

*Miss Littlemeyer*



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

ADMINISTRATIVE BOARD  
THURSDAY, JANUARY 13, 1977  
9:00 AM - 1:00 PM

CHEVY CHASE ROOM  
WASHINGTON HILTON HOTEL  
WASHINGTON, D.C.

FUTURE MEETING DATES  
1977

COD Administrative Board-----January 13, 1977  
Executive Council-----January 14, 1977

COD Administrative Board-----March 31, 1977  
Executive Council-----April 1, 1977

COD Spring Meeting-----April 17-20, 1977  
Scottsdale, Arizona

COD Administrative Board-----June 23, 1977  
Executive Council-----June 24, 1977

COD Administrative Board-----September 15, 1977  
Executive Council-----September 16, 1977

AAMC Annual Meeting-----November 5-10, 1977  
Washington, D.C.

COUNCIL OF DEANS  
ADMINISTRATIVE BOARD  
January 13, 1977  
9 a.m. - 1 p.m.  
Chevy Chase Room  
Washington Hilton Hotel

AGENDA

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

Minutes

September 16, 1976  
9 a.m. - 1 p.m.  
Kalorama Room  
Washington Hilton Hotel

DRAFT

PRESENT

(Board Members)

J. Robert Buchanan, M.D.  
Christopher C. Fordham III, M.D.  
Neal A. Gault, M.D.  
John A. Gronvall, M.D.  
Andrew D. Hunt, M.D.  
Julius R. Krevans, M.D.  
William H. Luginbuhl, M.D.  
Chandler A. Stetson, M.D.  
Robert L. Van Citters, M.D.

(Guests)

Ivan L. Bennett, Jr., M.D.  
Richard Janeway, M.D.  
Thomas A. Rado, Ph.D.  
Richard S. Seigle

(Staff)

Gerlandino Agro  
Robert J. Boerner  
Judith B. Braslow  
John A. D. Cooper, M.D.  
H. Paul Jolly, Ph.D.  
Joseph A. Keyes  
Diane Newman  
Jaimee S. Parks  
James R. Schofield, M.D.  
Emanuel Suter, M.D.  
Bart Waldman  
Marjorie P. Wilson, M.D.

I. Call to Order

The meeting was called to order at 9:00 a.m. by John A. Gronvall, M.D., Chairman, who called for an Executive Session.

II. Executive Session

Dr. J. Robert Buchanan, Chairman-Elect of the Council of Deans, had accepted the Presidency of Michael Reese Hospital in Chicago, effective January 1, 1977. Dr. Buchanan submitted his letter of resignation from the Council of Deans and its Administrative Board and the problem of succession was raised for discussion.

After substantial discussion, the Administrative Board referred the problem of succession to the Chairmanship to the Nominating Committee, requesting that they develop a proposal for consideration of the entire Council of Deans at the Annual Meeting.

The Board suggested that the Chairman request Dr. Buchanan to continue to work with the Spring Meeting Planning Committee.

By unanimous vote, the Chairman was instructed to express formally to Dr. Buchanan the sincere appreciation of the members of the Board for his dedicated, enthusiastic service to the Board and Council and his sound contributions to the deliberations of the various governing and advisory bodies of the Association, and to express regret that the Board's expectations for his continued service could not be fulfilled.

III. Minutes of the Previous Meeting

The minutes of the June 24, 1976 meeting of the Administrative Board were approved as submitted.

IV. Executive Council Actions

A. Election of Institutional Members

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduated a class of students and are eligible for Full Institutional Membership in the AAMC:

University of South Alabama  
College of Medicine

Mayo Medical School

University of Minnesota--Duluth  
School of Medicine

Eastern Virginia Medical School

Action:

The Board recommended that the Executive Council nominate the above listed institutions to the Assembly for election to Institutional Membership in the AAMC, subject to ratification by the full Council of Deans.

B. Election of Provisional Institutional Member

The following medical school has received provisional accreditation by the Liaison Committee on Medical Education and is eligible for Provisional Institutional Membership in the AAMC:

Uniformed Services University of the Health Sciences

Some concern was expressed regarding the status of provisional accreditation for the Uniformed Services University of the Health Sciences, which was on the Executive Council agenda for ratification.

The Board wanted to withhold its decision on Provisional Institutional Membership until those concerns were resolved. The Board, therefore, stated its intention to recommend Uniformed Services University for election to membership following the ratification of its provisional accreditation by the Executive Council.

Action:

Contingent upon the ratification of the LCME action for provisional accreditation, the Board recommended that the Executive Council nominate the Uniformed Services University of the Health Sciences to the Assembly for election to Provisional Institutional Membership in the AAMC, subject to ratification by the full Council of Deans.

C. Election of Distinguished Service Members

Dr. Christopher Fordham, Chairman of the COD Committee on Distinguished Service Membership, reported the Committee's recommendation of Dr. Cheves McC. Smythe for election to that body.

In addition, Dr. Fordham reported the Committee's suggestion that the criteria for nomination of Distinguished Service Members be clarified for future committees. After discussion, the Board concluded that the AAMC Bylaws read together with the previously adopted requirement that each recommendation be accompanied by a description of the "active and meritorious participation of the candidate in the affairs of the AAMC while a member of the Council of Deans" provided sufficient guidance in this matter.

The Board expressed its belief that the Committee had discharged its responsibilities correctly and thoroughly and accepted its recommendations.

The Board also considered the recommendation by the COTH Administrative Board that Stanley Ferguson and T. Stewart Hamilton be included for election.

Action:

The Board recommended that the Executive Council approve the nominations submitted by the COTH Administrative Board and further recommended that the Executive Council approve the COD's nomination of Cheves McC. Smythe, M.D. to Distinguished Service Membership.

D. Approval of Subscribers

The following schools have applied for Subscriber status:

University of Illinois--Peoria School of Medicine

University of Illinois--Rockford School of Medicine

University of Illinois--School of Basic Medical  
Sciences, Chicago

University of Illinois--School of Basic Medical  
Sciences, Urbana

Action:

The Board recommended that the Executive Council approve the above as Subscribers.

E. JCAH Accreditation Manual for Hospitals: Medical Staff Standards

The Joint Commission on Accreditation of Hospitals asked the AAMC to review a proposed paragraph to be included in the Medical Staff and the Governing Body and Management sections of the Accreditation Manual for Hospitals. This paragraph is as follows:

Where the appointment and reappointment to the hospital's medical staff is contingent on appointment to the faculty of a university's medical or dental school, the loss of faculty status in the medical or dental school automatically results in the loss of medical staff membership and clinical privileges in the hospital. No due process is required in this case unless it can be shown that the hospital authorities induced the faculty action by the university in order to obtain hospital separation while avoiding due process.

JCAH legal review resulted in a recommendation to replace the second sentence with this one:

In such cases the medical staff bylaws should provide for a hearing in instances where there are reasonable grounds to believe that the hospital authorities induced the faculty action by the university in order to obtain hospital separation without a hearing.

Following a review of the background by Dr. Cooper, members of the Board agreed that the original paragraph be used with the sentence dealing with due process deleted. There was a proposal to broaden the first sentence of the paragraph by deleting the references to "medical and dental schools" making the statement inclusive of all University faculty. The Board decided, however, that this proposal raised more issues than it resolved and suggested that they should be addressed at a local rather than a national level.

Action:

The Board recommended that the JCAH retain its original formulation modified by the deletion of the second sentence, beginning "No due process..."

V. Administrative Board Actions

A. OSR Representation on Executive Council

At its June meeting, the Council of Deans Administrative Board discussed the OSR's request that the number of OSR voting seats on the Executive Council be increased from one to two. During that discussion, Richard Seigle and Tom Rado pointed out that the OSR's preference would be to grant ex officio voting status on the Executive Council to the OSR Immediate-Past-Chairperson. The COD Board considered this proposal at length and reached a consensus that it would be neither appropriate nor desirable to have an individual who would in many cases be a house officer represent undergraduate medical students on the Executive Council. Appended to these minutes are a letter from Dr. Gronvall summarizing the outcome of the COD Board's deliberations on this issue and a letter from AAMC's legal counsel describing the legal implications of OSR's preferred alternative. At its June 25 meeting, the Executive Council approved the addition of the OSR Chairperson-Elect as an ex officio voting member and requested that staff draft the necessary AAMC Bylaws and OSR Rules and Regulations amendments.

1. Proposed Amendments to AAMC Bylaws

Title III.

There shall be an Organization of Student Representatives related to the Council of Deans, operated in a manner consistent with rules and regulations approved by the Council of Deans and comprised of one representative of each institutional member that is a member of the Council of Deans chosen from the student body of each such member. Institutional members whose representatives serve on the Organization of Student Representatives Administrative Board may designate two representatives on the Organization of Student Representa-

tives, provided that only one representative of any institutional member may vote in any meeting. The Organization of Student Representatives shall meet at least once each year at the time and place of the annual meeting of the Council of Deans in conjunction with said meeting to elect a Chairman and Chairman-Elect and other officers, to recommend student members of committees of the Association, to recommend to the Council of Deans the Organization's representatives to the Assembly, and to consider other matters of particular interest to students of institutional members. All actions taken and recommendations made by the Organization of Student Representatives shall be reported to the Chairman of the Council of Deans.

Title VI. Section 2

The Executive Council shall consist of fifteen members elected by the Assembly and ex officio, the Chairman, Chairman-Elect, President, the Chairman of each of the three councils created by these Bylaws, and the Chairman and Chairman-Elect of the Organization of Student Representatives, all of whom shall be voting members. Of the fifteen members of the Executive Council elected by the Assembly, three shall be members of the Council of Academic Societies, three shall be members of the Council of Teachings Hospitals; eight shall be members of the Council of Deans, and one shall be a Distinguished Service Member. The elected members of the Executive Council shall be elected by the Assembly at its annual meeting, each to serve for three years or until the election and installation of his successor. Each shall be eligible for reelection for one additional consecutive term of three years. Each shall be elected by majority vote and may be removed by a vote of two-thirds of the members of the Assembly present and voting.

Richard Seigle, OSR Chairperson, reported to the Chairman that the OSR Administrative Board requested that the OSR officers be referred to throughout the document as "Chairperson" and "Chairperson-Elect".

Action:

The Board recommended that the Executive Council approve the proposed Bylaws amendment with the change of the words "Chairman" and "Chairman-Elect" to "Chairperson" and "Chairperson-Elect" throughout the document when referring to OSR officers.

2. Proposed Change to OSR Rules and Regulations

Section 4. A.2.

The Chairperson-Elect, whose duties it shall be to preside or otherwise serve in the absence of the Chairperson.

Section 4. B.

Officers other than the Chairperson shall be elected at each annual meeting of the Organization and shall assume office at the conclusion of the annual meeting of the Association. The Chairperson shall assume office as provided in Section 6. Regional Chairpersons shall be elected by regional caucus.

The term of office of all officers shall be one year. Each officer must be a member of the Organization of Student Representatives throughout his/her entire term of office, and no two officers may be representatives of the same institutional member. Any officer who ceases to be a member of the Organization must resign from the Administrative Board at that time. Vacant positions on the Administrative Board shall remain unfilled until the annual meeting, except as provided for in Section 6.

Section 4. D.

Presence at the Annual Meeting shall be a requisite for eligibility for election to office. At the time of election, each candidate for office must be a member of the Organization of Student Representatives or must have been designated to become a member of the OSR at the conclusion of the annual meeting. In addition, each officer must be an undergraduate medical student at the time of assuming office. If it becomes necessary to elect a Chairperson, candidates for the office of Chairperson shall in addition have attended a previous meeting of the Organization, except in the event that no one satisfying

this condition seeks the office of Chairperson, in which case this additional criterion shall be waived.  
Section 4. F.

There shall be an Administrative Board composed of the Chairperson, the Chairperson-Elect, the Regional Chairpersons, the Representatives-at-Large, and as a non-voting member the immediate past Chairperson of the Organization.

Section 5. 2)

The Chairperson-Elect of the Organization of Student Representatives;

Section 6.

A. The Chairperson-Elect shall assume the office of Chairperson at the conclusion of the annual meeting of the Association, dependent upon receipt of a vote of confidence from the Administrative Board prior to the annual business meeting of the OSR. If the Chairperson-Elect fails to receive this vote of confidence or otherwise resigns from office, the next Chairperson shall be elected in accordance with the procedures established in Section 4. A Chairperson-Elect who does not succeed to office as provided by this section may not subsequently become a candidate for the office of Chairperson.

B. If the Chairperson of the Organization is for any reason unable to complete the term of office, the Chairperson-Elect shall assume the position of Chairperson for the remainder of the term. Further succession to the office of Chairperson, if necessary, shall be determined by a vote of the remaining members of the Administrative Board.

Richard Seigle addressed the COD Administrative Board with a series of revisions and additions to the Rules and Regulations as presented to the Board. These were as follows:

- a. Section 4d., line 6 -- underline the rest of that line;

- b. add to Section 4 -- "Any officers of the Organization may be recalled by a two-thirds vote of those present and voting at any official meeting.
- c. Section 6 -- delete last sentence.

The first part of the discussion focused on the deletion of the sentence in Section 6 dealing with the eligibility of a Chairman-Elect not receiving a vote of confidence by the OSR Administrative Board to independently become a candidate for election to Chairperson. Staff explained its reasons for inclusion of the clause as being a) to prevent the circumvention of continuity of OSR officers; b) to prevent divisiveness which might be caused by having a candidate use the non-positive response of the Administrative Board as a platform for his/her candidacy. Dr. Thomas Rado, OSR Vice-Chairperson, explained the desire of the OSR Administrative Board to keep the ultimate decision in the hands of the OSR constituency by limiting the otherwise complete and unreviewable power of the OSR Administrative Board to remove an officer.

At this point, Dr. Krevans questioned the wisdom of requiring a vote of confidence before the assumption of the chair. He expressed his judgment that the office should be assumed to pass automatically; that if a strong negative feeling was encountered, an explicit vote of no confidence could be required to dispose of the matter. Other members of the Board agreed that a more positive approach ought be taken. Mr. Seigle was of the opinion that the OSR Administrative Board would be agreeable to a change along those lines. At this time, it was agreed that the proposed changes to the OSR Rules and Regulations be tabled while the sense of the COD Board was sent to the OSR for their discussion and possible revision of the Rules. The COD Board agreed that the Bylaws change would still be forwarded to the Executive Council.

The Board then discussed the addition of the recall provision to Section 4. Staff responded to an inquiry by Dr. Gronvall that no other Council had such a provision for recall. Dr. Gronvall expressed the judgment that no provision for recalling officers was needed. He saw the provision as a stimulus to discontinuity and dissension. It was his opinion that if this matter arose as an issue, it could be effectively dealt with without a specific provision. Dr. Rado stressed the significance of the two-thirds vote requirement and argued that this specificity was preferable to leaving the matter open. A lack of specificity would leave open the possibility of the OSR voting by simple majority; this would make it easier for a small, strong group to make changes rather than a more representative segment of the Organization.

The COD Board asked Mr. Seigle and Dr. Rado to relay this discussion to the OSR Board and to contact the COD Board with any further revisions.

Action:

The Board advised the OSR that deletion of the proposed revision making a Chairperson-Elect who failed to receive a vote of confidence of Administrative Board of the OSR ineligible for election to the Chairpersonship was acceptable to the COD. The provision calling for a vote of confidence should be reframed in terms which would make the Chairperson-Elect automatically succeed to the Chairpersonship unless he/she had received a vote of no confidence.

The Board saw substantial problem with the suggestion that a recall provision be included: a) because it was non-parallel with the Association Bylaws and the Rules and Regulations of other Councils; and b) because it would seem to provide a stimulus to discontinuity in the leadership of the OSR.

B. Medical School Admissions--A Proposed Policy Statement

The Board reviewed a sample of press clippings which have appeared over the past year pertaining to allegations that admission to some medical schools can be gained through political or financial influence. The Board considered what response the AAMC might properly make to strengthen the hand of institutions seeking to resist such pressure and to discourage those who were tempted to exercise it. The Board concluded that it would be ineffective for the Association to simply adopt a public position denouncing the practice. Such an approach would call additional public attention to the allegations but would do little to inhibit the practices themselves. A more appropriate approach seemed to be to handle this matter through the accreditation process. Thus, the Board recommended that the LCME include in the "Guidelines for Functions and Structure of a Medical School", currently in the final stages of revision, an appropriately forceful statement embodying the following affirmations:

- a. Admission to medical school should be determined on the basis of criteria which are defined, public and made available to all applicants.
- b. The application of the criteria in the selection of individuals for the study of medicine is a proper role and prerogative of the academic faculty.

Action:

The Board proposed that an appropriate statement appear in the Guidelines for the Functions and Structure of a Medical School affirming that admission to medical school should be based on defined criteria, which are available openly, and that the selection process itself was a prerogative of an academic faculty.

C. COD Program Selection: "Current & Choice: Developments in Medical Education

The decision to hold a program session for the COD in conjunction with the Annual Meeting was announced by memorandum on July 22, 1976. Each member of the COD was invited to submit an outline or precis of a proposed presentation relating to an innovative development in medical education undertaken by his institution. The responses received were distributed to the Board.

Action:

The Board authorized Drs. Luginbuhl and Stetson to confer on and select six of the proposals for presentation at the COD program session at the Annual Meeting in November.

D. AAMC Data Development Activities

At its September 1975 meeting, the Administrative Board reviewed the recommendations of the Association's Data Development Liaison Committee (DDLC) regarding the classification of a large number of data items maintained by the AAMC on its member institutions. While in most instances the Board agreed with the Committee's recommendations, it disagreed on several categories of information. The DDLC met twice in the intervening period to consider the classification of new data items and to consider the Administrative Board's disagreement with its previous recommendation. Dr. Richard Janeway, Chairman of the DDLC, agreed to meet with the Board in order to describe the activities of his committee and to discuss its recommendations with the Board.

At the conclusion of the Board's discussions of this subject last year, the Board expressed an interest in being briefed on the internal procedures used by the staff to respond to requests for information from various sources. Dr. Paul Jolly, Director of the Division of Operational Studies subsequently formalized the procedures and prepared a presentation of them for the Board. His presentation described the operational implications of the application of the Data Release Policy and the assignment of a release category ("unrestricted", "restricted", and "confidential") to the items of information.

As background for these presentations, three documents were included in the agenda book: Scope of AAMC Data Activities; Role of the Data Development Liaison Committee; AAMC Data Release Policy.\*

The Board engaged in an extensive dialogue with Dr. Janeway regarding the deliberations of the DDLC and its rationale for the proposed classifications.

Action:

The Board endorsed the recommendations of the Data Development Liaison Committee regarding the security classifications of the data contained in the LCME Questionnaire Parts I and II.

E. Women Liaison Officers

The AAMC Special Assistant to the President for Women in Medicine related her perception that she would be greatly assisted in her work if she had access to a person on each or most campuses knowledgeable and active in this area. The Board was asked to review a proposal that each dean be contacted to name such a person and provide comments for staff guidance.

Action:

The Board recommended that the deans be encouraged to appoint women liaison officers.

IV. Adjournment

The meeting was adjourned at 1:00 p.m.

\*This information was provided in a somewhat different form to the entire Council of Deans at its Annual Meeting, November 12, 1976.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

July 19, 1976

Richard S. Seigle  
Chairperson  
Organization of Student Representatives  
969½ Farnum  
Los Angeles, California 90024

Dear Rich:

I am writing in follow-up to our conversations on June 24 regarding the actions of the Council of Deans Administrative Board in response to the OSR recommendation on the proposals for providing a second OSR vote on the Executive Council. While you were present at those discussions and thus can provide a full report on the deliberations to the OSR, we agreed that it would be useful for me to report on the matter in writing from my perspective.

When you and the OSR Vice Chairperson, Dr. Tom Rado, appeared before the COD Administrative Board and presented the OSR position, you made it very clear that the strong preference of OSR would be to exchange the non-voting ex officio seat of the Vice Chairperson for a voting ex officio seat for the immediate-past-chairperson. You reported that when the OSR Board was informed of potential legal and policy problems related to that option, it discussed the possibility of stipulating that the chairperson, when elected, have at least two years remaining as an undergraduate medical student. You indicated that the OSR rejected that stipulation since the educational demands on third-year students appear to be so great as to make the position unattractive and unlikely to be filled as responsibly as desired. You also reported to the COD that the OSR recommended an alternative which it considered far less desirable than the immediate-past-chairperson option. The

alternative would provide for the second OSR vote on the Executive Council to be held by a chairperson-elect who would in the subsequent year assume the office of chairperson unless recalled by a vote of the OSR Board or membership for inadequate performance during his/her first year.

The Council of Deans Administrative Board considered your preferred option first and in some detail. You and Tom pointed out that your knowledge of unsatisfactory experiences of student organizations with the chairperson-elect structure was the primary reason for selecting the immediate-past-chairperson option. The tax status considerations appeared to the OSR Board to be technicalities which could be overcome if approached creatively. The COD Board considered the mechanisms by which a student who had graduated could be designated an OSR representative. These mechanisms included: 1) appointment for two years by the M.D. granting school initially designating the student; 2) appointment by that school of the person as its representative in the second year even though the student is no longer in residence; 3) appointment by the medical school affiliated with the house officer program that the student is currently enrolled in; and 4) appointment, by the hospital in which the student is a house officer, as a COTH representative.

The reaction of the COD Board to these proposals was that they appeared to be contrived, difficult in their administration, and inconsistent with the objectives of the AAMC Bylaws specifying the various classes of membership. The OSR representative is required to be elected from the student body of an institutional member and serves as a second institutional representative to the AAMC. If a student were no longer a part of the undergraduate student body, this fundamental concept would be violated.

The COD Administrative Board in its discussion further pointed out that house officers and students frequently have conflicting points of view and that it would in many cases be inappropriate to have a house officer as a spokesman for medical students. In any event, it seemed unwise for the AAMC to establish a house officer as a voting institutional representative to the Association by such an indirect means. The COD Administrative Board then voted to defeat a motion in support of the OSR proposal.

After additional discussion, which focused primarily on the desirability of including a specific recall provision in any scheme involving the establishment of a chairperson-elect position, the Council of Deans endorsed the OSR alternative proposal. This alternative proposal was subsequently adopted by the Executive Council.

I understand that you continue to have some skepticism regarding the validity of the tax consequences problem identified by the staff regarding the first alternative. Although it is not my perception that the COD Board rejected your preferred option on those grounds, I have asked that Dr. Cooper seek a written opinion of the AAMC counsel regarding this matter and the approaches you have suggested. He has assured me that he will do so.

I hope this adequately sets out the issues and the stance of the Council of Deans. I trust that the matter is well on the way toward resolution and that staff will present the necessary bylaw amendments to consider in September.

Sincerely,

John A. Gronvall, M.D.  
Chairman  
Council of Deans

/jsp

cc: Robert J. Boerner  
John A. D. Cooper, M.D.  
Joseph A. Keyes

June 30, 1976

Joe L. Oppenheimer  
Williams, Myers and Quiggle  
288 17th Street, N.W.  
Suite 900  
Washington, D. C. 20006

Dear Joe:

The Administrative Board of our Organization of Student Representatives last week considered several means of attaining a second vote on the AAMC Executive Council. The mechanism favored by the OSR would be to modify the AAMC Bylaws to allow both the chairman and immediate past chairman of the OSR to sit on the Executive Council ex officio with vote. (Currently, only the OSR chairman has that status.)

In most years the OSR chairman will be a 4th-year medical student, graduating halfway through the November to November term of office. As you may remember, last year we modified the OSR rules and regulations to allow a medical school to designate its representative "from the student body of each..." so that elected officers of the OSR could be designated as institutional representatives beyond graduation until the completion of their term of office the following fall. Providing a vote on the Executive Council to the immediate past chairman would mean that this individual might retain voting status one and one-half years beyond graduation from medical school.

This raises several questions in our minds as to the consistency of this arrangement with applicable provisions of the tax code and with the Association's articles of incorporation. The OSR exists as part of the AAMC "Institutional Membership," which is defined as medical schools and colleges of the United States. Can the immediate past chairman vote on the Executive Council as an OSR representative:

- a) when he/she is no longer the institutional representative to the OSR?

Joe L. Oppenheimer - Page 2  
June 30, 1976

- b) when he/she is no longer a medical student, even though the institution which he/she represented might be willing to continue his/her designation as one of the two representatives to the OSR?

The OSR has suggested several ways by which the past chairman might be designated as an institutional representative. One method would be to have his/her school appoint that person to the OSR for two years, beginning in November of the senior year. Another method would be for the medical school affiliated with the residency program in which the past chairman enrolls after graduation to designate that person as an OSR representative. In either case, the school would be permitted to designate another representative who would be an undergraduate medical student and not an intern or resident, but this second representative would not have the privilege to vote in any meeting at which the past chairman voted. And in either case, the OSR, which was established to represent medical students in the AAMC, would be represented on the Executive Council by an individual who is not a medical student in the general sense of what the OSR was established to represent in 1971. (The Association views interns and residents as graduate medical students while the OSR was created to represent undergraduate medical students.)

I would appreciate your general impressions, considered legal opinion, and any other advice which you would like to offer. If I can explain or clarify any of this, please let me know. For your background information, I am enclosing copies of the current AAMC Bylaws and OSR Rules and Regulations.

Sincerely,

Bart Waldman  
Special Assistant to the  
President

Enclosures

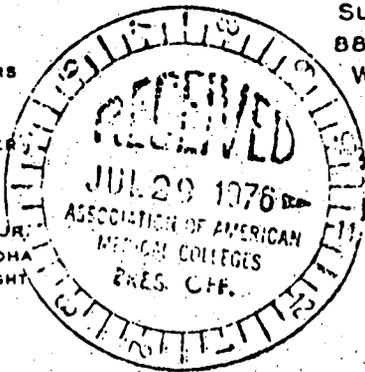
WILLIAMS, MYERS AND QUIGGLE  
ATTORNEYS AND COUNSELORS AT LAW

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AREA CODE 202-333-5900

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JOHN HOLT MYERS  
JAMES W. QUIGGLE  
JOE L. OPPENHEIMER  
ROBERT O. TYLER  
BRUCE R. HOPKINS

ROBERT H. MYERS, JR.  
THOMAS ARDEN ROMA  
DONALD LEWIS WRIGHT



WILLIAM M. WILLIAMS  
(1921-1932)  
EDMUND B. QUIGGLE  
(1921-1935)  
PAUL FORREST MYERS  
(1921-1965)

July 28, 1976

Mr. Bart Waldman  
Special Assistant to the President  
Association of American Medical Colleges  
One Dupont Circle, N. W.  
Washington, D. C. 20036

Re: Organization of Student Representatives

Dear Bart:

I refer to your recent correspondence addressed to me and our conversations regarding the proposal that the immediate past chairman of the Organization of Student Representatives become a member of AAMC's Executive Council ex officio with vote. Such a change in the structure of AAMC would of course require amendment to its by-laws which presently limit the Executive Council to fifteen members elected by the Assembly and certain officers of the Association including the Chairman of the OSR (Article VI, Section 2 of the by-laws). As a matter of procedure, an amendment to affect this change could be adopted as long as the requirements of Article VIII, Section 8 of the by-laws are met.

I understand, however, that in most situations, the chairman of the OSR is a fourth year medical student who, in the normal course of events, graduates before completion of his term as an officer of OSR. I recall that the Association's by-laws and OSR's Rules and Regulations were amended last year to permit the OSR chairman to complete his term of office, even though doing so would confer upon him the authority and responsibilities of the position during the period subsequent to his graduation, after which he would no longer be an undergraduate medical school student. If the same individual as Past Chairman were to continue to participate in the affairs of the Association as a voting member of its Executive Council for an additional twelve month period, he would in fact continue to serve as a representative of undergraduate students for as long as 18 months subsequent to his graduation. For the reasons set forth below, I do not believe that such an arrangement is in the best interest of the Association or OSR.

July 28, 1976

First, I believe it is most important to recognize that the OSR was created and is intended to function as a means of participation in AAMC policy and activities by the undergraduate medical school student community. It is inconsistent with this purpose to permit an individual who is not a member of that community to continue to represent it for a substantial period of time in the important role of a voting member of the Executive Council. I would expect that medical school students and the members of OSR themselves would justly criticize such representation by an individual not chosen from the constituency being represented. Further, I think that this possible situation is significantly different from that presently existing, namely where the chairman of OSR may complete his term of office and continue to serve as a voting member of the Executive Council, even though he may graduate from medical school during that period. Completion of a role once begun is, in my opinion, not comparable to assumption of further authority and different responsibilities by virtue of occupying a different office (past chairman) not held until subsequent to graduation.

Moreover, I do not believe it would be a satisfactory solution to these objections to have the institution at which the past chairman may become affiliated as a resident to designate him or her as one of its representatives to the OSR. This would reverse the procedure inherent in any representative organization which is, specifically, that the constituents determine collectively through whatever procedures they may choose who shall represent them. To require that an individual first named by another institution must necessarily become the representative of an organization with which he becomes associated in a different capacity at a later time is contrary to the basic concept of representation inherent in OSR and AAMC. Furthermore, as noted above, such an individual would not be a member of the undergraduate medical school student body he is purportedly representing.

Finally, as you know, this matter presents a question concerning the tax-exempt status of the Association under the Internal Revenue Code. AAMC is a charitable and educational organization exempt from payment of federal income tax under Internal Revenue Code Section 501(c)(3). A requirement of that section is that such an organization not be organized or operated for the benefit of any "private individual". It is arguable that including among voting members of the Association's governing board individuals who do not represent in a bonafide capacity any part of the community involved in medical education is inconsistent with this restriction in that such an individual would be participating for his personal gain or "private benefit" and that of other individuals - not institutions. I believe the Association is best advised not to adopt a procedure or policy which could generate such issues with the Internal Revenue Service. (As you know, all amendments to the Association's by-laws must be submitted to the Service as a matter of routine.)

Mr. Bart Waldman

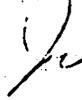
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July 28, 1976

I hope the foregoing is fully responsive to your questions. I shall, of course, be pleased to discuss this matter with you or others if it will be helpful to do so.

With best regards, I am,

Sincerely,

A handwritten signature in cursive script, appearing to be 'Jc', written below the word 'Sincerely,'.

COUNCIL OF DEANS SPRING MEETING PLANNING

The attached material is a staff summary of the status of planning for the COD Spring Meeting. The material has been distributed to the Planning Committee consisting of: Chandler A. Stetson, M.D., Chairman; Steven C. Beering, M.D.; J. Robert Buchanan, M.D.; Frederick C. Robbins, M.D. and John A. Gronvall, M.D., ex officio, but has not been formally considered by them. We expect to conclude the planning and begin contacting speakers before the end of January.



# association of american medical colleges

December 14, 1976

## MEMORANDUM

TO : COD Spring Meeting Planning Committee  
FROM : *[Signature]* Marjorie P. Wilson, M.D. and *[Signature]* Joseph A. Keyes  
SUBJECT: Planning Considerations

Graduate medical education has been identified as the "hot issue" by many within the Association. Simultaneous with our planning, the Department of Academic Affairs was developing plans for an AAMC Institute on the subject (Attachment I). In addition, the Association's Executive Staff discussion regarding the theme of the 1977 Annual Meeting concluded with an agreement that graduate medical education was the most appropriate topic for that meeting. The DAA staff then agreed with us that it would be appropriate for the CAS to hold a Spring Meeting parallel to the COD meeting, both devoted to this subject, as a prelude to an Association-wide consideration at the Annual Meeting and in lieu of the development of plans for an Institute.

These considerations add a new dimension to our Spring Program planning. Is there an appropriate sequencing of meeting topics such that the COD and CAS deliberations culminate in a fruitful Annual Meeting? Does this involve parallel consideration of the same issues by the CAS and the COD, a division of labor between the two Councils such that each consider wholly separate issues, or an overlap of issues with some being unique to the COD and the CAS?

We are concerned that a division of the issues might result in the COD being allocated issues related to institutional management and the CAS devoting its attention to academic and research issues. This would not, it seems, fulfill the deans' desire to deal with matters of academic substance at the Spring 1977 meeting.

Perhaps it is appropriate to reflect on the objectives of the several meetings. If the Annual Meeting is to result in an Association-wide consensus on appropriate approaches to the resolution of identified issues

and problems, it would appear that the Council meetings should have already identified the key issues and have developed some preliminary agreement on appropriate approaches. If this be true, it would appear that the planning committee needs to present to the Council of Deans a comprehensive list of issues with those which are key identified as such, and lesser issues so indicated. The initial portion of the meeting might then be devoted to the development of a consensus throughout the Council on the proper classification of the issues and remainder of the meeting devoted to: 1) the presentation of data relevant to each issue; 2) the generation of alternative approaches or solutions to particular problems, and 3) an analysis of the alternatives.

As a result of our previous discussions which passed from a discussion of the issues to be covered to a discussion of appropriate speakers, we developed the attached outline for the meeting with some of the suggested speakers (Attachment II). While this seems to be a fairly reasonable summary of the committee's tentative conclusions (which could, of course, be strengthened), it: a) was not developed with the perspective of the meeting sequence in mind and b) does not devote comprehensive treatment to all of the issues the planning committee discussed. It does not, for example, deal directly with the matter of the projected gap between the number of graduates and the number of post-graduate experiences available. It does not address directly the relationship of graduate medical education to cost containment concerns. Both of these topics have been discussed at length by the committee.

Questions for the Committee:

1. Does the enclosed draft outline of the meeting sessions basically meet the committee's objectives for the meeting, such that with tinkering we can proceed with contacting speakers?
2. Does the prospect of the Annual Meeting (and possibly a CAS meeting) being devoted to this subject require a complete relook at our planning?
3. Should the planning committee undertake a delphoid survey of itself for the purpose of identifying and prioritizing issues? If so, should it go the next step in identifying alternative approaches for discussion and analyses of these issues? The purpose would be to test whether we had overlooked any important issues and to identify the highest priority issues for inclusion on the program.
4. Are 1, 2, and 3 mutually exclusive steps? In other words, #3 might be an appropriate task even if we decide to go with #1. (It might, for example, feed into the third presentation in Session I, the first in Session II, or the last in Session VI, or some combination of the above.)

From our discussions and notes, we have tried to formulate some objectives. (Attachment III) Do these adequately state the case? Should we be more precise in stating objectives in terms of outcomes which can be evaluated?

MPW/JAK/jsp

Copies to: Steven C. Beering, M.D.  
J. Robert Buchanan, M.D.  
John A. Gronvall, M.D.  
Frederick C. Robbins, M.D.  
Chandler A. Stetson, M.D.

## CONFERENCE ON GRADUATE MEDICAL EDUCATION

## - DRAFT PROPOSAL -

A two-day conference on graduate medical education could encompass the major topic areas outlined on the attached pages. Development of the detailed plans of the conference should be delegated to an ad hoc planning committee composed of two members each from the Council of Deans, Council of Academic Societies, Council of Teaching Hospitals, the Section on Graduate Medical Education from the GME, and two from OSR.

A major problem is how to limit the size of the conference. If each medical school, teaching hospital, and member society of CAS sent one representative, the number would approach 600. This seems too large. On the other hand, if attendance is restricted to the medical schools only, or to only selected teaching hospitals and academic societies, we may have problems from the standpoint of public relations. In any event, it seems likely that such a conference will be attended by a sufficient number of people so that the format will have to be presentations to the plenary group. Small group discussions and workshops do not seem a likely possibility.

For this conference to have maximum impact it should be modeled as an institute with support provided to the selected speakers to develop first-class papers which can be collated into a proceedings. This will require outside funding and the costs will be in the range of the Primary Care Institute. It would be desirable to find an individual from the constituency who could be conference coordinator on a half-time basis during the six to nine months necessary to develop the program.

GRADUATE MEDICAL EDUCATION CONFERENCE

- PROPOSED OUTLINE -

I. Providing Graduate Medical Education Opportunities for U.S. Medical School Graduates

1. Should the number of available positions in graduate medical education be maintained at some proportion of the number of students graduating from U.S. medical schools?
2. Should the distribution of graduate medical education opportunities be controlled? How? By whom?

II. Transition from Undergraduate to Graduate Status

1. Is the broad first year needed?
2. Can the medical schools modify senior year programs to permit direct entry into specialty graduate medical education?
3. If a broad first year is needed, should there be a broad year for:
  - a. medical specialties.
  - b. surgical specialties.

III. Institutional Responsibility for Graduate Medical Education

1. To what degree has it developed?
2. What are the intra-institutional problems?
3. What are the extra-institutional impediments?

Proposed Outline

- 2 -

IV. Quality Control and Accreditation of Graduate Medical Education

1. How is it now accomplished?
2. What modifications are needed?

V. Financing of Graduate Medical Education

1. Is the present system rational and defensible?
2. What are the alternatives, if any?

VI. Specialty Development

1. In the future will there be increasing specialism?
2. Is there a need to control specialism?

VII. Educational Settings for Graduate Medical Education

1. What has been done to diversify educational settings?
2. What are the problems caused by diversification?
3. How should affiliation agreements be written?
4. Are integrated programs the wave of the future?

COUNCIL OF DEANS SPRING MEETING  
April 17-20, 1976

Session I (1 hr. 40 min.) --

An Historical Perspective -- Coggeshall

A treatment of major trends in GME from the 1930's to 1965 leading to the recommendations re university responsibility in the Coggeshall Report.

The Public Isn't Buying -- Byrom

A development of public perceptions that GME as presently constituted is not effective in educating physicians to meet public needs--in some ways is counterproductive.

An Analysis of Where We Are -- Stetson

A statement of the issues, their relevance to the deans; has institutional responsibility happened? If not, why not?

Session II (1 hr. 40 min.) --

Why GME Today -- Beering/Buchanan/Robbins

A total justification for GME in the preparation of a physician for independent practice. Is GME necessary? Whose responsibility is it?

Academic Objectives of GME Programs -- Kipness/Robbins/Bondurant

A program director's perspective on the academic content and objectives of GME programs: What is the character of the idealized GME experience? Discussion of 3 or 4 models. (Do we have to do business in the same old way?--Robbins)

A Science Policy Perspective -- Gerard Piel/Name from T. Morgan

The relationship between GME programs, research, research training and fellowships in the advancement of knowledge, improvement of clinical practice and the training of future investigators and academicians.

Session III (2 hours) --

IOM Study - What House Officers Do -- Hanft/Lee

The results of recent studies of house officer activity to provide a data base for the comparison of program objectives to program implementation.

A Hospital's Objectives in GME Programs -- Heysell/C. Saunders

Why hospitals participate in GME programs; expectations and how they are fulfilled; problems in accommodating academic objectives in a service institution.

A House Officer's Own Experience -- A House officer (someone from Michigan?)

The response of a house officer to the statements of the objectives of others for his training program; his own objectives and how his experience matches with these sets of aspirations.

Session IV (1 hr. 40 min.) --

IOM Social Securities Studies Revisited: Implications of Alternative Financing Schemes -- Gronvall

Recapitulation of the IOM findings and recommendations of the IOM Study and AAMC response. Background and analysis of financing alternatives.

Funding Prospects Beyond 1977 -- Tierney/McNerney

Public policy alternatives and prospects for funding GME in the future.

Session V (1 hr. 40 min.) --

The Role of External Agencies in Shaping GME --

Educational Requirements and Program Evaluation: Who Measures Competence and How?

--The Role of Specialty Boards - Perspectives of specialty boards of their own influence in determining program structure and content through specification of criteria for specialty certification.

- The Role of the LCGME - Accreditation as an external influence on program determinations, positive and adverse impacts.
- The Role of the Federal Government - Manpower legislation.
- The Institutional Response - A dean discusses the meaning of "Institutional Responsibility" and the prospects and problems in its exercise.

Leymaster/Chase/Mellinkoff -- Possible panel

Session VI (2 hours) --

The Canadian Experience -- Naimark/Holmes

Lessons to be learned from the governmental involvement in GME in Canada.

The Northwestern Approach -- Eckenhoff

One institution's strategy for treating residents as students.

Directions for the Future -- Robbins/Buchanan/Stetson

Outlines of possible points of agreement on approaches to handling key outstanding issues.

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Issues Not Covered

- Jaws issues
- Cost Containment issues: GME and Cost Containment - Is it part of the solution or part of the problem?
- Quality of Life issues
- Affiliations issues
- Collective Bargaining issues

Approach Not Accomplished

- Definition of Problem followed by Alternative Solutions



**association of american  
medical colleges**

November 1, 1976

M E M O R A N D U M

FOR : The Record  
FROM : Marjorie P. Wilson, M.D. and Joseph A. Keyes  
SUBJECT: Objectives for Spring 1977 COD Meeting re: Graduate Medical Education

It was agreed among the members of the Program Planning Committee that the deans wished to return to a consideration of educational matters for the Spring 1977 meeting. The subject of Graduate Medical Education was selected and will be announced in the Chairman's Report at the Annual Meeting in November.

It was agreed that the purpose of the Spring Meeting would be as it has been in the past; namely, that--

- ...the people who attend the meeting will recognize the significance of graduate medical education;
- ...will recognize the problems currently surrounding it, and
- ...be stimulated to think about possible solutions.

More specifically, with regard to graduate medical education we will want to examine the following:

What is the present situation?

What should it be?

How do we get there?

As a result of the meeting, we would hope to get clear about the following:

1. What is the justification for GME? Is it necessary? Whose responsibility is it?
2. What are the objectives and character of idealized GME? What are some alternative models?
3. How is GME evaluated? The programs? The individual who has undergone the training? How effective are these methods? How do we measure what we are doing and prove its utility to the participants and to the public?
4. To understand the relationship of financing of GME to the educational content of GME. Do financial pressures erode educational content? What are the pros and cons of alternative financing mechanisms?

It is assumed that as in previous years a "proceedings" would be made available in whatever printed form the COD/DID budget would allow.

MPW/JAK/jsp

TESTIMONY OF ROBERT E. TRANQUADA, M.D.

The attached testimony given by Dr. Tranquada, Associate Dean for Post-graduate and Regional Medical Education, UCLA, before the House Subcommittee on Labor Management Relations, addresses the issue of collective bargaining by housestaff under the National Labor Relations Act. The hearings, held in San Francisco on November 29, the Monday after Thanksgiving, were called on very short notice to open public consideration of the "Thompson Amendment". This proposal would amend the National Labor Relations Act to specifically include house officers under its coverage. The AAMC was precluded from testifying by both the short notice and the agreement to consider the issue at the Officers' Retreat.

Dr. Tranquada's testimony is provided for your information.

7.

STATEMENT OF  
ROBERT E. TRANQUADA, M.D.  
TO THE  
HOUSE SPECIAL LABOR COMMITTEE  
HONORABLE FRANK THOMPSON, CHAIRMAN

November 29, 1976  
San Francisco, California

I am Robert E. Tranquada, M.D., Professor of Medicine and Associate Dean for Postgraduate and Regional Medical Education at the University of California at Los Angeles, School of Medicine. From 1969 to 1975 I was the Medical Director of the Los Angeles County-University of Southern California Medical Center and Associate Dean at the University of Southern California School of Medicine. At UCLA I coordinate fifteen teaching hospitals affiliated with the School of Medicine and offering some 1,540 internship and residency positions. At USC I was responsible for the supervision of some twenty-six residency programs involving about 850 interns and residents.

I come before you to express my deep concern about the potential effects of the legislation you are considering today which would include graduate medical students, that is interns, residents and fellows, under the National Labor Relations Act. Such legislation would have profound negative effects on graduate medical education. Moreover, it would prove largely unworkable. I propose to indicate in some detail my reasons for making such a statement. A very complete and well documented exposition of these objections already exists in the form of the amicus curiae brief filed by the Association of American Medical Colleges with the NLRB in April, 1975. It will be my purpose to emphasize those items which are of deepest concern to medical educators deeply involved in the process of graduate medical education.

The following are the major considerations which have led me to this conclusion.

1. Interns and residents are students in every sense of that term. If they were not students, there would be no reason for maintaining such programs as they are neither efficient nor economical in provision of medical care. To consider them primarily as employees would destroy the basic relationship of student and teacher essential to the purpose of their learning experience.

2. The nature of the learning experience for the intern and resident is one that is tailored to individual student needs. As such, it defies resolution into the traditional patterns of labor-management interactions on a collective basis. Inordinate amounts of energy would be expended attempting to reduce these complex individual arrangements to collective bargaining terms consistent with the regulations of the NLRB. The most probable result would be major interference with well established educational values without any redeeming benefits.

3. The problems involved in managing a teaching hospital already involve numerous external agencies, local, state, and national. The addition of one further external agency would further compound the existing incompatibilities.

4. The National Labor Relations Board would inevitably become involved as an arbiter of concerns which are strictly

educational. The National Labor Relations Act never contemplated that purpose. The NLRB is not constituted to provide such input, and if it were to do so, the result would be disastrous to medical education.

5. There is a basic incompatibility between the provisions of PL 94-484, the Health Professions Educational Assistance Act of 1976, and the potential effect of the legislation you are considering with respect to the medical schools' responsibility to achieve a congressionally mandated balance between primary care and other specialized physicians.

In the process of preparing an individual for the independent practice of medicine, several steps are necessary. Undergraduate medical students are given a large base of knowledge and some clinical skills with the principal objective of preparing a student for postgraduate medical education, i.e., his internship and residency. The average of four years spent as an undergraduate medical student does not provide adequate time to acquire the supervised experience in actual care of sick patients deemed necessary to allow the level of skill and judgment required for the independent practice of medicine. This is provided through a supervised postgraduate educational experience termed internship, residency or fellowship. That this is neither a capricious nor lightly considered requirement is affirmed by the fact that most state licensing laws require at least a year of approved internship before a license to practice medicine independently

may be issued. Additionally, the national accrediting agencies for the specialties of medicine have determined that recognition of adequate preparation to be eligible to take specialty examinations requires additional education as a resident of from two to five years. At least three postgraduate residency years are required for certification in Family Practice.

During this educational process, a major task of the student is to gain first hand, supervised experience with actual sick patients in the hospital and in the clinic in addition to participation in formal didactic education. Through such supervised experiences with his faculty and regular evaluation of his progress he achieves the first hand knowledge and skills, along with the degree of clinical judgment which allows the gradual transfer of increasing responsibility to the young physician as he demonstrates increasing proficiency.

To obtain this essential experience the student intern or resident must participate in the fully supervised provision of care for an appropriate cross section of the patients for which his institution is responsible. In so doing, he will participate in the care of many people with common medical or surgical problems and will usually gain early proficiency in the management of such problems long before he has completed his education and experience with more complex or unusual problems. Because there is no practical way (nor would it be educationally desirable to do so) to screen out common problems and allow concentration only

on the rare or complex, many interns and residents spend significant amounts of their supervised patient care time with repetitive problems which may sometimes seem unrewarding and therefore infer that their sole purpose is that of providing medical services and not that of attaining medical education. The fact is that one major educational goal of the postgraduate student is to learn to deal successfully with individual patients with their endless variations of personality, life style, and social and economic settings. Such apparently repetitive "service" functions are essential elements in achieving that goal and in developing, with the help of medical educators, conscientious methods of problem solving which will influence a whole life time of medical practice.

It is true, that in the educational process just described, much service of value to the patients and the institutions is provided. That, however, does not change the resident's primary status to that of employee. That is a product of the nature of medicine and what must be mastered to be competent for independent practice. Graduate students in journalism produce articles for publication, physics students participate in research that may or may not be of value, and students of poetry write poems. It has not been determined, however, that such students should be considered employees, merely because a product of their learning experience has some value to others, even if they receive a fellowship stipend. Indeed, the NLRB has specifically refused

to identify students in such instances as employees within the meaning of the NLRA, just as they have recently ruled with respect to interns and residents. Will it be the intent of this Committee then to enact special legislation for each such class of individuals which thoughtful review by the NLRB has resulted in a decision that they are not within the scope of its mandate?

Similarly, interns and residents are students. It happens that the by-product of their learning process is often of significant value to the patients and the institution sponsoring their education. Certainly, the emotional value of medical care has more impact upon the lay public than the results of a physics research problem. However, as a by-product of a learning experience it has a precisely analogous character. Are we to accept the fact that because society places a higher economic and emotional value on one product over the other, that the producer of the one can be said to be an employee and of the other a student? The production of something or some service of value incident to education does not alter the fact that these are students and that the primary purpose of their experience is educational and not wage earning. The purpose of the stipend is to allow the learning to take place without undue hardship on the student.

If the above reality is denied, let us consider the effects of the transition from student to employee and the substitution of collective bargaining for individual negotiation that would be occasioned by the legislation under consideration. The very

nature of collective bargaining requires the reduction of employee status to certain tangible standards which can be clearly identified, quantitated, disputed and objectively bargained for. The very purpose and diversity of the internship and residency experience make such reductionism to the usual concepts and restraints of commercial labor and management principles impossible. Some examples follow:

Practice settings for various medical training programs vary widely, as do the learning objectives, skills and functions. These vary from learning to interpret x-ray films in a quiet office, to assisting in surgical operations in operating rooms, to learning to provide emergency medical and surgical care for acutely ill or injured patients. The first is subject to careful scheduling and regular hours, the second somewhat less so, and the third, until traffic accidents and heart attacks can be scheduled in advance, defies scheduling altogether.

It is essential to the learning process that an intern or resident follow and provide care with appropriate supervision to individual patients in all stages of their illnesses. Sometimes this can be accomplished Monday through Friday between 8:00 a.m. and 5:00 p.m. Sometimes the continuous participation in the full course of, say, a patient with diabetic coma extends beyond 5:00 p.m. or into the weekend. If the resident were seen as an employee, when does the resident's presence at the patient's bedside cease to be part of his work and become educational? How is it possible

in this educational process, to define normal working hours and overtime? Given the educational mission, hours in which services are provided must be those in which the most appropriate experience can be gained. That requirement applied to the care of sick patients, defies reduction into a concept of regular time and overtime.

Each student learns at a different pace and each develops special needs for his own program. How can such arrangements, normally provided for by exchange between individual student and teacher, be reduced to collective bargaining and a grievance procedure which would inevitably involve educational decisions by the NLRB? This is neither possible nor desirable, nor is it anywhere proximal to the intent of Congress in providing the parent labor legislation for the orderly conduct of commerce in the business sense.

Many postgraduate training programs include required or elective experiences which may include laboratory research, library research, participation in the private practice of a faculty preceptor, or other activities totally outside the scope of productive employment but central to the educational experience. By no stretch of the imagination can such activities which consume weeks or months of time, be construed as productive in the usual context of labor.

How would such assignments be dealt with under employee status of the resident? If the hospital ruled that they were

outside the realm of "employment" and refused to pay "wages" for them, but the accrediting medical board and the teachers of medicine required them, could the NLRB in arbitration of a grievance action then make educational policy by declaring such requirements to be illegal or capricious? Or could the NLRB hold that such activities, purely in the students interest, be compensated for by regular wages and overtime? If so, what would be the ruling of other agencies who make policy governing costs which may be appropriately attributed to medical care?

How would we deal with the complexities involved in the fact that a sizable proportion of intern and resident service assignments take place outside the parent institution? These assignments are made either to satisfy the need for a fully rounded educational experience, or as elective selections by the student who recognizes his own need for a special experience. Under the proposed legislation "employees" of one covered institution might be providing services for and under the direction of another "employee" of an exempt federal, state, or county institution, or "employees" of exempt government hospitals might be providing services in private institutions where their status would be in considerable doubt. It is difficult indeed, to see how the mandatory rules and regulations of the NLRB, never designed to respond to such situations, could be made to cover such circumstances without the generation of more confusion, regulations and bureaucratic procedures than can be justified by any doubtful

benefits.

Clearly the potential confusion of adding another external agency to the control of medical education would be, at best, confusing. If such an agency had no mechanisms, no experience and no expertise to deal with questions of medical education, what logic can there be to including it? The NLRB has, to our knowledge, no such mechanism, experience or expertise, nor was it intended to have them. The management of postgraduate medical education is unique, complex, highly specialized and often determined subjectively. It can be governed successfully only by those who have experienced it and made long use of its benefits.

The complaint has been voiced that some residencies require excessive work from residents with little supervision and that such situations justify the proposed inclusion of residents and interns under the NLRA. In fact, if such situations occur, it is directly within the province of the appropriate national residency review committee to identify such deficiencies and either insist on improvement or withdraw the accreditation of such programs as inadequate teaching experiences. Within the past year, two such actions have taken place in Los Angeles. Both occurred at county hospitals, which would not be covered by the proposed legislation.

In one case, a very large residency program in internal medicine was put on probation because of a lack of nurses and

ancillary personnel and equipment to support the residents in their educational tasks. In another instance, a program in family practice was disaccredited for similar reasons. These are judgments made by those familiar with and knowledgeable of the circumstances and problems involved. These judgments are reached after consultation with the residents in these programs as a significant part of the decision making process. Can there really be the need to add the additional judgment of a mechanism established to regulate and arbitrate labor-management problems which has no foundation and no expertise in medical education? The proper remedy for residencies which are not good educational experiences is either to improve or abolish them, and not to preserve them under the rubric of labor organizations.

Finally, the Congress recently passed and the President signed into law PL 94-484, the Health Professions Educational Assistance Act of 1976. Section 771, (b), (2) (A) et. seq. of Title V of that Act places upon the medical schools the responsibility for maintaining a certain balance of residency programs as between those educating primary care physicians and those educating physicians in other specialties. The Act thus presupposes the ability of the medical schools to determine the number and location of its residency programs. Such a determination, however, could fairly be interpreted as affecting the "wages, hours and other terms and conditions of employment" which are among the subjects of collective bargaining viewed by

the NLRA as mandatory. Thus removed from medical school control, how can the medical schools or any other agency hope to comply with the requirements imposed by PL 94-484? Even more significant, the possibility that the NLRB will be controlling such decisions would appear to be contrary to the intent of Congress as expressed in PL 94-484.

It is my feeling that the effect of the legislation being contemplated may be likened to that of hunting mosquitoes indoors with a shotgun. The object of the hunt may or may not be eliminated but the attendant damage to the house would convince the prudent person to find some less destructive method.

Residents are not now prevented from presenting their collective desires to the institutions which sponsor their education. What has developed in many fine teaching hospitals are house staff associations who can represent the needs and desires of their numbers to medical education and administrative management without being bound by rules and regulations designed for standard labor-management relationships.

Those responsible for internship and residency programs are subject to another set of pressures far more sensitive than those of collective bargaining. It is well known that new applicants to training programs are influenced to a major degree by incumbent interns and residents. It is a fact that medical educators are very sensitive to that and are continuously concerned that their residents are satisfied with their educational experience and

its surrounding conditions. Otherwise no new applicants would appear.

Many well known examples of effective collective bargaining exist in the context of graduate (medical) education. Grievance mechanisms and due process safeguards are being established in many residency programs simply because they are in the best interests of both teacher and student. The absence of NLRB jurisdiction over these programs, affirmed in their wisdom by their March 19, 1976 decision, however, assures that a statutory mechanism established for the regulation of substantial labor-management concerns in commerce will not be applied to the teacher-student relationship. After all, interns and residents are not inarticulate, illiterate or unintelligent individuals. Postgraduate medical students in internship and residency are in the process of being provided with the credentials that will bring them some of the greatest responsibilities and highest prestige and living standards in our society.

I have highlighted some of the dangers that the legislation you are considering would produce. They are not insignificant. I would once again stress that the adoption of this legislation would be inappropriate and unwise.