meaningful level, the program will not function as intended. A good example here is the Exceptional Financial Need Scholarship Program, funding for which was authorized at $17 million but for which only $7 million was appropriated in FY 1979. The House and Senate Appropriations Committees and their health subcommittees therefore merit great attention. Authorizing bills must be "marked up," i.e., committee deliberations must be completed, by May 15. Appropriations bills cannot be reported before this date. The actions which take place during the period between May 15 and October 1, when the new fiscal year begins, are extremely complex and will not be described here. The crucial thing to remember is that appropriations committees can become forums for change in health programs.

UNDERSTANDING THE LEGISLATIVE PROCESS

Knowing how Congress works is a prerequisite to effective input into the law-making process. Look upon it as a long, slow, complex game of give-and-take with numerous opportunities for you to influence the players (unless, of course, you prefer to remain a silent member of the audience). You don't need to be familiar with all the fine points, but understanding the basic rules of play will stand you in good stead so long as health issues are political issues, in other words, for the foreseeable future. While the following is only a bare bones summary of the rules, it should help to prepare you for active participation; if you desire a more detailed description How Our Laws Are Made and Congress and Health are two highly readable and easily obtainable booklets.

In a capsule this is what normally happens: A member of Congress introduces a bill. Bills initially introduced into the Senate are designated by the letter S. Once introduced, a bill is referred to one of the 11 standing committees of the House of Representatives or the 15 standing committees of the Senate. Each is referred to the committee or committees having jurisdiction over the subject with which the bill deals. The committee chairman then usually refers the bill to the appropriate subcommittee, whose chairman may schedule public hearings. Depending on the nature of a bill, hearings may be conducted for a few hours or last for several weeks. The subcommittee next holds "mark up" sessions at which amendments to the bill are considered and recommendations are prepared for submission to the full committee. What happens to a bill at this level frequently determines its eventual fate. At the end of the mark up sessions, the subcommittee votes either to recommend it favorably, with or without amendment, or to table it. If the bill is tabled, it is in effect killed for the current session of Congress. A bill favorably reported is next reviewed by the full committee, which, because of the breadth and magnitude of issues, generally relies heavily upon the conclusions of the subcommittee. The committee also holds mark up sessions during which the bill may be amended and then either reports the bill to the full House or Senate or tables it.

Several procedural items precede actual floor vote on a bill, including assignment of calendar numbers. Bills placed on a calendar are voted upon in order of numerical sequence, although both chambers have rules to bypass this sequence. A bill may be further amended during floor debate. When a bill has been passed, it is sent to the other chamber. A bill may separately pass both Houses of Congress but, having been amended at the subcommittee, committee and/or floor levels, emerge in different form from the legislation approved by the other body. When this happens—and it often does—the first body may vote to accept the bill as approved by the second. If it is not accepted in that form,
the bill must be sent to a conference committee whose task it is to reconcile areas of disagreement, then to make recommendations to both Houses, who in turn vote to approve or disapprove the recommendations. Should the conference committee fail to reconcile differences, the bill is said to “die in conference.” Once approved by Congress, a bill goes to the President, who may sign it into law or veto it. A veto may be a specific action, or if Congress is not in session, the simple refusal to sign. Congress may override a veto by a two-thirds vote of both houses. Once the President signs, or fails to veto a bill, it becomes a law and is assigned a public law number. The public law numbers run in sequence starting anew at the beginning of each Congress (which lasts two years) and are prefixed by the number of the Congress—e.g., the first public law of the present Congress is designated PL 96-1.

Even after passing through this lengthy process, a law may still never be fully implemented. Many laws require funding and getting funds appropriated requires enactment of another separate piece of legislation. Laws which establish a program also require the responsible federal agency, e.g., HEW, to propose regulations for the program's administration. This is often a long, necessarily slow process which provides interested parties with additional opportunities to express views that may significantly affect a program's final form. In some instances, the public will be invited, via a “Notice of Intent” published in the Federal Register, to comment on options developed by drafters of regulations. After the comments received have been evaluated, formal proposed regulations are written and interested parties have another opportunity to comment. Once the period established for public comment has ended, final regulations are adopted and published. The Exceptional Financial Need Scholarship Program once again provides a good example of how a promising program created by law (PL 94-484) can be subsequently eviscerated. Not only was the program not funded at a meaningful level but the final regulations defined “exceptional need” to mean “zero resources” so that a student with even $10 in a savings account would not be eligible.

Thus, you see the tortuous, winding staircase which is our legislative process and the multitude of doors which open on to it and which you can open.

WHO'S WHO IN HEALTH LEGISLATION

Listed on pages 5 and 6 are the members of the committees which have the most impact on health legislation; each of these committees has a health subcommittee. Under each committee and subcommittee the majority members, i.e., Democrats, are given first, followed in italics by the minority members, i.e., Republicans. The first Senate and House committees listed are the major authorizing committees for health programs. The Senate Finance Committee and the House Ways and Means Committee raise revenues through taxes, and programs such as Medicare are entirely their responsibility. The Senate Finance Committee also has jurisdiction over the Medicaid program. Medicare and Medicaid are especially important programs because they finance health care and comprise a significant proportion of all federal health dollars. The Senate Human Resources Committee and House Interstate and Foreign Commerce Committee authorize most other health legislation, such as that dealing with student loans and biomedical research. The amount of funds approved by Congress to be spent for any specific health program in a fiscal year is determined by the last pair listed—the House and Senate Appropriations Committee.

Keeping in Touch

Admittedly, keeping on top of the health legislative scene can be a full-time job, and you probably feel that you have little enough time for non-medical research and reading without trying to follow Capitol Hill activities. However, this effort should be viewed as part of the medical education process, and medical students can work together to keep informed. Perhaps your student government leaders could arrange to have a space set aside in the library or lounge as an information center. Current newspapers and periodicals with good national coverage could be kept there and a group of students could share the responsibility for marking items of special interest so that others can find them at a glance. OSR members are repositories of information on current health legislation which they could make available, e.g., the AAMC Weekly Activities Report and periodic memorandas from AAMC President John Cooper to deans and members of the AAMC Assembly describing important events on the Hill. Also posted should be the roster of Congressmen from the state in which your school is located, showing whether they serve on any health committees or subcommittees. You could seek the cooperation of your financial aid officer to provide up-dates on legislation affecting student assistance programs. One individual could be responsible for obtaining copies of bills and laws of interest; free copies of these can be obtained by sending a self-addressed label to the House Document Room, U.S. Capitol Building, Washington, D.C. 20510. You can also learn the current status of any bill by calling (202) 225-1772 and giving the person who answers the number of the bill. A final idea offered here is that one of the coordinators of this effort, perhaps in conjunction with the dean’s office, be designated as the repository for copies of communications to Congressmen; this would not only allow students to exchange approaches but also deans could gauge the level of their students’ involvement. These are just a few suggestions on how you might begin to organize an information exchange system. Probably because of lack of time and interest many students will not get involved. But certainly there is a core of students at each school who are ready to accept the responsibility to become informed.
A SHORT QUIZ ABOUT OSR

1. WHAT IS THE OSR?

A group of medical students, one from each school which chooses to participate (112 in 1978-79), that works together with deans, faculty and teaching hospital administrators to formulate the programs and policies of the AAMC.

2. WHAT IS THE AAMC?

The Washington-based organization representing all 125 U.S. medical schools, over 400 teaching hospitals and 60 academic and scientific societies, which works to insure the high quality of medical education in this country. The AAMC provides many services to its members, including annual publication of directories of medical school admission requirements and curricula descriptions. As health care and education issues become more and more complex, the combined wisdom of each party involved is needed, especially in such areas as the transition between undergraduate and graduate medical education, the supply of clinical researchers and federal support of medical education. The AAMC provides this forum for the exchange of ideas and opportunities to compare perspectives toward the end of common action. Because the President's and Congressional staffs, members of HEW, and the NIH look to the AAMC for leadership on issues dealing with medical education, it is particularly important for the Association to arrive at clear, unified positions, in order to incorporate such a diverse span of interests on such intricate matters, its governance is necessarily complex; to incorporate such a diverse span of interests on such intricate matters, its governance is necessarily complex. OSR/AAMC Annual Meeting November 3-7, 1979, Washington, D.C.

CHAIRMAN'S PERSPECTIVES

This issue of OSR Report brings to your attention a problem, the full extent of which has just recently come to light—that is, the declining numbers of physicians participating in research and entering academic careers. This decline not only spells trouble in terms of the quality of medical education that those who follow will receive but also threatens the progress of those many areas of research which depend upon the unique capabilities of the physician-investigator. In the midst of continual dialogues about the need for primary care physicians, of financial aid being linked to service in underdoctored areas, of curriculum innovations in the direction of first-contact medicine, and of the expansion of residencies in family practice, general internal medicine and general pediatrics, we are also surprised to find that another, completely different shortage area in medicine had appeared. Most of us have probably also become rather skeptical about projections of what kinds of physicians are needed, given the Federal government's seemingly quick change in policy about whether this country is over- or under-doctored and the resulting difficulties medical schools are having to face. Nevertheless, as you will learn if you read this issue, a problem is here which holds in jeopardy the future quality of clinical teaching and research.

It is noteworthy that at our 1979 Annual Meeting, the OSR passed a resolution urging greater availability of research opportunities for medical students. The governing body of the AAMC adopted the OSR resolution, thus stimulating a number of related efforts not only to expand research opportunities for medical students but encompassing the entire range of factors having to do with research training. Even if you have already dismissed the idea of devoting a portion of your career to research, you will smile from understanding the concern in the OSR, regardless of which area of medicine you choose, constraints similar to the ones at work here will be involved. If you have an open mind about research or know for sure you want to participate, the following pages should be most helpful. I hope you will contact me or any other member of the Administrative Board if you desire more information on the issues addressed here or if we can be of assistance in any other way.

Peter Shields OSR Chairperson

THE NEED FOR M.D. INVESTIGATORS

Without the physician-investigator there to observe the links, discoveries in basic science laboratories and problems on the wards and in the clinics remain as unrelated as medical students often perceive the basic science and the clinical years to be. Possessing both research and clinical skills, these individuals play the all important cross-over role between lab and bedside. While any alert physician will convert details observed in practice into a learning experience, the physician-investigator has the training and resources necessary to design and carry out the experiments which form the basis of new clinical practices, new drugs and new devices. Combining the continual search for relationships between diseases and their treatment with testing and demonstration of these relationships, the work of the M.D. investigator may be the most challenging and exciting that the medical profession has to offer. Research is usually combined in various degrees with patient care and teaching and can range from occasional participation in epidemiological studies or drug trials to a full-time commitment. Likewise, there are no hard and fast rules regarding training for research; training can begin as late as the post-residency level or can be a continuous engagement.
beginning with enrollment in an M.D.-Ph.D. program. However, at all levels there is now evidence that participation of medical students and physicians in research and preparation for research careers have declined:

A. A recent attitudinal study of medical students at Harvard showed that the percentage of graduating students signing a high priority to research dropped from a peak of 49% in 1963 to 2% in 1976 (1). AAMC studies have also indicated that while 39% of medical school graduates in 1960 stated that research would be a component of their careers, only 20% expressed the intent to devote any portion of their careers to research in 1976 (2).

B. The principle of research training to physicians has been through the mechanism of fellowships supported by the National Institutes of Health (NIH). The number of M.D.'s in these training programs has declined from over 15,000 in 1968 to fewer than 8,000 in 1975 (4); during the same seven years the number of full-time faculty at U.S. medical schools increased by 160%. Moreover, in 1966 approximately 44% of competing research grant awards to new principal investigators were made to M.D.'s; in 1978 M.D.'s received only 23% of the number of new and competing grant awards.

While solutions may not be obvious, the implications of these trends are clear. The continuing search for new scientific knowledge to improve the nation's health depends on the number of medical students and physicians in research and preparation for research careers have declined:...