

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MEMORANDUM

March 11, 1974

TO: Council of Deans Administrative Board  
FROM: Joseph A. Keyes  
SUBJECT: COD Administrative Board Meeting, March 21, 1974

Attached is the COD Administrative Board meeting agenda. Please note that many of the action items are also on the Executive Council agenda. Thus, rather than duplicate the material, we ask that you bring the Executive Council agenda to the Board meeting and we will work from that agenda as well.

Attachment

JAK:mac

AGENDA

COUNCIL OF DEANS  
ADMINISTRATIVE BOARD

AAMC Conference Room (218)  
March 21, 1974

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\*Other important information items appear in Executive Council Agenda.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
MINUTES  
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

December 13, 1973  
9:00 a.m. - 4:00 p.m.  
Conference Room  
AAMC Headquarters

PRESENT:

(Board Members)

Emanuel M. Papper, M.D.  
Ivan L. Bennett, M.D.  
Ralph J. Cazort, M.D.  
Andrew Hunt, M.D.  
William D. Mayer, M.D.  
Robert L. Van Citters, M.D.

(Staff)

Jane Becker  
Marcia Collette  
John A.D. Cooper, M.D.  
Nan Hayes  
Doris Howell, M.D.  
Joseph A. Keyes  
James R. Schofield, M.D.  
Marjorie P. Wilson, M.D.

(Guests)

Sherman M. Mellinkoff, M.D.  
Daniel Clarke-Pearson

ABSENT

J. Robert Buchanan, M.D.  
John A. Grönvall, M.D.  
Clifford G. Grulee, M.D.  
Julian R. Krevans, M.D.  
William F. Maloney, M.D.

I. Call to Order

Dr. Papper, Chairman, called the meeting to order shortly after 9:00 a.m.

II. Minutes of the Previous Meeting

- The minutes of September 13, 1973 and the November 5, 1973 meetings were approved as circulated.

III. The Chairman's Report

The Chairman's report was devoted to a description of the AAMC Officer's Retreat. A brief summary of the discussion of each of the retreat agenda items appearing on p. 8-10 of the Board agenda was provided.

IV. Review of the Officers' Retreat:  
Establishment of Association Priorities

The Chairman's report led directly to a discussion of the retreat conclusions provided in summary form via a 2-page handout distributed at the meeting. (Attachment I to these minutes). Several reservations were expressed about the listing provided in the second paragraph on p.1: a) item 4 was viewed as a procedural or operational matter and of an entirely different order of concern than the remaining items which dealt with substantive issues; b) one member questioned whether the order of listing implied an order of priority or emphasis. (Answered in the negative).

Board members not at the retreat registered their dissatisfaction with the AAMC's process for setting priorities, noting that being provided a write-up of the retreat conclusions on the day of the Board meeting did not permit careful, substantive deliberation. This created the appearance that all that was really desired was a rubber stamp of the retreat outcomes. Staff cited the AAMC Bylaws requirement that the first Executive Council be held within 120 days of the Annual Meeting. In order that this meeting be devoted to setting priorities, the Executive Committee meets in the first part of December. The elapsed time between the retreat and the Council meeting is insufficient to allow for the write-ups of meeting conclusions and advance distribution of a report.

After further discussion, the Board took two actions:

- A. Endorsed the recommended AAMC priorities as presented in the summary of the retreat.
- B. Voted to recommend that the Executive Council place on its March agenda the matter of the retreat and the process by which AAMC priorities are developed, reviewed, and approved.

V. Report of the AAMC Committee on Health Manpower

The Board endorsed the report of the Committee as modified by the AAMC Officers.

The Board agreed to the newly proposed capitation formula of four parts including a base grant and incremental increases for: expansion of enrolment; emphasis in the curriculum on primary care; and developing models for shortage area care.

The Board also heard and had no objection to the provision of capitation support for graduate training in primary care and support of the development of the new facilities for undertaking expanded programs in primary care training.

VI. Policy for Release of AAMC Information

The Board endorsed the proposed policy for the classification and release of AAMC information.

VII. Classification of Salary Study Information

The Board endorsed the Data Development Liaison Committee request that the Executive Council confirm public classification for statistics from the annual Faculty Salary Survey.

VIII. LCGME Bylaws

The Board endorsed the adoption of the LCGME Bylaws, provided that the following recommended amendments be made:

- A. Article VIII - MODUS OPERANDI, Section 3, Appeals (c): delete from the second sentence the words "made the adverse decision or concurred in the adverse decision of the Review Committee" and insert in their place, "served on the appeals board."
- B. Article X - AMENDMENTS, Section 1: add the sentence "All amendments require approval by the five bodies with representatives on the Liaison Committee."

IX. AAMC Recommendations on Medical School Acceptance Procedures

The Board adopted the proposed AAMC recommendations on medical school acceptance procedures with the addition of the following sentence at the end of paragraph two: "By April 1, each accepted applicant must withdraw from every institution in which he does not intend to enroll."

X. Policy Guidelines on Extramural Academic Experiences

The Board endorsed the Guidelines on Extramural Academic Experiences after amending it to delete: 1) entire second page with the exception of item III E, which becomes item II D; 2) the word "policy" wherever it appears in the document.

XI. Report of the Graduate Medical Education Committee

The Board responded to the request for comments on the preliminary recommendations with numerous suggestions:

- The report gives the appearance of being very superficial and illconsidered; a much more scholarly approach needs to be taken in this important effort.

- As worded, paragraph 2 is either ambiguous or highly inaccurate.
- The combining of primary care training and ambulatory settings in paragraph 3 is inappropriate.
- The 50% figure in paragraph 3 should be examined and justified.
- Paragraph 3 D properly belongs under paragraph 4.
- The 110% - 120% figure in paragraph 4 needs to be examined and justified.

XII. Physician Manpower and Distribution - Report to the CCME

The Board provided a number of specific comments on the report suggesting refinements, but on the whole considered the report very well drafted.

XIII. Report of the Advisory Committee on Academic Radiology

The Board recommended that the Executive Council receive the report, express its appreciation for the work of the Committee and suggest that it respond to the comments of the individual Board and Council members.

XIV. Regional Medical Libraries Program

The Board heard from Dr. Schoolman of the NLM who argued persuasively that a more full utilization of the regional libraries and the biomedical communications network could result in substantial savings to the schools.

XV. COD Spring Meeting

Tentative program in final form; announcements will go out shortly.

XVI. AAMC Task Force on Foreign Medical Graduates

In general, the Board concurred in the approach of the Task Force.

XVII. Relationship to the VA

The Board endorsed frequent and vigorous interchange between the VA Department of Medicine and Surgery and the AAMC at both the staff and constituent level by all appropriate means.

XVIII. Invitation to Vice-Chairperson of OSR

The Board acted favorably on a request from the OSR Administrative Board that, in the interest of providing informed continuity of leadership in that body, the COD Administrative Board would offer a standing invitation to the OSR Vice-Chairperson to attend its meetings.

XVIX. Reporting State Level Developments

The Board could reach no judgment regarding either the desirability or feasibility of a proposal that the AAMC develop a system for reporting on state level developments relevant to the medical schools.

XX. Adjournment

The meeting adjourned at approximately 3:45 p.m.



REPORT OF THE AAMC OFFICERS' RETREAT

December, 1973

The Chairman, Chairman-Elect, and President of the Association along with the Chairman and Chairman-Elect of each Council, the OSR Chairperson, and key AAMC staff met from December 5 - 7 to review the activities of the Association and to discuss the major issues which the AAMC will confront in the coming year.

Foremost among the issues identified for major Association effort are:

- 1) the development of recommendations on the financing of medical education by the Sprague Committee with the input already put forth by the Krevans Committee on Health Manpower;
- 2) the development of a more specific AAMC position on national health insurance by a Special Task Force; such a position must lay out legislative specifications on every aspect of national health insurance affecting the medical schools and teaching hospitals;
- 3) the consideration, by the AAMC Graduate Medical Education Committee with input to the Coordinating Council on Medical Education, of ways to better relate the specialty and geographic distribution of physicians to the needs of the population;
- 4) the organization of agencies collecting data on medical schools to avoid duplication and provide a more coherent and better utilized information system -- charge to the Data Development Liaison Committee;
- 5) an examination of the role of the medical schools and teaching hospitals in educating the public about health; this topic would be the theme of the 1974 AAMC Annual Meeting.

Another major consideration was felt to be biomedical research, particularly the issue of assuring adequate research manpower. The Braunwald Committee was asked to evaluate the need for researchers in specialty areas and to recommend an appropriate financing mechanism. This committee was also asked, through the appointment of subcommittees, to consider the peer review system and recommend a mechanism for assuring the appointment of qualified individuals to Advisory Councils and to develop criteria for determining which research areas might benefit from a targeting of federal support (research center approach).

The Retreat participants discussed the Foreign Medical Graduate issue and the overall question of how many physicians are needed. While it was felt impossible to determine the number of M.D.'s needed until problems such as specialty and geographic maldistribution and the disorganization of the health care system are resolved, it was asserted that the number of graduate positions must reflect the needs of the population and all who enter graduate training must demonstrate a high level of competence.

After supporting in concept the use of the health care team to alleviate shortages caused by maldistribution of physicians and recommending that financial incentives to encourage schools in this area be built into Comprehensive Health Manpower legislation, the Retreat considered the accreditation of physician assistants' and allied health educational programs. The newly-formed Commission on Physician Assistants and the proposed Joint Council for the Accreditation of Allied Health Education were discussed, along with the established AAMC position that the LCME should accredit Type A physician assistants programs. The issue of separating the Type A programs from the remainder of the allied health field was left unresolved. If the Association supports this segregation of Type A programs, it may choose to continue to support LCME accreditation or, alternately, may accept the jurisdiction of the CPA and choose to participate on that body. The relationship of the Coordinating Council to the CPA and JCAHE must also be defined.

There is mounting pressure to form a Liaison Committee on Continuing Medical Education under the Coordinating Council. The Retreat recommended that the Association elaborate detailed specifications on the role and function of such a Liaison Committee during the deliberations of a now-appointed CCME ad hoc committee. The stress should be placed upon stimulating continuing education programs which are linked to quality of care appraisal. The Group on Medical Education should be encouraged to include in its membership those individuals in the institutions who are responsible for continuing medical education, and should evolve programs directed toward improving the effectiveness of educational efforts directed toward practicing physicians. Association activities directed at helping the institutions effectively meet the requirements of the PSRO legislation should include the establishment of a central clearinghouse to collect and disseminate information on medical care evaluation studies. This would include developing a network of quality assurance correspondents at each institution.

The Retreat considered pressures being brought to develop national curricula to train medical students in categorical disease areas such as cancer and high blood pressure. It was felt that the Association should encourage these efforts at the level of public and continuing education, but should not support this at the undergraduate level.

The Retreat participants also discussed issues concerning the constituent composition of the AAMC, the responsiveness of the Association to the needs of various segments of the membership, and the AAMC's liaison with other organizations in the health field. As a final item, the format and program of the 1974 Annual Meeting were briefly discussed and referred to the Executive Committee, which serves as the Annual Meeting Program Committee.

ACTION ITEM IV - 13

OSR Request for Budget for an OSR Bulletin

Attached are two memoranda dealing with the OSR request. The first is from Mr. Dan Clarke-Pearson, OSR Chairperson detailing the justification for the Bulletin, the plans for its content and estimated costs. The second from Dr. Johnson provides the results of a staff investigation of the possible use of the STAR as an alternative to a new publication.

The alternative plan envisions the dedication of several pages to the OSR and prepared substantially by its representatives. The alternative has the advantage of bringing OSR perspectives to deans and others on the STAR distribution.

MEMORANDUM

TO: Drs. Swanson and Thompson, Mr. Boerner  
OSR Administrative Board

FROM: Dan Clarke-Pearson  
OSR Chairperson

SUBJECT: Budget Request for OSR Bulletin

Over the past two years the OSR has grown in its range of activities, interests, and participation in the affairs of the AAMC. At the same time, however, several major weaknesses have been identified which, when corrected, would make the Organization more effective. The weakness which this memo addresses is communications between the AAMC/OSR and medical students.

At the moment most medical students have no idea of what the AAMC is or stands for. Other students associate the Association primarily with the MCAT or AMCAS.

The OSR was created in order "to provide a means by which medical student views on matters of concern to the AAMC may find expression" and "to provide a mechanism for medical student participation in the governance of the affairs of the Association." (OSR Rules and Regulations) As with any representative group, however, it is important that the constituency be well informed on issues of importance.

At the present time, communications of this sort are dependent upon the initiative, time, and creativity of each school's sole OSR member. Although many OSR members have tried to fulfill this role, there remains a sense of frustration in attempting to fully depict the AAMC and OSR to the students whom we represent. OSR members also feel that better feedback from their campuses could be obtained through educating their student bodies as to the role of the AAMC and OSR.

Rather than continue with these widely variable efforts of OSR members single-handedly attempting to communicate the activities, interests, and policies of the Association and OSR to their campuses, it is felt that a high quality publication should be created to fulfill the following purposes.

I. Purpose

The major purpose of such a publication would be to communicate to medical students the activities and policies of the AAMC and OSR. At the present time there is no such publication designed with the medical student audience in mind. As has been reinforced by the active enthusiasm of medical student participation in the OSR, medical students are interested in the affairs of the Association and have demonstrated that they

are responsible and thoughtful spokesmen on many AAMC Committees and task forces.

In general it is felt that a Bulletin would raise the profile of the AAMC and OSR in the medical student's mind and would make the student more aware of the wide variety of activities in which the AAMC and OSR are involved. It must be emphasized that many of today's medical students will be tomorrow's Deans, biomedical researchers, hospital administrators, and faculty members. Thus, an understanding of the Association as a student will surely strengthen the AAMC's membership and support in the future.

This Bulletin will also facilitate the job of each OSR member in depicting the AAMC and OSR to his/her student body. Presently, this is inadequately done via medical student newspapers, bulletin board items, and special memos.

Furthermore, this Bulletin would greatly enhance the continuity within the OSR in that not only would there be a visible record of policies and activities, but also projects initiated prior to the election of a new OSR member would be better understood. We have found that our relatively short time as medical students hampers our year-to-year continuity and function as an effective organization. This is an inherent and uncorrectable weakness which is not present in other AAMC Councils.

The Bulletin would obviously aid the OSR member in creating points of discussion on his/her campus and would facilitate feedback, thus making the OSR more truly representative of student views.

Finally, it is felt that such a Bulletin would make each OSR member more accountable to his/her campus for activities and policy of the AAMC/OSR. With an information source external to the OSR member, each representative would have to keep up with AAMC and OSR activities in order to discuss them intelligently with his/her constituency.

## II: Content

The Bulletin will incorporate the following items into a 4 to 8 page format which will be published 5 times during the academic year at approximately 2 month intervals.

A. Feature Articles: Each issue of the Bulletin would be "Built" around one or two feature articles. These articles will be long enough to explore in depth a specific issue of interest to medical students. Topics might include:

- Financial Aid and Financing of Medical Education
- The NIRMP
- The NBME and the GAP Report

- Confidentiality of Student Records, Information Release, etc.
- MCAAP and Admissions
- Minority Affairs
- Student involvement in medical school administration;  
Report on the OSR Study of Student Administration
- Medical Student Rights
- Redistribution of health care personnel within geographical  
and speciality areas
- The Foreign Medical Graduate

B. OSR Activities Column: This would be either a column or short articles about current OSR activities.

C. AAMC Activities Articles: These would be short articles about activities of the AAMC which would catch the interest of medical students. Items would be culled from existing AAMC publications.

D. Journal of Medical Education Abstracts: These would be one or two short articles about an interesting discussion appearing in a recent issue of JME. Hopefully, it would arouse the student's interest enough to go to the JME and read the article itself.

E. Committee Reports: These would be short articles by the student members of the various AAMC and GSA committees regarding significant action of the committee. We might include 2-3 such articles or have a column of committee activities in each issue.

F. Regional News: If significant these would warrant a separate article. Usually, however, it would be incorporated into the OSR Activities Column (B).

G. Editorials: Included in the Bulletin would be one or two well written editorials relating to either the feature article(s), OSR and AAMC activities, or other issues of particular concern to medical students.

H. Student Opinion Poll: Since one of the goals of the Bulletin is to elicit student response to issues raised in it, a well thought out and constructed questionnaire might be included. The questionnaire could be returned to the local OSR member for tabulation.

### III. Organization and Function of the Editorial Board

The Bulletin will be handled by a student editorial board of small enough size that it can communicate with each other, and yet large enough so that no single person is overwhelmed with responsibility or work. Of course, it will be necessary for

the Editor to coordinate the effort of the board, and to insure that all deadlines are met.

Basically, the editorial board will be composed of individuals responsible for each of the various departments of content already listed. These individuals would be responsible for obtaining and/or writing the articles, and editing outside articles. The final copy of the article would then be sent to the Editor. Upon receiving the final articles from the various departments, the Editor would lay out the issue of the bulletin and handle all arrangements for printing and distribution. This, then, is a simple outline, or flow-diagram of how the various articles would be written, edited, laid out, and finally published and distributed.

In terms of specific department's functions and responsibilities, let me return to the eight major areas of content.

A. Feature Articles: These articles would be written by various OSR members or other medical students. They would be solicited by the Bulletin's editorial board from people with particular interest or expertise in the areas we want featured. Therefore, it would be up to the editorial board to decide which topics we want to feature and who to ask to write them. Once the article is written and has been received, it should be reviewed by the editors responsible for Features. These would be three people whose responsibility it would be to get the article into form for publication. They might wish to circulate the article to others for comments or suggestions. After working over the article, they would submit it to the Editor for final lay out.

B. OSR Activities Column: The information for this column would come from the various people in charge of activities in the OSR. The editor of the Column, most probably the OSR Chairperson, would write and edit the column and then submit it to the editor.

C. AAMC Activities Articles: This department would be handled by two people. These people would receive all of the AAMC publications and would review them for pertinent articles of student interest. They might "lift" the article directly from the AAMC publication, or they might re-write it into a more coherent, concise or catchy form. They would then submit these articles to the Editor.

D. Journal of Medical Education Abstracts: This department would be handled by one person, most likely the OSR member on the JME Editorial Board. He/she would identify an article in a recent issue of JME as of interest to medical students and then would write a short summary of it. The article would not be in such dry form as an abstract, but would be fairly concise. The final article would then be submitted to the Editor.

E. Committee Reports: The OSR member on the specific AAMC or GSA committee would submit these reports to a single editor who would edit and compose a final article. The final articles would be submitted to the Editor. If the Report editor so choose, he might compose a committee column, rather than submit separate articles.

F. Regional News: These reports would be submitted by the correspondant from each region. This person most likely would be the regional chairperson or secretary. The report would be submitted to the OSR chairperson who would then decide whether or not they warrant a separate article or whether it would be best incorporated into the OSR Activities Column. In either event, the final article would be submitted to the Editor.

G. Editorials: The writing of editorials would be under the supervision of the Feature Department, along with the Editor. Most likely the editorials will speak to the point of the feature article. On other occasions, they would be written about other areas of concern. In any event, the Feature editors would seek out a person to write an editorial and supply that person with sufficient background materials. The editorial would be sent to the Feature staff and then forwarded to the Editor.

H. Student Opinion Poll: In order to be effective, a questionnaire must be very carefully written. This effort would be coordinated by a single editor with the cooperation of the rest of the editorial board. It is important that the questionnaire be circulated to the editorial board for approval and recommendation, prior to submitting the final form to the Editor.

When the above mentioned articles are completed they are sent to the Editor by a specified deadline. The Editor will do the final editing and proof reading of all articles and then give the copy to the printer for the setting up of the galley proofs. The galley proof is then laid out by the Editor and a professional editorial assistant, who has experience in this area of publication work. The final paste-up copy is sent back to the printer for printing and final distribution.

It should be noted that only in these final stages of lay out will it be necessary to have a part-time professional lay out assistant. It has been suggested that this professional assistant might be either the medical school's PR person or a graduate student in journalism or graphic arts.

The final copy would be sent in bulk to each school c/o the OSR member who would then distribute the Bulletin. At nearly all schools, there are student mail boxes available for such distribution purposes.

Ultimately, the Editor of the Bulletin, the professional lay out person, and the Printer must be in very close geographical



contact. Therefore, we propose that in its first year, the Bulletin will be edited by Mr. Dan Plautz, a second year medical student at the University of Missouri at Columbia. Dan Plautz has been an active OSR member for the past two years and is presently the vice-chairperson for the OSR Central Region. Of additional importance, is that the University of Missouri has an excellent school of journalism on the same campus, which Mr. Plautz feels will be a very significant resource in the development of the Bulletin. The school of journalism will also be the source of some very fine support in graphic design and lay-out.

Finally, we have been given a quote by American Press of Columbia, Missouri, which is significantly cheaper than the estimates we received from AAMC Staff. Thus, for at least the first year, it seems logical to base the editing and publishing of the Bulletin in Columbia, Missouri.

This, as with all points made in this memo, is open for revision and compromise with the AAMC. I would emphasize again, that such a Bulletin for medical students is needed and that the OSR is seeking the most efficient and economical way to achieve the goals listed in Item I.

#### IV. Costs

The cost estimates of publishing a Bulletin have varied widely.

A. In January 1974, Mr. Charles Fentress estimated that the cost of the Bulletin, based on the cost of the AAMC Education News, would be approximately \$6,000 for 5 issues, each 4-8 pages in length, with distribution of only 100 copies to each of the medical school campuses. That is, 10,000 copies published per issue. This cost does not include any professional staff or operational expenses, such as phone calls and postage. It does include photos in the publication, as well as an additional color ink.

B. Quote #172: American Press, Division of Standex  
5601 Paris Rd.  
Columbia, Mo. 65201

Materials: 8 3/8" x 11 3/8" finished 60 lb. offset Dearskin  
Opaque grade #4

Costs include unlimited photographs and one colored ink in addition to black.

Printing Costs:

	#copies: 10,000	20,000	40,000
4 page issue	\$314.00	\$436.50	\$681.50
8 page issue	\$642.00	\$883.00	\$1365.00

Estimated Total Cost Per Issue:

4 Pages/Issue

	# copies: -	10,000	20,000	40,000
Set-up & Printing.....		\$314.00	\$436.50	\$681.50
Packaging.....		\$ 50.	50.	50.
Shipping (Est.).....		\$ 50.	100.	200.
Staff-lay out.....		\$100.	100.	100.
Phone and operating expenses.....		\$100.	100.	100.
	TOTALS	\$614.00	\$786.50	\$1131.50

8 Pages/Issue

	# copies:	10,000	20,000	40,000
Set-up & Printing.....		\$642.00	\$883.00	\$1365.00
Packaging.....		\$ 50.00	50.00	50.00
Shipping (Est.).....		\$100.00	200.00	400.00
Staff-lay out.....		\$150.00	150.00	150.00
Phone and operating expenses.....		\$150.00	150.00	150.00
	TOTALS	\$1092.00	\$1433.00	\$2115.00

It is felt that we should attempt to distribute this Bulletin to all medical students and therefore 40,000 copies ought to be printed per issue. The Editorial Board also feels that two 4 page issues and three 8 page issues per year are ideal. Consequently, the estimated costs for the Bulletin, published 5 times between July 1, 1974 and July 1, 1975, with circulation of 40,000 copies per issue, 2 issues 4 pages in length and 3 issues 8 pages in length would be:

4 page issues (2) @\$1131.50/issue.....	\$2263.00
8 page issues (3) @\$2115.00/issue.....	\$6345.00
TOTAL	\$8,607.50

Although split in opinion, the Editorial Board feels that in an effort to economize, while still assuring fair distribution, the total number of copies per issue might be cut to 20,000. This still places 200 copies on each medical campus and we may reach most interested students. The cost of this compromise plan would be:

4 page issues (2) @\$786.50/issue.....	\$1573.00
8 page issues (3) @\$1433.00/issue.....	\$4299.00
TOTAL	\$5872.00

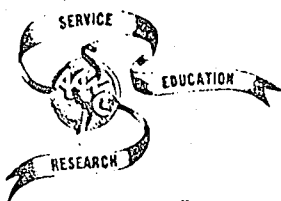
Page 8.

The OSR sincerely requests that we receive budgeting of \$8607.50 for the publication of a Bulletin to be published 5 times between July 1974 and July 1975.

Although there will be many details which will need to be developed with AAMC staff, the Bulletin Editorial Board, and the printer prior to the first issue, I hope that this request is sufficiently complete so that the OSR may be budgeted for this important project.

Dan Clarke-Pearson  
OSR Chairperson  
February 17, 1974

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INTER-OFFICE MEMO

Retain - 6 mos.	<input type="checkbox"/>
1 yr.	<input type="checkbox"/>
5 yrs.	<input type="checkbox"/>
Permanently	<input type="checkbox"/>
Follow-up Date	<input type="checkbox"/>

DATE February 15, 1974

TO: Dr. Swanson

FROM: Dr. Johnson *DJ*

SUBJECT: Proposed Use of STAR as Alternative to a Separate OSR Bulletin

This is in response to your memo of February 7 requesting a figure on the additional cost involved in increasing the volume of printing of STAR so that 100 copies could be distributed in bulk to each medical school.

Summarized below are estimates based on our past costs for STAR and The Advisor plus information obtained from Sam Morey and from the Goetz Printing Company:

<u>Variable</u>	<u>Cost per Issue</u>	<u>Cost per Year (4 issues)</u>
1) Composition of 8 pages at \$20 per page.*	\$160	\$640
2) Printing of 11,400 extra copies on 60 lb. paper at \$65 per thousand.	741	2,964
3) Bulk mailing of 100 copies to each of the 114 medical schools @ \$2.30 per school.	<u>262</u>	<u>1,048</u>
TOTAL	\$1,163	\$4,652

Cost of one copy = \$1,163 ÷ 11,400 = 10.2¢

Cost per school per issue = \$10.20

\* Although we are now merely typing the copy for STAR, it should probably be professionally set for larger quantity printings as is now done for The Advisor.

I trust that this provides the information needed for consideration by the Council of Deans Administrative Board. If not, don't hesitate to contact me or Sally George for further details.

COPIES TO: Messrs. Boerner, Keyes and Morey; Ms. Dube and George

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DISCUSSION ITEM V - 1

Council of Deans Annual Meeting Program

We need to begin planning now for the activities of the Council of Deans at the AAMC Annual Meeting. The theme of the Plenary Sessions is "Educating the Public about Health."

The official dates for the 85th Annual Meeting are November 12-16, 1974. This represents a Tuesday - Saturday schedule. All meeting space will be located in the Conrad Hilton Hotel, Chicago, Illinois. All hotel accommodations, barring unforeseen demand, will be located in either the Conrad Hilton or the Palmer House (6 blocks away).

Plenary Sessions will be held on Wednesday and Thursday mornings (13th and 14th). The AAMC Assembly will meet on the afternoon of the 14th. The following time schedule has been tentatively established for the formal AAMC sessions:

	T	W	T	F	S
AM	Misc. CAS Business Mtg.	Plenary	Plenary	Misc.	Misc.
PM	COTH Luncheon CAS Program	CAS COTH Program	AAMC Assembly	Misc.	Misc.

DISCUSSION ITEM V - 3

AAMC Salary Surveys

We have received a variety of comments and criticisms on the matter of the AAMC Salary Surveys. We, therefore, solicit your suggestions regarding means by which their accuracy and utility might be enhanced.

DISCUSSION ITEM V - 4

Distribution of Confidential  
Institutional Reports

The Association sends a number of confidential reports to the medical schools during the course of the year. A good example is the Institutional Profile Ranking Report sent to you on February 7. Because some of the data in these reports are considered confidential by many of the schools, they have been distributed only to medical school deans. We have received frequent requests for additional copies of such reports from the chief business officers, designated planning coordinators and associate deans at the medical school. These people are frequently the ones who labor to complete our questionnaires, and they have an interest in seeing the results of their labors.

Our policy in such cases has been to send an extra copy to the dean, with the explanation that it has been requested by a named individual on his staff. A copy of the transmittal letter is sent to the person making the request. This system has worked well in maintaining institutional confidentiality, but it has been cumbersome and has caused unnecessary delays in responding to requests from individuals who would routinely have access to confidential institutional information.

The Data Development Committee of the Association has recommended that we supplement this procedure by maintaining for each institution a list of staff authorized to receive and give permission for the release of confidential institutional information. In order to implement this recommendation, we would send a letter to each dean, asking for a list of individuals to whom confidential reports may be released and also for a list of individuals who may authorize AAMC to release institutional data to others. We would then refer to this list whenever a request for confidential information is received. Naturally, some deans might prefer not to give such blanket authorization to receive confidential reports to anyone.

REQUEST: That the COD Administrative Board provide us with its advice as to the advisability and feasibility of this procedure.

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BIOMEDICAL RESEARCH MANPOWER CONFERENCE  
BATTELLE SEATTLE RESEARCH CENTER  
OCTOBER 1-3, 1973

In June of 1973, the inexorable elimination of the National Institutes of Health and National Institutes of Mental Health research training programs for developing young biomedical investigators had so clearly become the policy of the Federal government that a meeting of representatives from the major universities responsible for research training was called. These institutions recognized that their role must now extend beyond responding to requests for developing talented youth and become one of participating actively in the planning for preservation of research capability in the sciences basic to medicine. The two-and-one half day meeting was held in Seattle in October, 1973, and was attended by representatives from 20 university medical schools, several voluntary health agencies, private foundations, the Office of the Assistant Secretary for Health, Education and Welfare and the Director of the National Institutes of Health. The Association of American Medical Colleges, through its Council of Academic Societies, and the University of Washington School of Medicine arranged the meeting. The Battelle Memorial Institute kindly provided us with excellent conference facilities in Seattle.

For two-and-one half days the 62 participants met in plenary and small workshop sessions. The principal focus was on developing ideas and plans for the assumption of increased responsibility by non-governmental agencies for planning and monitoring the development of the Nation's biomedical research manpower. Three major groups were considered by the Con-



ference participants as inseparably interdependent in carrying forward research talent development. These are: the faculties of the Nation's colleges and universities; the informed laity, particularly those in the voluntary health agencies; and the legislative and administrative branches of the Federal government. Major supporting roles are expected from private foundations and the commercial-industrial sectors of society.

The recommendations emanating from the meeting placed great responsibility on the non-governmental sector for monitoring and planning the research training effort of the country in the future. This is not intended to imply that the Congress, the National Institutes of Health, the Department of Health, Education and Welfare and the National Science Foundation do not have principal responsibility for the Nation's biomedical research manpower policies. However, recent experience demonstrates that educational training policies can be radically changed by politically motivated decisions. A more stable element in policy development must be included if public expectations for improved health through research are to be met. This element must come from the responsible input of professional scientists and their academic institutions.

The appendix to this report contains the schedule of the Conference, a list of attendees, the letter to the participants regarding the purposes of the Conference, and an outline regarding the task forces that met and the report of each task force that formed the basis for developing the enclosed report. The individuals participating in each task force are also listed in this appendix.

## RECOMMENDATIONS

Three principal recommendations were derived from the Biomedical Research Manpower Conference.

1. That the Congress establish a national commission, possibly under the auspices of the National Academy of Sciences, to help in determining the appropriate role for the federal government in the support of biomedical research and research training, with particular attention to the mission of its principal agency, the National Institutes of Health. Such a commission should have broad representation from business, labor, consumers, foundations, the scientific community, and other interested parties.
2. The Association of American Medical Colleges should take a leadership role in the evaluation of needs for manpower development and should call upon the assistance of the voluntary health agencies such as the American Heart Association, the American Cancer Society, the Muscular Dystrophy Society, Planned Parenthood and others. This program should also involve the biomedical scientific societies participating in the Council of Academic Societies of the AAMC in order to obtain a broad consensus of needs. The informed support of business, labor and individual citizens should be utilized to promote a rational, national biomedical research and research training policy. The academic medical community, the

professional biomedical scientific associations and the voluntary health agencies should also develop mechanisms to foster public education regarding the implications of biomedical research programs on the public and individual health of the American citizens.

3. A systems analysis group should be established to evaluate biomedical research from the standpoint of optimizing contributions to health care and suggesting guidelines for the allocation of resources to basic and applied research. This group will require input of biomedical scientists and should include among its topics for consideration the factors which contribute to the career choice of students who enter biomedical research.

The task forces which met in Seattle to consider the issues related to biomedical research manpower training arrived at these recommendations based upon their evaluations of needs, priorities, evaluation mechanisms, the problems of finding public support and establishing new funding mechanisms. The workshop participants also considered that a high priority item must be the development for mechanisms for interaction between the institutions and universities associated with biomedical research and research training and the appropriate non-federal agencies, foundations, and voluntary health groups as well as the various arms of the federal government interested and involved in the support of biomedical research and research training.

The improvement of health as a stated national goal has received strong bipartisan support and major federal funding. Support for biomedical research grew sharply between 1950 and 1968. Throughout this entire period, approximately 15 percent of the extramural research budget of the NIH was assigned to support training in the biomedical sciences. During the late 1960's health care was supported through Medicare legislation and development of health care workers through health manpower legislation. The expanding cost of the latter two programs and shifts in policy have resulted in increased competition for federal dollars, reduced support for research and withdrawal of federal dollars for research training. Termination of support for research training was based upon two major arguments: 1) That the cost of training represents an equity for the individual leading to increased earning capacities; therefore, he should pay for the training himself; and 2) That the market forces should determine the entry of biomedical research workers into the various fields, rather than central planning.

The members of the conference take issue with both of these assumptions. The first premise ignores the very large costs involved in training for research, and the limited enhancement of earning power through attainment of research expertise. The argument that market forces will determine the entry of biomedical scientists ignores the long pipeline between entry and attainment of independence as a biomedical scientist.

Furthermore, in many of the more lucrative fields, such as anesthesiology, market forces have never drawn sufficient manpower to meet community or teaching needs.

Research and research training are national assets and not regional ones. They receive their funding from national agencies because only they can rise above the local constituencies and because they represent a partnership between the universities and institutions pursuing research and the sources of funding. Inasmuch as there is presently no dispassionate body to speak for either the Congress or the Executive Office relative to biomedical research needs, we propose the establishment of a national commission to help to determine the role of the federal government in the support of biomedical research and research training. This commission would have responsibility to propose public policy relative to research activity and manpower training. The commission should have broad representation including representatives from labor, industry, medical schools and other universities, and institutes pursuing biomedical research, consumers, voluntary health agencies, foundations, and other appropriate representatives of interested parties.

The necessity of bringing together the voluntary health agencies, the professional societies, the medical and non-medical institutions pursuing biomedical research and research training, and the National Institutes of Health and other national organizations associated with the support for biomedical research and research training to reach common goals in pursuit of support for these efforts to evaluate programs to produce biomed-

ical scientists, is clearly recognized. To accomplish this, a scientific registry of all programs to produce biomedical scientists should be developed by the commission suggested under recommendation No. 1, which will have university, state, federal and public input. Thus, the establishment of a mechanism for continuous monitoring of the optimal levels of biomedical support, of the entry of biomedical scientists by discipline and the outcome of training programs can be established. This mechanism should be responsive to the best advice of the scientific community as to directions of research so as to insure an adequate investment in non-categorical research as well as in special initiatives. It should be capable of influencing the flow of manpower into biomedical science in general, and specific disciplines in particular, based upon its best perception of scientific opportunities and of market forces. The latter are substantially influenced by the level of support for biomedical research by the federal government. Until such a mechanism can be established, we recommend that approximately 15 percent of the extramural NIH budget continue to be allocated to research training.

We recommend that the present mix of mechanisms of research training be maintained until further evaluation can assess its relative success; namely, the departmental training grants, direct fellowships for pre- and post-doctoral support and inclusion of research associates in research grants as well as the research career development award; and that within this mix the training grant be accorded a high priority. We also recommend that research training grants and fellowships which

tend to strengthen institutions with established reputations for research productivity be supplemented by continuation of capitation support of all medical schools, and of the Health Science Advancement Fellowship, that is offered only to trainees in departments that do not have training grants. These latter two mechanisms, therefore, offer an egalitarian balance between these programs. Loans should also be made available as an additional modality useful to a small percentage of students or research trainees who can't afford the increased costs of this mechanism. We suggest, however, that this mechanism is the least satisfactory for guaranteeing an adequate flow of biomedical research manpower in that it is unattractive to students from disadvantaged backgrounds who most need the help. Where the loan mechanism is employed, we recommend that payback be possible through service such as research, teaching, or activities in the health care system, rather than dollars.

In addition to the federal sources indicated above, every effort should be extended to recruit non-federal sources for supporting training in biomedical research. Generous programs are already in effect through several voluntary health agencies and foundations, but these need to be enlarged wherever possible. Thus, an association of the voluntary health agencies, together with the other parties recommended previously, should gather to review from time to time the status of research training funds, and research funds so that the most effective application of

these funds can be made to help meet the national health needs.

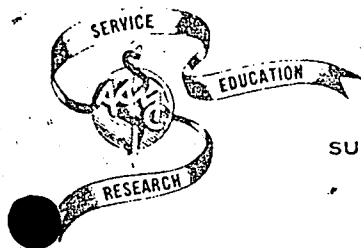
Money is potentially available through industry and other interested parties for biomedical research and research training. Therefore, we would encourage the development of a consortium in an effort to recruit increased funds from both general industry and those immediately concerned with biomedical sciences as well as foundations and voluntary health agencies not currently involved with funding biomedical research training. Such funds could be more economically administered by the central agency previously recommended, but yet could retain the advantage of identifying the recipient with the donor.

Needs can be assessed by the establishment of a data base that would include the present number of investigators as well as training opportunities funded by federal and non-federal sources. The funding of research grants and training grants, the distribution of investigators, training grants and trainees and the turnover of each of these individuals will be important to monitor. Areas in which there are deficiencies in the current supply of investigators and in which there are qualified, unemployed investigators need to be clearly established. The extent to which the presence or absence of stipends affects the access to research training for disadvantaged groups also needs to be monitored. Thus, a systems analysis group which will continue to investigate biomedical research from the standpoint of the optimization



of research contributions to health care and the allocation of these resources to basic and applied research can take into account factors derived from an adequate data-based analysis of the needs, appropriate means for evaluating the quality of the training and research programs, and the participation of the appropriate parties to determine priorities as needs change.

It is hoped that these recommendations can be implemented through the establishment of the appropriate groups with the help and support of the AAMC as the principal catalyzing body to permit their establishment.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MINUTES OF THE RESEARCH MANPOWER MEETING

AAMC CONFERENCE ROOM

WASHINGTON, D.C.

TUESDAY, FEBRUARY 12, 1974

The recent decisions by the Federal government to phase-out pre-doctoral support for graduate students in the basic medical sciences has prompted expressions of concern throughout the biomedical scientific community about the implications of these decisions on the supply of basic medical scientists in the years ahead. As a manifestation of this concern, staff of the AAMC was requested by its Executive Council to ascertain whether there was need to mount a new program of data collection and coordination to evaluate patterns of supply of basic medical scientists.

A meeting was held at the AAMC Headquarters, Tuesday afternoon, February 12, of a selected group of individuals interested in this problem. A listing of the participants is attached to these minutes.

It was the consensus of the participants that the basic information necessary to evaluate the number of students being trained by discipline, the pattern of doctorates being conferred by discipline and the career patterns of these students is currently being gathered by various agencies and associations. The participants strongly believe that there is no need to mount a major program of data collection.

Minutes of Research Manpower Meeting (Continued)

However, it was felt that a coordinated effort should be made to apprise each of the organizations interested in this problem of the efforts currently under way or planned by other organizations.

As the next step in this coordination effort, each of the individuals present is asked to supply Dr. Michael F. Ball, at the AAMC, with the following.

1. The names of individuals not present at the initial meeting who should be advised of progress and included in any future meetings.
2. Ten copies of survey instruments, either in use at this time or in various stages of development.
3. A listing of current data accumulation programs regarding manpower assessment in the basic biomedical sciences.
4. Ten copies of current publications pertaining to manpower in the basic medical sciences and a listing of publications being planned.
5. Suggestions as to positive actions this ad hoc group might take to facilitate coordination of data being developed in the area of basic science manpower.

MFB:ms

February 19, 1974

RESEARCH MANPOWER MEETING PARTICIPANTS  
February 12, 1974  
AAMC

Michael F. Ball, M.D.	Association of American Medical Colleges
Dr. T.H. Curry	National Research Council
Carl D. Douglass, Ph.D.	National Institutes of Health
Greg Fawcett	Association of American Medical Colleges
Eugene L. Hess, Ph.D.	Federation of American Societies for Experimental Biology
Dr. Louise Marshall	National Research Council
J. Boyd Page, Ph.D.	Council of Graduate Schools
Roger Robertson	National Institutes of Mental Health
Dr. Herbert H. Rosenberg	National Institutes of Health
Dr. Solomon Schneyer	National Institutes of Health
Allen Singer	National Research Council
Richard D. Stephenson, M.D.	National Institutes of Health

cc: John A.D. Cooper, M.D., AAMC  
Robert Caine, National Science Foundation  
Robert Grant, FASEB  
August G. Swanson, M.D., AAMC  
D.C. Tosteson, M.D., Chairman, AAMC

NIXON'S HEALTH INSURANCE MESSAGE CALLS FOR ACTION THIS YEAR

TO THE CONGRESS OF THE UNITED STATES:

One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.

In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who were seeking equal opportunities in education, jobs and voting.

*Now it is time that we move forward again in still another critical area: Health Care.*

Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.

Three years ago, I proposed a major health insurance program to the Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk.

Today the need is even more pressing because of the higher costs of medical care. Efforts to control medical costs under the New Economic Policy have been met with encouraging success, sharply reducing the rate of inflation for health care. Nevertheless, the overall cost of health care has still risen by more than 20% in the last two and one-half years, so that more and more Americans face staggering bills when they receive medical help today:

*Across the nation, the average cost of a day of hospital care now exceeds \$110.*

*The average cost of delivering a baby and providing post-natal care approaches \$1,000.*

*The average cost of health care for terminal cancer now exceeds \$20,000.*

For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.

Beyond the question of the prices of health care, our present system of health care insurance suffers from two major flaws:

First, even though more Americans carry health insurance than ever before, the 25 million Americans who remain uninsured often need it the most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage which is balanced, comprehensive and fully protective:

\*Forty percent of those who are insured are not covered for visits to physicians on an out-patient basis, a gap that creates powerful incentives toward high-cost in hospitals;

\*Few people have the option of selecting care through prepaid arrangements offered by Health Maintenance Organizations so the system at large does not benefit from the free choice and creative competition this would offer;

\*Very few private policies cover preventive services;

\*Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers, and

\*Fewer than half of our citizens under 65 - and almost none over 65 - have major medical coverage which pays for the cost of catastrophic illness.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills - or worse. Delays in treatment can end in death or lifelong disability.

#### Comprehensive Health Insurance Plan (CHIP)

Early last year, I directed the Secretary of HEW to prepare a new and improved plan for comprehensive health insurance. That plan, as I indicated in my State of the Union message, has been developed and I am presenting it to the Congress today. I urge its enactment as soon as possible.

*The plan is organized around seven principles:*

*First*, it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits;

*Second*, it will cost no American more than he can afford to pay;

*Third*, it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system;

*Fourth*, it uses public funds only where needed and requires no new federal taxes;

*Fifth*, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the federal government;

*Sixth*, it encourages more effective use of our health care resources;

*And Finally*, it is organized so that all parties would have a direct stake in making the system work - consumer, provider, insurer, state governments and the federal government.

#### Broad and Balanced Protection for All Americans

Upon adoption of appropriate federal and state legislation, the Comprehensive Health Insurance Plan would offer to every American the same broad and balanced health protection through one of three major programs:

1) *Employee Health Insurance*, covering most Americans and offered at their place of employment, with the cost to be shared by the employer and employee on a basis which would prevent excessive burdens on either;

2) *Assisted Health Insurance*, covering low-income persons, and persons who would be ineligible for the other two programs, with federal and state government paying these costs beyond the means of the individual who is insured; and,

3) *An improved Medicare Plan*, covering those 65 and over and offered through a Medicare system that is modified to include additional, needed benefits.

One of these three plans would be available to every American, but for everyone, participation in the program would be voluntary.

The benefits offered by the three plans would be identical for all Americans, regardless of age or income. Benefits would be provided for:

- hospital care;
- physicians' care in and out of the hospital;
- prescription and life-saving drugs;
- laboratory tests and X-rays;
- medical devices;
- ambulance services; and,
- other ancillary health care.

There would be no exclusions of coverage based on the nature of the illness. For example, a person with heart disease would qualify for benefits as would a person with kidney disease.

In addition, CHIP would cover treatment for mental illness, alcoholism and drug addiction, whether that treatment were provided in hospitals and physicians' offices or in community-based settings.

Certain nursing home services and other convalescent services would also be covered. For example, home health services would be covered so that long and costly stays in nursing homes could be averted where possible.

The health needs of children would come in for special attention, since many conditions, if detected in childhood, can be prevented from causing lifelong disability and learning handicaps. Included in these services for children would be:

- preventive care up to age six;
- eye examinations;
- hearing examinations; and
- regular dental care up to age 13.

Under the Comprehensive Health Insurance Plan, a doctor's decisions could be based on the health care needs of his patients, not on health insurance coverage. This difference is essential for quality care.

Every American participating in the program would be insured for catastrophic illnesses that can eat away savings and plunge individuals and families into hopeless debt for years. No family would ever have annual out-of-pocket expenses for covered health services in excess of \$1,500, and low-income families would face substantially smaller expenses.

*As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his state. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency*



rooms, doctors, and clinics across the country. This card could also be used to identify information on blood type and sensitivity to particular drugs - information which might be important in an emergency.

Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if any.

The entire program would become effective in 1976, assuming that the plan is promptly enacted by the Congress.

#### How Employee Health Insurance Would Work

Every employer would be required to offer all full-time employees the Comprehensive Health Insurance Plan. Additional benefits could then be added by mutual agreement. The insurance plan would be jointly financed with employers paying 65% of the premium for the first three years of the plan, and 75% thereafter. Employees would pay the balance of the premiums. Temporary federal subsidies would be used to ease the initial burden on employers who face significant cost increases.

Individuals covered by the plan would pay the first \$150 in annual medical expenses. A separate \$50 deductible provision would apply for out-patient drugs. There would be a maximum of three medical deductibles per family.

After satisfying this deductible limit, an enrollee would then pay for 25% of additional bills. However, \$1,500 per year would be the absolute dollar limit on any family's medical expenses for covered services in any one year.

#### How Assisted Health Insurance Would Work

The program of Assisted Health Insurance is designed to cover everyone not offered coverage under Employee Health Insurance or Medicare, including the unemployed, the disabled, the self-employed, and those with low incomes. In addition, persons with higher incomes could also obtain Assisted Health Insurance if they cannot otherwise get coverage at reasonable rates. Included in this latter group might be persons whose health status or type of work puts them in high-risk insurance categories.

*Assisted Health Insurance would thus fill many of the gaps in our present health insurance system and would ensure that*

*for the first time in our nation's history, all Americans would have financial access to health protection regardless of income or circumstances.*

A principal feature of Assisted Health Insurance is that it relates to premiums and out-of-pocket expenses to the income of the person or family enrolled. Working families with incomes of up to \$5,000, for instance, would pay no premiums at all. Deductibles, co-insurance, and maximum liability would all be pegged to income levels.

Assisted Health Insurance would replace state-run Medicaid for most services. Unlike Medicaid, where benefits vary in each state, this plan would establish uniform benefit and eligibility standards for all low-income persons. It would also eliminate artificial barriers to enrollment or access to health care.

As an interim measure, the Medicaid program would be continued to meet certain needs, primarily long-term institutional care. I do not consider our current approach to long-term care desirable because it can lead to over-emphasis on institutional care as opposed to home care. The Secretary of HEW has undertaken a thorough study of the appropriate institutional services which should be included in health insurance and other programs and will report his findings to me.

#### Improving Medicare

The Medicare program now provides medical protection for over 23 million older Americans. Medicare, however, does not cover outpatient drugs, nor does it limit total out-of-pocket costs. It is still possible for an elderly person to be financially devastated by a lengthy illness even with Medicare coverage.

*I therefore propose that Medicare's benefits be improved so that Medicare would provide the same benefits offered to other Americans under Employee Health Insurance and Assisted Health Insurance.*

Any person 65 or over, eligible to receive Medicare payments, would ordinarily, under my modified Medicare plan, pay the first \$100 for care received during a year, and the first \$50 toward out-patient drugs. He or she would also pay 20% of any bills above the deductible limit. But in no case would any Medicare beneficiary have to pay more than \$750 in out-of-pocket costs. The premiums and cost sharing for those with low incomes would be reduced, with public funds making up the difference.

The current program of Medicare for the disabled would be replaced. Those now in the Medicare for the disabled plan would be eligible for Assisted Health Insurance, which would provide better coverage for those with high medical costs and low incomes.

Premiums for most people under the new Medicare program would be roughly equal to that which is now payable under Part B of Medicare - the Supplementary Medical Insurance Program.

#### Costs of Comprehensive Health Insurance

When fully effective, the total new costs of CHIP to the federal and state governments would be about \$6.9 billion with an additional small amount for transitional assistance for small and low wage employers:

- \*The federal government would add about \$5.9 billion over the cost of continuing existing programs to finance health care for low-income or high risk persons.
- \*State governments would add about \$1 billion over existing Medicaid spending for the same purpose, though these added costs would be largely, if not wholly, offset by reduced state and local budgets for direct provision of services.
- \*The federal government would provide assistance to small and low wage employers which would initially cost about \$450 million but be phased out over five years.

*For the average American family, what all of these figures reduce to is simply this:*

- \*The national average family cost for health insurance premiums each year under Employee Health Insurance would be about \$150; the employer would pay approximately \$450 for each employee who participates in the plan.
- \*Additional family costs for medical care would vary according to need and use, but in no case would a family have to pay more than \$1,500 in any one year for covered services.
- \*No additional taxes would be needed to pay for the cost of CHIP. The federal funds needed to pay for this plan could all be drawn from revenues that would be generated by the present tax structure. I am opposed to any comprehensive health plan which requires new taxes.

## Making the Health Care System Work Better

Any program to finance health care for the nation must take close account of two critical and related problems - cost and quality.

When Medicare and Medicaid went into effect, medical prices jumped almost twice as fast as living costs in general in the next five years. These programs increased demand without increasing supply proportionately and higher costs resulted.

This escalation of medical prices must not recur when the Comprehensive Health Insurance Plan goes into effect. One way to prevent an escalation is to increase the supply of physicians, which is now taking place at a rapid rate. Since 1965, the number of first-year enrollments in medical schools has increased 55%. By 1980, the nation should have over 440,000 physicians, or roughly one-third more than today. We are also taking steps to train persons in allied health occupations, who can extend the services of the physician.

*With these and other efforts already underway, the nation's health manpower supply will be able to meet the additional demands that will be placed on it.*

Other measures have also been taken to contain medical prices. Under the New Economic Policy, hospital cost increases have been cut almost in half from their post-Medicare highs, and the rate of increase in physician fees has slowed substantially. It is extremely important that these successes be continued as we move toward our goal of comprehensive health insurance protection for all Americans. I will, therefore, recommend to the Congress that the Cost of Living Council's authority to control medical care costs be extended.

To contain medical costs effectively over the long haul, however, basic reforms in the financing and delivery of care are also needed. We need a system with built-in incentives that operates more efficiently and reduces the losses from waste and duplication of effort. Everyone pays for this inefficiency through their health premiums and medical bills.

The measure I am recommending today therefore contains a number of proposals designed to contain costs, improve the efficiency of the system and assure quality health care. These proposals include:

### 1) Health Maintenance Organizations (HMOs)

On Dec. 29, 1973, I signed into law legislation designed to stimulate, through federal aid, the establishment of prepaid comprehensive care

organizations. HMO's have proved an effective means for delivering health care and the CHIP plan requires that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system.

## 2) *Professional Standards Review Organizations (PSROs)*

I also contemplate in my proposal a provision that would place health services provided under CHIP under the review of Professional Standards Review Organizations. These PSRO's would be charged with maintaining high standards of care and reducing needless hospitalization. Operated by groups or private physicians, professional review organizations can do much to ensure quality care while helping to bring about significant savings in health costs.

## 3) *More Balanced Growth in Health Facilities*

Another provision of this legislation would call on the states to review building plans for hospitals, nursing homes and other health facilities. Existing health insurance has overemphasized the placement of patients in hospitals and nursing homes. Under this artificial stimulus, institutions have felt impelled to keep adding bed space. This has produced a growth of almost 75% in the number of hospital beds in the last 20 years, so that now we have a surplus of beds in many places and a poor mix of facilities in others. Under the legislation I am submitting, states can begin remedying this costly imbalance.

## 4) *State Role*

Another important provision of this legislation calls on the states to review the operation of health insurance carriers within their jurisdiction. The states would approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit and take other appropriate measures. For health care providers, the states would assure fair reimbursement for physician services, drugs and institutional services, including a prospective reimbursement system for hospitals.

A number of states have shown that an effective job can be done in containing costs. Under my proposal all states would have an incentive to do the same. Only with effective cost control measures can states ensure that the citizens receive the increased health care they need and at rates they can afford. Failure on the part of the states to enact the necessary authorities would prevent them from receiving any federal support of their state-administered health assistance plan.

### Maintaining a Private Enterprise Approach

My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.

Any insurance company which could offer those benefits would be a potential supplier. Because private employers would have to provide certain basic benefits to their employees, they would have an incentive to seek out the best insurance company proposals and insurance companies would have an incentive to offer their plans at the lowest possible prices. If, on the other hand, the government were to act as the insurer, there would be no competition and little incentive to hold down costs.

*There is a huge reservoir of talent and skill in administering and designing health plans within the private sector. That pool of talent should be put to work.*

It is also important to understand that the CHIP plan preserves basic freedoms for both the patient and doctor. The patient would continue to have a freedom of choice between doctors. The doctors would continue to work for their patients, not the federal government. By contrast, some of the national health plans that have been proposed in the Congress would place the entire health system under the heavy hand of the federal government, would add considerably to our tax burdens, and would threaten to destroy the entire system of medical care that has been so carefully built in America.

I firmly believe we should capitalize on the skills and facilities already in place, not replace them and start from scratch with a huge federal bureaucracy to add to the ones we already have.

### Comprehensive Health Insurance Plan - A Partnership Effort

No program will work unless people want it to work. Everyone must have a stake in the process. This Comprehensive Health Insurance Plan has been designed so that everyone involved would have both a stake in making it work and a role to play in the process - consumer, provider, health insurance carrier, the states and the federal government. It is a partnership program in every sense.

By sharing costs, consumers would have a direct economic stake in choosing and using their community's health resources wisely and prudently. They would be assisted by requirements that physicians and other providers of care make available to patients full information on fees, hours of operation and other matters affecting the qualifications of providers.

But they would not have to go it alone either: doctors, hospitals and other providers of care would also have a direct stake in making the Comprehensive Health Insurance Plan work. This program has been designed to relieve them of much of the red tape, confusion and delays in reimbursement that plague them under the bewildering assortment of public and private financing systems that now exist. Healthcards would relieve them of troublesome bookkeeping. Hospitals could be hospitals, not bill collecting agencies.

#### Conclusion

Comprehensive health insurance is an idea whose time has come in America. There has long been a need to assure every American financial access to high quality health care. As medical costs go up, that need grows more pressing.

*Now, for the first time, we have not just the need but the will to get this job done. There is widespread support in the Congress and in the nation for some form of comprehensive health insurance.*

Surely if we have the will, 1974 should also be the year that we find the way. The plan that I am proposing today is, I believe, the very best way. Improvements can be made in it, of course, and the Administration stands ready to work with the Congress, the medical profession, and others in making those changes.

But let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington. Let us continue to have doctors who work for their patients, not for the federal government. Let us build upon the strengths of the medical system we have now, not destroy it.

Indeed, let us act sensibly. And let us act now - in 1974 - to assure all Americans financial access to high quality medical care.

February 22, 1974

The NIRMP Program

The 1974 NIRMP matching process was completed on February 20; results are to be mailed to hospitals and students about the first of March thus advancing the notification date six weeks ahead of the 1973 program. This improvement in operation was achieved by the NIRMP Board and Staff with the assistance of a private consulting group and is significant in maintaining the credibility of an essential mechanism in the continuum of medical education. Operational improvements, however, are only one side of the present concerns for the NIRMP.

The occurrence of violations involving some students and some program directors, especially in certain first-year residency programs, have resulted in the establishment of an NIRMP Monitoring Program within the AAMC. The Group on Student Affairs and the Organization of Student Representatives of the AAMC were responsible for developing this program announced by Dr. John A.D. Cooper on February 22. The program is essentially a means for committees in the medical schools to report incidents of non-compliance to the AAMC President for communication to the program director and the school involved. It is hoped that this program will serve as a potential deterrent to many violations. The occurrence of some violations may be also traced to problems resulting from basic changes in the process of medical education, this is particularly so in psychiatry.

The AAMC has responded to a request from the members of a Task Force on the Internship and Residency of the American Association of Chairmen of Departments of Psychiatry to assist them in assessing the concerns of members of this specialty group about problems relating to the NIRMP. The AAMC has identified



two projects in which staff can give direct assistance. The first is to gather information about the numbers and characteristics of the applicant pool for residency programs in psychiatry. The second is a review of the NIRMP to determine whether this program or one similar to it can function satisfactorily as a logical entry point for medical school graduates into the second phase of the continuum of medical education.

The AAMC suggests that information of this nature would be useful to other specialty groups whose applicants and program directors are finding the NIRMP to be less than satisfactory.

Robert Thompson, Ed.D.  
Director of Student Programs and Services  
Department of Academic Affairs

OSR Administrative Board Agenda  
March 16, 1974  
AAMC Headquarters, Washington, D.C.

9-10am I. Call to Order  
OSR Admin. Board in Executive Session

10-11:30 am

II. Discussion with AAMC Staff  
Dr. Swanson, Mr. Boerner

- A. Open-Ended discussion of staff and board regarding OSR function
- B. OSR Budget
- C. Proposed OSR National Bulletin
- D. Proposed Task Forces on GAP Report
  - 1. AAMC
  - 2. OSR

11:30-12:30

III. Minutes of Previous OSR Administrative Board Meeting

IV. REPORTS

- A. Regional--Cindy, Lisa, Serena, Stan
- B. NIMMP--Elliott
- C. Student Administrative Listing--Elliott
- D. Liaison:
  - 1. SAMA--Elliott
  - 2. SNMA--Mark
  - 3. Others--Mark, Dan
- E. Senior Electives Catalogue Committee--Dan
- F. AAMC and GSA Committee Reports
- G. NCAAP Progress Report--?Mr. Jim Angel

12:30-1pm LUNCH

1-4:30

V. ACTION ITEMS

- A. Appointment of Committee Members
  - JME Editorial Board
  - Study Committee on Continuing Medical Education

VI. DISCUSSION ITEMS

- A. Executive Council Agenda Items--Dr. Swanson, Mr. Boerner, Mr. Waldman
- B. Plans for OSR Annual Meeting--Mr. Waldman
- C. OSR Rules and Regulations--Russ Keasler, Dan
- D. Students' Rights--Ernie
- E. Women in Medicine--Cindy
- F. Plans for OSR Regional Meetings
- G. Long Range OSR Goals and Priorities

VII. NEW BUSINESS

4:30pm VIII. ADJOURNMENT

ORGANIZATION OF STUDENT REPRESENTATIVES  
Of The  
Association of American Medical Colleges

MINUTES:  
ADMINISTRATIVE BOARD MEETING

January 11-12, 1974

One Dupont Circle, N.W., Washington, D.C.

1. Call to Order

Daniel Clarke-Pearson, Chairperson of the O.S.R., called the meeting to order at 9:00 AM.

2. Roll Call

PRESENT:	<u>Chairperson</u>	Dan Clarke-Pearson
	<u>Vice chairperson</u>	Mark Cannon
	<u>Secretary</u>	David Stein
	<u>Regional Representatives</u>	Serena Friedman (Northeastern)
		Stan Pearson (Southern)
		Lisa Bailey (Central)
		Cindy Johnson (Western)
	<u>Representatives-at-Large</u>	Russ Keasler
		Ernest Turner
		Elliott Ray
	<u>AAMC Staff Participants</u>	Bob Boerner
		Diane Matthews
	<u>Guest</u>	Russ Kridel (S.A.M.A.)

3. AAMC Orientation

The morning and early afternoon of the first business day were spent in orientation to the AAMC. Dr. John A. D. Cooper, president of the Association, presented an overview of A.A.M.C. goals and activities and spoke briefly of the organization's new vice-president and Director of Planning, Dr. John Sherman.

Dr. Cooper was followed sequentially by twelve speakers representing twelve divisions or departments within the AAMC. Each speaker discussed the structure and function of the division in which he or she serves and answered questions from the floor. A short outline of each presentation is included in Addendum #1. The orientation program concluded at 3:30 PM., January 11.

4. Minutes of Previous Meetings

The minutes of the National Meeting (11/3 - 4/73) were discussed. It was explained that these minutes have not been distributed to the OSR membership because they were not received by Mr. Boerner until late December.

Acting Secretary, H. Jay Hassel, did not submit these minutes until that time. The Administrative Board was assured by Mr. Boerner that the minutes were at the printers and would be distributed shortly.

It was generally felt that the National minutes lacked sufficient detail. Attempts to avoid this situation in the future were urged.

Minutes of the 11/5/73 Administrative Board meeting were reviewed without comment.

5. Regional Reports

A. Lisa Bailey, Chairperson of the Central Region, informed the Administrative Board that a subregional meeting within the Central Region had been held in Chicago and that 5 schools had attended to discuss the proposed changes in the National Board Examinations. (see: "Evaluation of the Continuum of Medical Education", AAMC). Members of the Central Region felt a House Officer should sit as a voting member on the Administrative Board of the N.B.M.E. and that passage of Part I of the National Boards should not be required by any medical school for promotion to the clinical years. The proposed O S R Bulletin was considered favorably while 3 -year medical curricula met with disfavor. The Central Region Subregion will meet again in February.

B. Stan Pearson, Chairperson of the Southern Region, stated that financial conditions and dispersed membership prohibit multiple regional meetings in the South. A questionnaire on OSR functions and representative selection processes for each southern medical school campus will be distributed to gather information on OSR structure. Elliott Ray mentioned that his questionnaire on Student Administrative Listings in each medical school has been returned by only 30 OSR members. It was suggested that each Regional chairperson promote the return of this questionnaire from his/her membership.

C. The Northeast Region, Chaired by Serena Friedman, also held a subregional meeting since the National Convention and has formulated several resolutions for consideration by the Administrative Board (see Resolutions Section). The Eastern Region has tentatively chosen not to meet with the G S A for its Regional meeting due to geographic inconvenience but rather to send delegates to the G S A convention.

D. Cindy Johnson, Chairperson of the Western Region, stated that "women in medicine", and "continuity in the OSR" were issues discussed at the Western Regional meeting during the National Convention. A "mini" Senior Electives Catalogue for the Western Region has been constructed

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and attempts are underway to contact schools not sending OSR representatives to the AAMC.

By general consensus the Administrative Board agreed that each region should consider the topic of women in medical education. Russ Kridel, President of SAMA, spoke briefly of that organization's committee on women in medicine.

6. Task Force Reports

A. MCAAP and Admissions Crisis: This was an information Task Force that formulated the resolution on random admissions.

B. Legislation and Medicine: Also an information Task Force that is no longer active. Elliott Ray suggested distribution of the SAMA "Legislative Round-up" to each OSR Administrative Board member in an effort to keep abreast of changes in medical legislation.

C. Financial Aid Task Force: Submitted a list of recommendations to the AAMC. (see National Minutes Addendum #4).

D. Student Information Task Force: Presented the resolution on the safeguarding of data systems. As suggested by Kevin Soden, Chairperson of this group, the resolution will be submitted to SAMA for consideration. If adopted, SAMA will submit it to the AMA House of Delegates for approval and implementation in June. The OSR will present it to the AAMC Executive Council for consideration in March.

E. Evaluation of OSR Structure and Function: As an offshoot from this group, Dan Plautz is working to establish better communications within the OSR. Representatives are again urged to create and maintain a file of AAMC and OSR communications to be passed on to the succeeding OSR representative at each school.

7. OSR Committee Reports

A. NIRMP Violations Monitoring Committee: The activities of this group were outlined by Elliott Ray who presented an information packet for distribution to the OSR membership regarding the information and function of an NIRMP Monitoring Committee at each school. Administrative Board members were instructed to read this in preparation for Saturday (1/12) Business Meeting.

Elliott has communicated with the chairman of the American Psychiatric Association Task Force studying the value of participation in the NIRMP in an attempt to retain the APA in the matching program.

B. Student Administrative Listings: Elliott Ray reiterated that the questionnaire on Administrative Listings distributed at the National Convention to each OSR member has been returned by only 30 schools. Members are again urged to complete this form and send it to Mr. Boerner.

C. Senior Electives Catalogue Committee: This committee is concentrating on adopting the AAMC Curriculum Directory to satisfy the need for a senior electives listing. The present Curriculum Directory lacks information on tuition and fees, housing, and who to contact for more information. It is the committee's plan to incorporate this information into the Directory.

Members of the Administrative Board suggested that this committee continue to investigate the feasibility of publishing its own senior electives catalogue. It was also suggested that the committee contact those in charge of the Curriculum Directory at the AAMC for more information and direction and create a computer listing of senior electives which would be available upon request for a fee.

The Eastern and Western OSR Regions have already created "mini-directories" for their regions. The efficacy of these pilot projects has yet to be ascertained.

D. Liason with External Organizations: An attempt will be made again this year to establish better communication with student facets of the Federation of Associations of Schools of the Health Professions, e.g., osteopaths, podiatrists, dentists, veterinarians, optometrists, as well as SAMA, SNMA, and the Canadian Medical Schools. Mark Cannon was asked to contact these groups and inform them of our interest in a liason and in the exchange of meeting minutes and publications. Invitations should be extended to these organizations to attend our Regional and National Conventions at their own expense.

Russ Kridel mentioned the strong liason between SAMA and the OSR. Each organization sends delegates to the other's major meetings and to the Administrative Boards. An intensified effort will be launched to introduce OSR resolutions and proposals to SAMA for consideration, and vice-versa. This will minimize duplication of effort, and double the exposure of any topic on a national level, thus increasing the likelihood of constructive action.

The February 1-2 AMA Congress on Medical Education was discussed. Russ Kridel will attempt to have information on this convention distributed to each OSR member. Further information is available at each Dean's office.

8. Chairperson's Report

Dan Clarke-Pearson briefly reviewed the topics of discussion

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at the AAMC officer's retreat, the COD Administrative Board meeting, and the AAMC Executive Council. Outlines covering this material are included as Addendum #2.

A. National Health Insurance Policy: Ernest Turner was nominated to the committee evaluating plans for National Health Insurance. It was suggested that the OSR membership receive copies of a table summarizing all the present health insurance proposals. (see Addendum #3).

B. Graduate Medical Education Committee: Dan Clarke-Pearson requested of of AAMC Executive Council a student delegate to be placed on this committee. Since the Graduate Medical Education Committee is an on-going group that must maintain continuity, the Executive Council felt that a transient student member might not be effective. A house officer, Christian Ramsey, who sits on this committee, and who was formerly the student representative, was agreed upon by the Executive Council to continue to represent student interests. Dan Clarke-Pearson will contact him.

9. Discussion Items

A. Moonlighting of House Officers: The COD voted to recommend that the AAMC Executive Council authorize the appointment of a task force, with representatives from the 3 councils, charged with the task of developing an appropriate AAMC policy statement on this subject. In regard to this matter, the Executive Board created such a committee with members from the COD, CAS, and COTH. The OSR Administrative Board felt that student or House Staff representation on this committee was highly desirable. The Physician's National Housestaff Association will be contacted on this subject to ascertain their interest in sending a representative.

Marc Cannon suggested that the AAMC form a committee to evaluate the quality of medical care rendered by moonlighting housestaff. The feeling arose that the burden of proof of incompetence should be placed on those individuals attempting to stop moonlighting rather than forcing moonlighters to prove their competency.

B. Evaluation, Certification, and Licensure in Medicine: Consideration of this topic was motivated by the proposed changes in the National Board Examinations.

Marc Cannon suggested that the OSR undertake its own study of the NBME Report and, in this regard, foundations for such a task force will be established. It was also proposed that the OSR seek voting positions on the Board of the NBME with SAMA and SNMA and that provisions be made for student representation on the Executive Board of the NBME. (see Addendum #4).

10. The meeting was concluded until the following day at 9:00 AM.
11. The meeting was recalled to order at 9:00 AM, January 12, by Chairperson, Dan Clarke-Pearson.
12. NIRMP Monitoring Committee

Elliott Ray presented a letter and an information packet to the Administrative Board for discussion before distribution to the membership. The packet is a "how-to-do-it" pamphlet which outlines the creation of a monitoring committee and answers common questions asked about the NIRMP. The letter is a more formal communication to be sent to the Deans of U.S. medical schools and to the Student Affairs Deans.

Russ Keasler proposed that each hospital be allowed to divulge its student rank order after the date of list submission to the NIRMP. This would give students greater time to solidify their plans such as moving and apartment hunting. It was suggested that a formal proposal be submitted on this topic.

Student Administrative Listing was again discussed. Members are again urged to return the completed form from Elliott Ray. Marc Cannon suggested re-sending this information to each OSR member; Russ Kridel suggested disseminating the form to SAMA in an effort to include all U.S. medical schools in this study. Both proposals were received favorably.

13. MCAAP Progress Report

A. Jim Angel, Program Director of MCAAP, has informed the OSR of new MCAAP committee positions which will be available to OSR members in the next few months. A newsletter regarding this subject will be forthcoming. Mr. Angel's present design is to have one OSR member and one minority student representative on each committee. This request will be discussed with SNMA.

14. OSR Bulletin

A. Bob Boerner offered the following comments:

1. A pilot issue might be established with a tear-off "R.S.V.P." on student interest.
2. The "AAMC Bulletin" is now being sent to Deans. It contains a great deal of information on AAMC functions and is obtainable from your Dean's office.
3. OSR items might be included in a separate two page section of the Student Affairs Reporter which is

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sent primarily to Student Affairs Deans at Medical schools.

4. OSR topics might be included in the Student Affairs Reporter and the Advisor. The latter publication is directed primarily to health professions advisors.
5. The Education News might be distributed to OSR members.
6. Administrative Board was told that money may be a problem. It would probably cost \$1200.00 for one pilot issue of 4 pages with 100 copies sent to each school. The present AAMC staff situation is such that they cannot take on full editorial responsibility for the OSR newsletter.
7. The OSR should consider utilizing existing publications as much as possible.

B. The following individuals volunteered to form a committee on this issue: Lisa Bailey, Dan Clarke-Pearson, Marc Cannon, David Stein, and Dan Plautz.

C. Money can be requested in next year's budget to finance such a bulletin.

15. "How to Run a Regional Meeting":

A pamphlet on "How to Run a Regional Meeting," created by Dan Clarke-Pearson, was distributed to each Administrative Board member.

16. Appointment of Committee Members:

The following OSR members were appointed to serve on AAMC Committees:

- A. Health Services Advisory Committee
  1. Joanne Scherr
- B. Committee on Relations with Colleges and Applicants (GSA)
  1. Susan Stein
- C. International Relations
  1. Jeff Horovitz
- D. Borden Award
  1. David Stein
- E. Flexner Award
  1. Jerry Zeldis
- F. Biomedical Research
  1. James Wright

- G. Medical Student Information Systems (GSA)
  - 1. Fred SanFillipo
- H. Financial Problems of Medical Students (GSA)
  - 1. Russ Keasler
  - 2. David VanWyck
- I. Resolutions Committee
  - 1. Serena Friedman
- J. Financing of Medical Education
  - 1. Paul Romain
  - 2. Craig Moffat
- K. Medical Education of Minority Group Students (GSA)
  - 1. Stan Pearson
- L. J.M.E. Editorial Board
  - 1. undecided
- M. Data Systems Development
  - 1. H. Jay Hassel

17. Action Items:

A. The Administrative Board approved Dr. Paul Jolly's recommendation to allow the limited release of information on 75 medical students to Dr. Herman A. Wilkin to promote a longitudinal study on cognitive factors in pre-medical education.

18. Status of OSR Resolutions: (see National minutes)

A. Proposed Policy on Release of AAMC Information:  
This resolution was sent to Dr. Paul Jolly, Director of the Division of Operational Studies. No further action needs to be taken on this item.

B. Primary Care Training:  
This resolution has already been implemented by the AAMC Task Force on this topic.

C. Safeguarding Data Systems:  
This will be presented to SAMA for their consideration and approval. If accepted, it will be submitted to the AMA House of Delegates for approval and implementation. The OSR will present this resolution to the AAMC Executive Council in March. This double approach allows a greater chance of acceptance.

D. Resolution on the NIRMP:  
It was felt that the objectives of this resolution have already been met and no further action needs to be taken at this time. Elliott Ray was asked to write Jacqueline Wertsch informing her of this decision.

E. Change in Rules and Regulations of the OSR:

This item was not submitted 30 days ahead of the National Convention and, therefore, is not in effect. It will be resubmitted 30 days prior to the upcoming National Convention for approval and implementation.

F. Resolution on Medical School Curriculum:

It was agreed that this item be directed to the LCME for inclusion as a desirable course of instruction. The idea of creating a task force to study this issue and gather information was considered favorably.

Russ Kridel pointed out that the LCME alluded to each school's responsibility of providing an education to meet the selected community or regional health needs (see "Functions and Structure of a Medical School", p. 4).

G. Resolution for OSR Committee Placement:

It was agreed that the OSR would benefit by voting membership on the CCME, LCME and LCGME. The LCGME already has a House Officer representative and is very reluctant to add a student member. Fred SanFillipo will be asked to compose a position paper on this topic.

H. Resolution on Random Admission Selection:

The objectives of this proposal are already integrated in a pilot study underway in California and Michigan. It was further felt that more background research is necessary on this topic, and Jerry Zeldis has been asked to write such a paper.

I. Resolution on Pass-Fail System:

Joel Daven has been asked to establish a committee to study the feasibility of creating a pass-fail grading system.

J. Resolution on Minority Applicant Pool:

It was suggested that a copy of this resolution be sent to Susan Stein, OSR delegate to the Committee on Relations with Colleges and Applicants and that a committee be formed to study the problem. Stan Pearson was selected to organize this committee.

K. Resolutions submitted by the Eastern sub-regions will be distributed to each region for consideration at the Regional Meetings.

19. Rules and Regulations of the OSR

A. It was suggested that the immediate past OSR chairperson sit on the new Administrative Board to provide continuity. This will be considered in detail later.

B. A Nominations Committee was suggested to request and evaluate nominations for OSR positions.

20. OSR Calendar

The following dates were mentioned in order to facilitate greater representation by allowing more time to plan for OSR events.

- A. March 16 - Administrative Board Meeting (tentative)
- B. June 15 - Administrative Board Meeting
- C. Sept. 14 - Administrative Board Meeting

21. Funding of the OSR

Mr. Boerner informed us of the following points of AAMC policy on funding of OSR Administrative Board members to Administrative Board meetings.

A. An Administrative Board member who is no longer the official OSR member from his or her school should seek funding first from his school. If funds from the school are not forthcoming, the AAMC will provide them.

B. An official member on the Administrative Board will be funded by the AAMC to attend Board meetings.

22. The Draft - 2M Classification:

With the expiration of the military medical specialist draft in July 1973, the U.S. government cannot resume medical inductions without approval of Congress. In an attempt to keep track of medical personnel, a new classification system has surfaced. Medical students have been reclassified from 1-H to 2-M which extends eligibility to age 35 years. Reclassification requires contacting the hometown draft board.

23. The 1974 Annual Meeting:

The theme for the 1974 Annual Meeting will be "The University Medical Center Role in the Education of the Public." Comments were entertained on whether the OSR should sponsor a special program geared to the student's viewpoint and whether the OSR should request student speakers before the General Assembly on this issue.

24. OSR Mailings:

Any member not receiving AAMC/OSR mail should send his/her address to the OSR secretary - David Stein  
18935 Wildemere  
Detroit, Michigan 48221

25. FMG Task Force Recommendations

This group has not formalized its final position.

26. The meeting adjourned at 6:00 PM.

Respectfully Submitted,

David Stein  
OSR Secretary

2649 E. 126 St.  
Cleveland, Ohio 44120  
January 27, 1974

Dr. Robert Thompson  
Director, Division of Student Programs  
and Services  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Dr. Thompson:

I have finally found time to drop you a note of thanks for your participation in the OSR administrative board meeting on January 11. Your presentation was very helpful to the Board. Overall, we had a very productive two days of meetings and I feel that the OSR will have its most active year yet.

I also want to express my appreciation to you for your time with me in private discussion on January 11. I think our talk helped to clarify some of the problems and concerns of our organization. During this talk we touched on the topic of the OSR budget and new OSR activities which I projected for this coming year.

Over the past two weeks, the issue of the OSR budget and finances have been discussed between Bob Boerner and myself on a number of occasions. The initial problem arose in seeking funding for the OSR members of GSA committees so that they could attend the GSA meeting in Chicago, February 3 and 4. Bob and I have come to a stalemate on this topic and I have finally accepted the fact that the GSA has no funds to send these five OSR members. The other rational is that the Chicago meeting does not include true GSA committee meetings, but rather it is a long-range planning meeting and therefore OSR members are not "officially" invited to participate as members of committees. It seems that there is a "Catch-22" situation here, where on the one hand the OSR has been invited and desires to participate as members of GSA committees, but on the other hand this meeting is not officially including the committees and even if it was, there would be no money in the GSA budget, or the OSR's for that matter. I tell you this only as a background to my present concerns. I feel that I acted too late on this particular topic to seek or expect funds from another source.

RECEIVED  
JAN 29 1974

DIVISION OF STUDENT PROGRAMS  
AND SERVICES  
ASSOC. OF AMERICAN  
MEDICAL COLLEGES

What I want to discuss now are future OSR activities, in hopes of avoiding another situation like the one I've just described. Firstly, Bob tells me that the OSR budget is set at \$6,300 for fiscal year 1974 and that at present we have a balance which is smaller than that necessary to fund one more administrative board meeting. This fact, in itself, is rather disturbing. I presume, however, that when the budget was drawn up last February, those responsible had little idea exactly how to project the expenses of our growing organization. It has always been my assumption that since the OSR is still developing in an unpredictable manner there is a certain built-in "flexibility" to funding.

As we discussed on January 11, the OSR has several new projects which will need additional funding. I would like to outline these projects and ask for your assurance that we will be able to proceed with them during the present fiscal year.

A. Administrative Board Meetings: The Board feels that the OSR now has enough business and interest in the activities of the AAMC to require administrative board meetings four times a year. Just as the three Councils, we would like to meet prior to the Executive Council meetings in order to carry out our business, as well as to consider the Executive Council agenda items. At our January 12 meeting, the Board felt that we should meet on March 15 or 16, June 14 or 15, and September 13 or 14.

The upcoming problem is that the budget contains funding for only one more meeting between now and July 1, while the Board would like to have two meetings. Will we be able to get funding for this additional meeting from some other source?

B. OSR Task Force on Evaluation, Certification and Licensure in Medicine: The administrative board created this task force which will correspond by mail and phone in conducting an evaluation of the National Board of Medical Examiner's GAP Report. As is described in the enclosed "Guidelines" the four task force members will come together in June in order to draw up the final OSR position paper. The estimated costs of this project run about \$1,200 including travel, lodging, phones and mailings.

The budget does not contain funds for this new project. Will we be able to obtain funding from another source?

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C. OSR National Bulletin: The administrative board wants to go full speed ahead with this project and was very happy to hear that your division will fund a pilot issue this spring. We are in the process of drawing up a formal proposal for funding in the next fiscal year, and will submit it to the budget committee through Bob.

D. Liason Activities: We have begun to develop close liason ties with SAMA and SNMA. This cooperation between student organizations is important so that we do not duplicate efforts or unknowingly undermine each other. SAMA's president attended the recent OSR administrative board meeting and we found his presence very helpful on a number of occasions.

SAMA has also invited me or another member of the Board to attend their Board of Trustee meetings as an ex-officio member. We feel that this is an important activity, but there are no visible funds present.

E. Additional Operating Expenses: With this increase in activities outlined above, as well as greater participation of more OSR members, I predict that we will incur greater expenses in terms of phone bills, mailings, and other communications. This is a dollar quantity which I cannot project, but we might be able to get a better figure by looking at these particular expenses from the past month.

In all instances, the Board is eager to proceed with reasonable economy. As an example, we asked Bob to do a cost analysis on travel to a number of cities in which we could potentially hold Board meetings. We had hoped that there might be a location more centrally situated which would save on airfare and travel time.

Finally, Dr. Thompson, I am asking for your assurance that we can move on these projects between now and July 1. I have set-out the major areas of anticipated expenditures so that we will not have to come to you each time with separate petitions for funds.

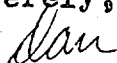
On a related subject, I feel that it is necessary to have OSR administrative board input to the budget requests for fiscal year 1975. By working more closely with the staff on this, we may be able to anticipate expenses and thus avoid repeating our situation of this year.



I will be in Chicago for the Congress on Medical Education and the GSA meetings, and I hope that we can talk about these issues in a spare moment there.

I hope I have been clear in this lengthy discussion. I appreciate your attention to these matters and look forward to your response.

Sincerely,



Dan Clarke-Pearson

cc: Bob Boerner  
Mark Cannon

Enclosure