AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AGENDA

Organization of Resident Representatives
Administrative Board Meeting

February 23-24, 1994
Washington, D.C.

AAMC Headquarters
2450 N Street, N.W.
(202) 828-0400

ANA Westin Hotel
24th & M Streets, N.W.
(202) 429-2400

AAMC Staff
Robert L. Beran
Associate Vice President
Section for Graduate Medical Education

Michelle Keyes-Welch
Staff Associate

LaTanya Johnson
Administrative Assistant

Organization of Resident Representatives
Administrative Board Meeting
February 23-24, 1994
Washington, DC

Wednesday, February 23 **9:30-3:00 p.m.**
AAMC Conference Room 128

CALL TO ORDER	Michele Parker, M.D., Chair
Approval of 1993 Annual Meeting Minutes	Michele Parker, M.D.
Review of 1993 Annual Meeting	Michele Parker, M.D.

REPORTS

Officers' Retreat	Michele Parker, M.D. Denise Dupras, M.D., Ph.D., Chair-elect
ORR Newsletter	Michele Parker, M.D. Cathy Halperin, M.D.
ORR and Resident Representation on the ACGME	Robert Dickler

NEW BUSINESS

HELP Loans/Healthcare Reform Update	Steve Northrup Mary Beth Bresch White
Designation of an ORR/OSR Liaison	Michele Parker, M.D.
Mentoring Medical Students	Denise Dupras, M.D., Ph.D.
Student Mistreatment-- Possible Joint ORR/OSR Projects	Denise Dupras, M.D., Ph.D.
Topics for 1994 Discussion	Michele Parker, M.D.
Executive Council Agenda Items (see Executive Council agenda book for specific items)	Michele Parker, M.D.

INFORMATION ITEMS

Evaluation of 1993 Annual Meeting

AAMC Policy on Working Hours and Supervision

Disability Information from the AAMC's
COTH Housestaff Survey of Stipends and Benefits

Generalist Physician Policy Statement

Medicine and Parenting

Association of American Medical Colleges
Organization of Resident Representatives
Minutes of the Fall Business Meeting

November 6-7, 1993
Washington, D.C.

Saturday, November 6

The ORR program opened with an orientation session for all new representatives. Joseph Auteri, M.D., Chair, began the session by explaining the history of the ORR as well as its current structure. He then reviewed the AAMC's organizational and governance structure. Dr. Auteri encouraged the new ORR members to get involved with the ORR, particularly the administrative board. He expressed concern over the level of communication between the representatives beyond the annual meeting. He further encouraged participation in some of the other activities during the annual meeting.

After a short break, Dr. Auteri called the ORR business meeting to order. Following brief introductions of the ORR members, administrative board, and AAMC staff that were present, Robert Petersdorf, M.D., AAMC President, welcomed the residents to AAMC's 104th Annual Meeting. He explained that he began generating an interest in this particular group's formulation 15 years ago and still today feels that residents play a very important part in the medical education enterprise. He also discussed the increasing interest in medicine as a career. There were more students that applied to medical school in 1993 than at any other time in history. He expects a 10% increase in the number of 1994 applicants. Next, Dr. Petersdorf accented some of the annual meeting's activities, including Mrs. Hillary Rodham Clinton as keynote speaker of the AAMC opening plenary session. He addressed health care reform and cited the four documents which the Association has developed on the issue in response to the Clinton Administration and other proposals. He suggested the members familiarize themselves with the Clinton proposal for health care reform. He went on to discuss the generalist initiative, as well as the residents ' role as teachers of other residents, medical students and patients. Finally, Dr. Petersdorf highlighted several ORR program activities including the workshops on residents as teachers and the new electronic residency application system. He encouraged the ORR members to get involved, ask questions and provide input into the many important issues facing academic medicine.

Next, Dr. Auteri reviewed the minutes of the 1993 ORR Administrative board meetings and 1992 ORR Fall business meeting. He then called for the reports from the residents on various task forces.

Michele Parker, M.D., Chair-elect, and Cathy Halperin, M.D., discussed efforts to produce and distribute the ORR newsletter this year. They are inviting other members' participation with the newsletter, as well as ideas on improvements. Drs. Parker and Halperin hope to distribute the next newsletter after this annual meeting and administrative board meetings next year.

Bernarda Zenker, M.D., Immediate Past-Chair, gave an update on the Generalist Physician's Task Force and the AAMC's Office of Generalist Physicians of which she is

now a staff member. She reviewed the Executive Summary of the Task Forces which includes the AAMC's pivotal policy statement that a majority of medical school graduates should enter the generalist's discipline as soon as possible. Those disciplines are defined as general internal medicine, general pediatrics and family practice. Dr. Zenker explained that the Office of Generalist Physician was established to be a resource for the AAMC's constitute members, and to increase the number of medical students choosing the generalist disciplines. The office has developed a database which consists of: 1) an annotated bibliography of all published literature on generalist disciplines/physicians; 2) a state legislative tracking record; and 3) generalist initiatives in the corporate world.

Barbara Tardifff, M.D., has been involved with the Electronic Residency Application project. There has been a positive response from medical students and deans; some program directors are apprehensive. Dr. Tardiff suggests the ORR and other residents work through their specialty organizations to affect the program directors.

Denise Dupras, M.D., addressed the issue of blood-borne pathogens and occupational risks. She stated that greater than 70% of housestaff nationwide have one or more needle sticks during the first two years of their training, and these injuries often go unreported. Dr. Dupras plans to disseminate pertinent information at a workshop during the annual meeting regarding disability, immunization, OSHA regulations and prophylactic AZT where there is HIV risk in a residency training program.

Susan Vaughan, M.D., distributed a survey on residents as teachers to the ORR members earlier this year. She expressed her disappointment in the number of responses and requested that the members present at the meeting complete and return the survey as soon as possible . She explained that the diversity within the group should provide a substantial insight into the various teaching methods used in residency programs throughout the country.

Next Dr. Louis Profeta discussed the trends in U.S. healthcare towards health maintenance organizations (HMO's) and preferred provider organizations (PPO's)--organizations whose goal is to provide medical care at a reduced cost. He also reviewed the objectives of the AAMC's Health Care Reform Advisory Panel which was essentially formed to develop a response to the current Administration and other proposals on behalf of the nation's academic medical centers. He cited the 4 publications that were produced by the Advisory Panel. Future projects of the panel will include seeking continued funding for basic sciences and clinical outcomes research.

The Health Care Reform briefing session that was held in Washington, DC., in October was attended by Drs. Biglow and Daniels. Dr. John Biglow distributed information from the session as well as a summary of the Clinton Plan for Health Care Reform.

Cathy Halperin spoke on the visit to Capitol Hill arranged by the Organization of Student Representatives (OSR). The visit was highly informative and a good experience for residents and students who are unfamiliar with the legislative process. The participants were able to meet several key staff in the Senate and provide input on the primary care/generalist issue. She suggested the ORR pursue this type of experience as a group.

Dr. Michele Parker discussed the OSR/ORR liaison and the significance of the

relationship between the two groups. She is excited by the OSR program for the annual meeting and their enthusiasm towards professional medicine. She noted that the OSR is "older" than the ORR, and in terms of AAMC operations, she believes their knowledge and experiences are valuable. She invites a resident volunteer seriously interested in medical student issues to be the next liaison between the two groups since she will not have time as the new ORR chair.

After the task force reports, Dr. Auteri apprised the group on the ORR's push for resident representation on the Accreditation Council for Graduate Medical Education (ACGME). He explained that the AMA has resident representation with the ACGME, and the ORR administrative board felt that the AAMC should certainly be afforded the same opportunity to provide resident input on issues pertaining to graduate medical education. Michelle Keyes-Welch informed the members of the process involved with requesting this representation. The AAMC/ORR's petition will be further examined by the ACGME at their upcoming meeting in February.

The business meeting was adjourned until the following morning.

The ORR broke into small group discussions on health care refom which continued over lunch after the business meeting's adjournment Six groups were formed hghlighting generalist supply and demand, medical student debt, capping residency slots, graduate medical education funding, tort reform and managed care. Key points raised include: 1) generalists should receive the same recognition as other specialties, 2) there need to be incentives to choosing a generalist specialty, 3) role models are needed in all specialties, 4) medical student debt, while not found to be a major specialty choice influence, can play a part in some career decisions, 5) financial aid is needed to allow all students to choose among the specialties, 6) quality of training must be considered if capping residency slots is implemented, 7) academic medical centers must receive appropriate amounts of direct and indirect funding support to undertake teaching responsibilities, 8) tort reform is needed to keep the costs of medical care and malpractice insurance from rising further, 9) reform is also needed to prevent practitioners from restricting their practice based on suits or malpractice insurance premiums, 10) managed care is increasing in popularity as a health insurance plan, 11) physicians must be included in quality and medical decisions within the managed care environment. Several other points were discussed, and residents expressed their comments and concerns over health care in general and the proposed plans for health care reform.

A joint CAS/ORR workshop on teaching residents how to teach was held Saturday afternoon. Dr. Neal Whitman, Professor of Family Medicine at the University of Utah and Dr. Marilyn Appel, Coordinator for Primary Care Programs at Hahnemann University School of Medicine, presented the program. Dr. Whitman discussed the clinical teaching model, team building and the "games" that learners and teachers play. He described the similarities and differences between managers, teachers and learners and the importance of appropriate feedback and interaction. Dr. Appel focused on the appropriate methods of teaching a skill, and ways in which to give feedback. Both verbal and non-verbal communication were discussed.

The ORR also held a joint workshop with the Graduate Student Association (GSA) to present the prototype of the electronic application system. AAMC staff Paul Jolly and Frances Hall highlighted the components of the student, Dean's office and

program directors work stations and demonstrated the application process for students using the electronic system. A reactor panel comprised of student Deans, a resident, program directors and medical school officials presented follow-up comments on the electronic system. Dr. Barbara Tardiff presented a resident perspective on the prototype.

Sunday, November 6, 1993

The second half of the business meeting opened with remarks from Dr. Edward Stemmler, AAMC Vice President. He stated that the ORR represents all residents in the educational systems whose input is necessary for the AAMC to take the appropriate kinds of policy positions. He was also pleased at the level of attendance at the meeting and hopes this involvement will continue.

With task force reports continuing from the previous day, Dai Chung, M.D., discussed his attendance at the Group on Student Affairs Southern Meeting in April. The meeting's focus was on the importance of the resident's role as teacher-especially to medical students. Dr. Chung intends to summarize some of the main points of the various seminars and distribute them to ORR members in the future.

The next agenda item was a proposed change in the ORR Bylaws. Before opening the floor for discussion, Dr. Auteri explained that several specialty groups have approached the ORR with the desire to appoint representation to the group. Currently, there are 44 members of the ORR, two residents designated from each of 22 Council of Academic Societies (CAS) specialty organizations. The administrative board also informed the group that any Bylaws changes are subject to the AAMC Executive Council's approval. After a lengthy discussion the ORR elected to amend the current Bylaws to allow consideration of other specialty groups wishing to designate residents to the ORR. The proposed change regarding Membership states: "to the extent that a specialty recognized by the ACGME with accredited residency training programs is not represented on the ORR by either a CAS member program director or clinical chair group, a member society may submit a letter of interest to the ORR stating a desire to designate one resident physician to the ORR. Upon approval by the ORR Administrative Board and the AAMC Executive Council, the society will be asked to forward the name of the resident physician the society wishes to designate."

Lisa Larsen, President of *Academic Physician and Scientist*, visited the business session to query the member's needs from the magazine in relation to position advertisements. Currently the magazine is published 6 times a year, and its producers are constantly working to improve its content/format. Several representatives stated they would like to see a more comprehensive listing of positions available nationwide; program directors and specialty groups should be contacted for support and advertisement.

Next, Dr. Auteri expressed the need for new appointments on the AAMC Advisory Panel for Health Care Reform, volunteers to work with the ORR newsletter, and a new OSR liaison. Interested representatives should contact Michelle Keyes-Welch.

The ORR also discussed the use of electronic mail and communication using computers. Residents with access to Internet should contact Michelle Keyes-Welch with their e-mail address.

ORR administrative board elections for 1994 were held. The results were: Chair-elect--Denise Dupras, M.D., and new members--Deborah Baumgarten, M.D., Fernando Daniels, III, M.D., William J. Fortuner, M.D., Nicholas Gideonse, M.D., Michael Greenberg, M.D., and Cathy Halperin, M.D. Drs. Mary Elise Hodson, Louis Profeta, Joshua Port (absent), Barbara Tardiff, and Bernarda Zenker were recognized as out-going officers and members. Michele Parker, M.D., presided over the duration of the meeting as the 1994 ORR Chair.

The final item for discussion was the topics of interest to the ORR for 1994. There was a wide range of suggested topics; however, the administrative board advised the group to choose six key topics and form discussion groups from these topics. The elected topics were: residents as teachers, cost containment, communication, tort reform, resident working conditions, disability, and GME funding. A list of each group's participants is attached.

The meeting was adjourned by Dr. Michele Parker.

Organization of Resident Representatives
Interest Groups

Residents as Teachers

Julia Corcoran
Susan Vaughan
Judy Hoover
Dai Chung
Joe Schwartz
Christina Gutierrez
Deborah Baumgarten
Brijit Reis

Cost Containment

Kelly Roveda
Alan Zacharias
Nick Gideonse
Bill Fortuner

Communication

Kevin Smith
Geronimo Sahagun
Nick Gideonse
Alicia Zalka

Tort Reform

Marci Roy
Brijit Reis
Raynor Casey
Bill Fortuner

Working Conditions, disability

Geronimo Sahagun
Marci Roy
Kishore Tipirneni
Steve Ripple
Joe Schwartz
Christina Gutierrez
Rayvelle Barney

GME Funding

Geronimo Sahagun
David Jones
Joe Schwartz
Nick Gideonse
Bill Fortuner

Other Interests:

Computers and communication--Geronimo Sahagun, Mark Epstein
Health Care Reform(Task Force)--Judy Hoover, Mark Epstein
Generalist Physician--Mark Epstein

RULES AND REGULATIONS
OF THE
ORGANIZATION OF RESIDENT REPRESENTATIVES
THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADOPTED BY THE ORGANIZATION OF RESIDENT REPRESENTATIVES
November, 1992
APPROVED BY THE EXECUTIVE COUNCIL
February, 1993

The Organization of Resident Representatives was established with the adoption of the Association of American Medical Colleges bylaw revisions of November, 1991.

Section One-Name

The name of the organization shall be the Organization of Resident Representatives (ORR) of the Association of American Medical Colleges.

Section Two-Purpose

The purpose of this organization shall be 1) to provide a mechanism for the interchange of ideas and perceptions among resident physicians and others concerned with medical education, 2) to provide a means by which resident physician views on matters of concern to the Association may find expression, 3) to provide a mechanism for resident physician participation in the governance of the affairs of the Association, 4) to provide a forum for resident physician action on issues that affect the delivery of health care, and 5) to provide professional and academic development opportunities.

Section Three-Membership

Members of the Organization of Resident Representatives shall be resident physicians or fellows when designated by the member organizations of the Council of Academic Societies of the Association of American Medical Colleges that represent chairs of medical school clinical departments or directors of residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Two resident representatives shall be designated by each of these member organizations by a process appropriate to the governance of the designating organization.

To the extent that a specialty recognized by the ACGME with accredited residency training programs is not represented on the ORR by either a CAS member program director or clinical chair group, a member society may submit a letter of interest to the ORR stating a desire to designate a (one) resident physician to the ORR. Upon approval by the ORR administrative board and Executive Council of the AAMC, the society will be asked to forward the name of the resident physician the society wishes to designate.

Members of the ORR shall be designated to serve for a two-year term and may be reappointed by the societies for another two-year term if they meet membership requirements. The selection process should involve resident input to the extent possible by the organization's administrative structure and governance. The president or chair of the organization will respond to the Association with the names of the two resident physicians the organization wishes to designate.

Each member of the Organization of Resident Representatives shall be entitled to one vote at meetings of the ORR.

Section Four-Officers and Administrative Board

The officers of the Organization of Resident Representatives shall be as follows:

1) The chair whose duties shall be to:

   a) preside at all meetings of the ORR
   b) serve as ex-officio member of all committees of the ORR
   c) communicate all recommendations and actions adopted by the ORR to the Executive Council
   d) represent the ORR on the Executive Council

2) The chair-elect whose duties are to preside or otherwise serve in the absence of the chair and to succeed the chair in that office at the completion of his/her term of office. If the chair-elect succeeds the chair before the expiration of his/her term of office, such service shall not disqualify the chair-elect from serving a full term as chair.

The term of office of the chair and chair-elect shall be one year.

There shall be an administrative board composed of the chair, chair-elect, immediate past chair and six members- at-large. The term of office of the members-at-large shall be for one year, and this service shall not disqualify them from serving a full term as chair-elect, chair and immediate past-chair if so elected[1]. The chair-elect and members-at-large will be elected annually at the time of the annual meeting of the Association of American Medical Colleges. Members-at-large may be re-elected to the administrative board providing they fulfill membership

[1] At the first meeting of the Organization of Resident Representatives, three members-at-large of the administrative board were elected to a two year term to facilitate an orderly transition and to allow administrative board members additional time to create an appropriate organizational and structural foundation. Following the conclusion of the three members' term of service, all at-large administrative board positions shall be for one year as stated above.

requirements. Those members serving as officers or administrative board members shall be designated resident representatives by their respective Council of Academic Societies member organization. Retiring officers and administrative board members shall be non-voting members at the annual meeting. The Council of Academic Societies' organizations who are represented by retiring officers or administrative board members shall designate a total of two voting resident representatives to the annual meeting.

Nominations for chair-elect and the administrative board will be accepted with appropriate supporting materials (curriculum vitae and a statement of intent) prior to the annual meeting. Additional nominations may be made by the membership of the Organization of Resident Representatives at the time of the election.

Candidates for each respective office will be allowed to provide a brief oral summary of their qualifications and interest in the Organization of Resident Representatives prior to the casting of ballots. Election will be by closed ballot. The first to be called will be for chair-elect. The nominee receiving the most votes shall be elected. In the event of a tie, a run-off election will be held.

The next ballot will be for members-at-large of the administrative board. The individuals receiving the highest number of votes shall be elected. In the event of a tie, a run-off election will be held.

The administrative board shall be the Organization of Resident Representative's executive committee to manage the affairs of the Organization of Resident Representatives and to take any necessary interim action that is required on behalf of the Organization.

Section Five-Representation on the AAMC Assembly

The Organization of Resident Representatives is authorized twelve seats on the AAMC Assembly. Representatives of the Organization to the Assembly shall be determined according to the following priority:

1) the chair of the Organization of Resident Representatives

2) the chair-elect of the Organization of Resident Representatives

3) the immediate past-chair of the Organization of Resident Representatives

4) members-at-large of the administrative board of the Organization of Resident Representatives

5) additional members as designated by the chair of the Organization of Resident Representatives

Section Six-Meetings, Quorums and Parliamentary Procedure

Regular meetings of the Organization of Resident Representatives shall be held in conjunction with the Association annual meeting.

Special meetings may be called by the chair upon majority vote of the administrative board provided that there is at least thirty days notice given to each member or the Organization of Resident Representatives and appropriate funding for a special meeting is available.

A simple majority of the voting members shall constitute a quorum.

Formal actions may be taken only at meetings at which a quorum is present. At such meetings decisions will be made by a majority of those present and voting.

Where parliamentary procedure is at issue, Roberts Rules of Order shall prevail, except where in conflict with Association bylaws.

All Organization of Resident Representatives meetings shall be open unless otherwise specified by the Chair.

Section Seven-Operation and Relationships

The Organization of Resident Representatives shall relate to all three Councils of the Association of American Medical Colleges and shall be represented on the Executive Council by the chair and the chair-elect of the Organization of Resident Representatives.

Section Eight-Adoption and Amendments

These Rules and Regulations shall be adopted and may be altered, repealed, or amended by a two-thirds vote of the voting members present and voting at any annual meeting of the membership for which thirty days prior written notice of the Rules and Regulations change has been given, provided that the total number of votes cast in favor of the changes constitutes a majority of the Organization's membership.

Organization of Resident Representatives

Bylaws Change

During the annual meeting in 1993, the ORR voted to amend its membership section of the bylaws. The change, shown below, would allow CAS member societies without program director groups or chairs of clinical department groups to submit a letter of interest to the ORR stating a desire to designate one resident. (bylaws addition noted in bold)

Section Three-Membership

Members of the Organization of Resident Representatives shall be resident physicians or fellows when designated by the member organizations of the Council of Academic Societies of the Association of American Medical Colleges that represent chairs of medical school clinical departments or directors of residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Two resident representatives shall be designated by each of these member organizations by a process appropriate to the governance of the designating organization.

To the extent that a specialty recognized by the ACGME with accredited residency training programs is not represented on the ORR by either a CAS member program director or clinical chair group, a member society may submit a letter of interest to the ORR stating a desire to designate a (one) resident physician to the ORR. Upon approval by the ORR administrative board and Executive Council of the AAMC, the society will be asked to forward the name of the resident physician the society wishes to designate.

Recommendation: The Executive Council approve the amendment to the ORR bylaws.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #88-12 March 8, 1988

TO: Council of Academic Societies
Council of Deans
Council of Teaching Hospitals
Organization of Student Representatives

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: AAMC Recommendations on Housestaff Supervision and Hours

During this decade, changes in the medical care system have had major effects on the environment of teaching hospitals. Very ill patients requiring close attention are hospitalized for tightly scheduled, short periods. This has increased the physical and intellectual demands on residents, and incidents of apparent lapses in the quality of care in teaching hospitals have focused public attention on residents' schedules and their supervision by the faculties. Medical schools and their teaching hospitals have been called upon to review and evaluate the policies and procedures for resident assignments and supervision.

As the organization representing medical schools, faculties, and teaching hospitals, the AAMC has taken this responsibility seriously. In September 1987 the Association's Administrative Boards and Executive Council considered a draft report and made a substantial number of suggestions for changes in the paper. Revised recommendations were subsequently discussed at the November meeting of the Executive Council; Annual Meeting sessions of the Councils of Academic Societies, Deans, and Teaching Hospitals; and the AAMC Officers' Retreat held in December. On February 25, 1988 a further revision was presented to the Association's Administrative Boards and Executive Council where it was revised and adopted.

Throughout the development and discussion of this issue, the AAMC has worked diligently to balance concerns for quality patient care and quality residency education. The attached recommendations--on the role of the resident, graded supervision of residents, hours assigned to residents, policy monitoring and evaluation, and the implications of changes in present practices--reflect the balancing of concerns and interests. Please read the complete statement and the recommendations and consider the need to review and evaluate institutional and program policies.

RESIDENT SUPERVISION AND HOURS:

Recommendations of the Association of American Medical Colleges

During the past decade the health service delivery system has accommodated to dramatic changes in medical technologies, patient expectations, and payment systems. Adjustments to these changes that affected teaching hospitals and their medical staffs include a greater use of preadmission and preoperative work-ups and a shift of postoperative care to the outpatient setting. Some patients who used to be admitted to hospitals are now treated only as outpatients. As a result, the patient admitted to a teaching hospital has a shorter length of stay during which the patient receives numerous diagnostic and treatment services compressed into a very few days.

These new patterns in the ways patients are cared for in teaching hospitals have significant implications for residency training programs. Residents participating in the admission of patients often see more patients, order and coordinate more ancillary and treatment services, perform more procedures and experience more calls to assist in the care of patients. This makes it appropriate to reassess the traditional operating characteristics of residency programs and to develop guidelines which may be used to evaluate current practices.

The Executive Council of the Association of American Medical Colleges (AAMC) has developed these recommendations and guidelines: (1) to help ensure high quality patient care and to preserve the high quality of residency programs, (2) to address the issues raised by changes in physician practice patterns and hospital characteristics, (3) to guide its members in responding to the issues raised by these changes, and (4) to alert policy makers and payers to the financial implications of changing resident supervision and hours. The policy statement is

presented in five sections: the role of the resident, graded supervision of residents, hours assigned to residents, policy monitoring and evaluation, and the implications of changes in present practices. Each of these sections contains recommendations designed to guide the AAMC constituency, including institutional executives, program directors, and external review bodies.

THE ROLE OF THE RESIDENT

To enter independent medical practice, an individual must complete the general professional education provided by medical school and a specialty education in an accredited residency program. During the residency, the physician occupies a unique position as both a learner and a provider of services. This combination is achieved by involving the resident in the care of patients under the supervision of more experienced physicians.

While the resident is both a student in training and a provider of medical services under supervision, residency programs should be established and conducted primarily for educational purposes. The educational purpose, however, must not be allowed to diminish the quality of service received by patients. Therefore, the AAMC recommends that:

EVERY TEACHING HOSPITAL HAVE GOVERNANCE AND OPERATIONAL MECHANISMS TO INSURE THAT RESIDENCY PROGRAMS NOT ONLY HAVE INHERENT EDUCATIONAL VALUE BUT ALSO ENHANCE THE QUALITY OF CARE PROVIDED TO PATIENTS.

THE SUPERVISION OF RESIDENTS

The objective of a residency program is to prepare physicians for the independent practice of medicine. In the course of a residency program, the

physician must develop the capabilities to examine and evaluate patients, to develop diagnostic and treatment plans, and to perform specialized procedures according to such plans. At the beginning of the training program, the resident has the least developed skills and must be regularly and consistently supervised by more experienced physicians, including more experienced residents.

If the capability to practice independently is to be achieved, the resident must be allowed to progress from on-site and contemporaneous supervision to more indirect and periodic supervision. There is no simple or single path for this transition from direct supervision to more independent responsibility. The resident's capabilities must be regularly assessed by more senior physicians and the authority to practice under indirect supervision must be granted gradually as the resident demonstrates competence.

Supervising and assessing the competence of each individual resident imposes a heavy responsibility on the more senior physicians. They must judge the clinical capabilities of the resident, provide the resident with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires both significant time and commitment.

While the progression from directly to indirectly supervised participation in the care of patients is based on the capabilities of the individual resident, supervisory decisions need to be made in the context of an institutional commitment that will assure patients that residents have adequate and appropriate supervision from more senior residents and medical staff physicians. Therefore, the AAMC recommends that:

TEACHING HOSPITALS AND RESIDENCY PROGRAMS HAVE POLICIES AND PROCEDURES SPECIFYING THE LEVEL OF SUPERVISION WHICH

FACULTY AND OTHER SUPERVISING PHYSICIANS EXERCISE OVER RESIDENTS AT EACH LEVEL OF TRAINING.

RESIDENT HOURS

Residency programs are very intense learning experiences. While each of the specialty disciplines may impose different requirements on its residents, the resident benefits by being exposed to patients throughout the course of their illnesses. This allows observation of both the natural history of the illness and the impact of the medical intervention. To experience all of the learning opportunities, the resident would have to be on-duty seven days a week, twenty-four hours a day. Clearly, such a schedule is unrealistic and does not recognize the possible adverse impacts of fatigue or the resident's commitments to other activities and interests. Therefore, assignment schedules for residents must be balanced between competing objectives and constraints.

There is no single assignment schedule that is optimal for all specialty disciplines, residents, or hospitals. In developing residency schedules, program directors should recognize differences in the clinical competence of residents resulting from factors such as specialty and year of training. They should also ensure that the resident's ability to make decisions about the care of patients is not impaired by fatigue resulting from excessive assigned hours or from the intensity of assigned responsibilities. Finally, they should distinguish between "on-call" hours which allow the resident to leave the hospital or sleep for a significant period and "on-call" hours which become working hours because the resident is repeatedly required to return to duty on-site and participate in the care of patients. While these differences preclude a single, uniform assignment schedule for all residents, the AAMC recommends:

THAT EVERY TEACHING HOSPITAL ADOPT GENERAL GUIDELINES FOR RESIDENTS' WORKING HOURS ACCORDING TO SPECIALTY, INTENSITY OF PATIENT CARE RESPONSIBILITIES, LEVEL OF EXPERIENCE AND EDUCATIONAL REQUIREMENTS. IN ORDER THAT DECISIONS ABOUT THE CARE OF PATIENTS ARE NOT IMPAIRED BY FATIGUE, RESIDENTS HOURS ACTUALLY WORKED SHOULD NOT EXCEED 80 HOURS PER WEEK WHEN AVERAGED OVER FOUR WEEKS.

In recommending guidelines for resident hours and in suggesting a maximum of eighty working hours per week, the medical education community is foregoing a more rigorous training schedule to help preserve and protect the quality of the care provided to patients. This adjustment serves neither the interests of education nor patient care quality if the resident is fatigued because the personal time provided has been used for moonlighting in another hospital or provider setting. The AAMC recognizes that some residents moonlight to earn extra income and part of this motivation may result from increasing levels of medical student debt. Nevertheless, if it is inappropriate for a resident to work more hours in the residency program, it is equally inappropriate to allow the resident to moonlight in another hospital beyond the training hospital's guidelines for working hours. Therefore, the AAMC recommends that:

TEACHING HOSPITALS AND RESIDENCY PROGRAMS HAVE POLICIES WHICH PROHIBIT UNAUTHORIZED MOONLIGHTING. THE TOTAL WORKING HOURS FOR RESIDENCY AND AUTHORIZED MOONLIGHTING SHOULD NOT EXCEED 80 WORKING HOURS PER WEEK WHEN AVERAGED OVER FOUR WEEKS.

POLICY MONITORING AND EVALUATION

In recommending that teaching hospitals and program directors have policies

for resident supervision and assignments, the AAMC is emphasizing the historic and continuing responsibility of the medical education community for both its trainees and its patients. As a self-regulating profession, medical education must develop mechanisms to help ensure a regular and impartial review of the practices of individual hospitals and residency programs. The Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committees (RRCs) provide a framework for the necessary monitoring and evaluation. Therefore, the AAMC recommends that:

THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION INFORM EACH RESIDENCY REVIEW COMMITTEE THAT IT MUST INCLUDE IN ITS PROGRAM SURVEYS AN ASSESSMENT OF THE POLICIES AND OPERATING PROCEDURES THAT PROVIDE FOR DIRECT AND INDIRECT RESIDENT SUPERVISION BY PROGRAM FACULTIES.

The AAMC further recommends that:

SURVEYORS SHOULD EXAMINE RESIDENTS' SCHEDULES AND VISITING REVIEW COMMITTEES SHOULD INCLUDE AN ASSESSMENT OF THE WORKING HOURS ASSIGNED TO RESIDENTS IN DETERMINING A PROGRAM'S ACCREDITATION STATUS

IMPLICATIONS OF CHANGE

The aforementioned recommendations may require significant changes in present practices in many teaching hospitals. The implications of these changes for quality of patient care, access of patients to care, future physician supply, and costs of teaching hospitals must be understood and accepted if the recommendations are to be implemented.

Quality of Care

Teaching hospitals have a number of distinctive characteristics. One of the most significant is the presence of physicians on-site twenty-four hours a day. Traditionally, part of this complement of on-site physicians has been met by residents whose on-call assignment begins one day, concludes the next and may last from 32-36 hours. The guideline for resident hours in the previous section recommends limiting a resident's working hours. As a result, teaching hospitals adopting these guidelines may need to alter present staffing patterns, and teams of physicians may be responsible for the patient. To transfer responsibility from one physician or team of physicians to another, it will be necessary to provide adequate time for the physician going off duty to brief fully the physician coming on duty about the patients and their problems. This imposes an additional service requirement on resident physicians; however, the time must be made available and funded or the quality of patient services may decline. Because of the multi-faceted impact on quality of care resulting from changes in resident assignment practices, the AAMC recommends that:

CHANGES IN RESIDENT HOURS BE PHASED IN GRADUALLY, ENHANCING THE QUALITY OF PATIENT CARE AND PRESERVING THE EDUCATIONAL GOALS OF RESIDENCY PROGRAMS.

Access to Care

Some teaching hospitals are located in communities with a shortage of physicians. In this setting the hospital becomes the primary provider of both hospital and physician services. Patients in these communities may face substantial problems in obtaining access to medical services unless the implications of the recommendations for resident supervision and hours are matched by the personnel

resources necessary to maintain at least the present supply of patient services. Hospitals in this situation should work with representatives of the local community, government regulators, and third party payers to obtain the financial and other resources required to hire and retain the physicians and other personnel necessary to provide care to the community.

Future Supply of Physicians

Another matter that warrants consideration is the long-term implications for physician manpower inherent in these recommendations. The simplest solution to a limitation in resident hours is to increase the number of residents. If the recommendation to limit hours is met by increasing the number of residents, then consideration must be given to the impact on those residents who are trained in medical, surgical and support specialties that may be overpopulated. The ultimate effect of increasing the number of residents on the supply of practicing physicians at a time when that supply is already increasing disproportionately to estimated requirements must be carefully evaluated by hospitals considering this option.

Where hospitals conclude that increasing the number of residents is inappropriate, the requirements for patient services may be met by employing other health professions. Nurse anesthetists may be used in place of anesthesiology residents, surgical technicians may be used in place of junior surgery residents, and nurse practitioners may be used to see primary care ambulatory patients and to triage emergency patients. The precise type of health professional required must be determined by the needs of patients, the availability of alternative personnel, and the acceptability of such personnel to the medical staff. Even where all factors encourage the use of "physician extenders," time and effort are needed to plan, recruit, train and integrate them into a hospital which has

formerly used residents. Finally, it also seems likely that where tasks presently performed by residents can be performed by alternative clinical, technical or support staff, it is incumbent upon the hospital to provide such help. Such measures are likely to increase resident productivity and reduce the need for additional residency positions.

One option that might be considered is to utilize fully-trained physicians in place of additional residents. While, at first glance, this strategy appears to be much more expensive, it has been shown that in certain patient settings (emergency room, intensive care units and operating rooms) the use of fully-trained and licensed physicians who do not require supervision can be cost-effective. Certainly it merits a trial in some circumstances.

Some hospitals cannot or should not expand their residents in response to the recommendation on resident hours. They may respond by abolishing their residency programs altogether. Such a step would put a greater onus for patient care on attending physicians themselves. This is the modus operandi in many community hospitals that do not have residency training programs. Progressively, over the past 10 years, such hospitals have cared for sicker patients. The absence of residents implies that practicing physicians will need to assume progressively greater responsibility. Given the sophisticated graduates of specialty training programs, physicians in hospitals that discontinue their residency programs should be well qualified to assume these additional duties.

Cost Implications

The hours residents are assigned are busy hours. While learning, they are seeing and caring for patients. As a result, efforts to decrease resident hours, either by an internal hospital decision or by external regulation will leave tasks

which need to be done. Increasing the number of residents, hiring physician extenders, employing hospital-salaried physicians, or increasing the involvement of attending physicians are alternative responses to a reduction in resident hours. While the responses are different, they share the common element of increased costs.

Increasing the hospital's complement of residents, physician extenders or salaried physicians immediately and visibly increases academic medical center personnel costs. These costs can be met only through generating higher revenues, greater productivity using existing resources, or reduced hospital earnings. Increasing the responsibilities of attending staff also increases costs, albeit more indirectly because they may not show up on the hospital's books, since attendings derive their fees through services provided to patients. Where academic attending physicians spend more time caring for hospital inpatients, additional faculty physicians will be needed to perform the educational, research, or administrative services formerly performed by the attending physicians. These additional physicians need to be paid; it is likely that these costs will be shifted to other cost centers in the hospital, or, as seems more likely, the medical school. No matter what course is chosen to address the problem, the economic implications of limiting resident hours are clear: tasks previously performed by residents will need to be performed by others who must be paid. Therefore, the AAMC recommends that:

ALL PUBLIC AND PRIVATE PURCHASERS OF HOSPITAL SERVICES SUPPORT TEACHING HOSPITAL EFFORTS TO ENSURE HIGH QUALITY PATIENT CARE BY REIMBURSING THE HOSPITAL FOR ALL OF THE INCREMENTAL COSTS INCURRED AS A RESULT OF ALTERING RESIDENT

CONCLUSION

The AAMC supports examining and re-evaluating current practices on resident supervision and on the number of assigned hours. Many of our current practices have a long history and tradition. They have resulted in well-trained physicians able to make critical decisions about seriously ill patients. At the same time, the teaching hospital has experienced dramatic changes in the past few years: patient stays are shorter, more procedures and treatments are scheduled in a shorter period of time, and the less ill are often treated on an ambulatory basis. As a result, residents are called upon to make more decisions about sicker patients than their predecessors. Consequently, training practices that were appropriate in an earlier time may need to be re-examined to ensure that they meet sound objectives of both patient service and medical education

In making recommendations for hospital policies on resident supervision and assignment, the AAMC is appreciative of the different characteristics of individual teaching hospitals and the different requirements of individual specialty disciplines. Accordingly, the recommendations are presented as guidelines, not as formulas, which each hospital and program should consider and utilize in a manner appropriate to its setting, role, and resources.

Table 20

Other Housestaff Benefits by Region
All Hospitals
1993-94

ALL HOSPITALS	Northeast	South	REGION Midwest	West	All
Life Insurance					
Offered, Fully Paid	87%	81%	82%	68%	82%
Offered, Cost Shared	8	14	8	0	9
Offered, Not Paid	3	4	3	18	5
Not Offered	3	1	7	14	5
Disability Insurance					
Offered, Fully Paid	73	71	81	63	74
Offered, Cost Shared	6	11	3	4	6
Offered, Not Paid	8	8	5	19	8
Not Offered	13	10	12	15	12
Housing					
Offered, Fully Paid	4	1	6	0	4
Offered, Cost Shared	21	6	15	10	15
Offered, Not Paid	15	10	10	29	14
Not Offered	59	83	69	61	68
Parking					
Offered, Fully Paid	46	78	62	56	59
Offered, Cost Shared	33	10	15	9	20
Offered, Not Paid	12	10	13	34	14
Not Offered	8	3	10	0	7
Meals, When Working					
Offered, Fully Paid	18	20	27	28	22
Offered, Cost Shared	38	33	20	24	30
Offered, Not Paid	18	9	17	20	16
Not Offered	26	38	35	28	32
Meals, When on Call					
Offered, Fully Paid	67	81	81	88	76
Offered, Cost Shared	25	12	17	13	18
Offered, Not Paid	2	1	1	0	1
Not Offered	7	5	1	0	4

Table 21

Other Housestaff Benefits by Region
State Hospitals
1993-94

	REGION				
STATE HOSPITALS	**Northeast**	**South**	**Midwest**	**West**	**All**
Life Insurance					
Offered, Fully Paid	50%	58%	67%	83%	64%
Offered, Cost Shared	17	17	8	0	11
Offered, Not Paid	0	17	8	17	11
Not Offered	33	8	17	0	14
Disability Insurance					
Offered, Fully Paid	67	64	91	100	79
Offered, Cost Shared	0	9	0	0	3
Offered, Not Paid	33	27	0	0	15
Not Offered	0	0	9	0	3
Housing					
Offered, Fully Paid	0	8	0	0	3
Offered, Cost Shared	0	0	8	0	3
Offered, Not Paid	17	0	8	29	11
Not Offered	83	92	83	71	84
Parking					
Offered, Fully Paid	17	67	25	14	35
Offered, Cost Shared	17	0	8	14	8
Offered, Not Paid	50	25	50	71	46
Not Offered	17	8	17	0	11
Meals, When Working					
Offered, Fully Paid	0	0	8	0	3
Offered, Cost Shared	0	27	25	20	21
Offered, Not Paid	67	9	17	20	24
Not Offered	33	64	50	60	53
Meals, When on Call					
Offered, Fully Paid	67	75	83	86	78
Offered, Cost Shared	17	17	8	14	14
Offered, Not Paid	0	8	8	0	5
Not Offered	17	0	0	0	3

Table 22

Other Housestaff Benefits by Region
Municipal Hospitals
1993-94

MUNICIPAL HOSPITALS	REGION Northeast	South	Midwest	West	All
Life Insurance					
Offered, Fully Paid	80%	100%	88%	40%	81%
Offered, Cost Shared	0	0	0	0	0
Offered, Not Paid	20	0	0	40	12
Not Offered	0	0	13	20	8
Disability Insurance					
Offered, Fully Paid	20	71	88	50	62
Offered, Cost Shared	0	0	0	17	4
Offered, Not Paid	60	14	13	33	27
Not Offered	20	14	0	0	8
Housing					
Offered, Fully Paid	0	0	22	0	7
Offered, Cost Shared	33	25	0	40	21
Offered, Not Paid	33	0	11	0	11
Not Offered	33	75	67	60	61
Parking					
Offered, Fully Paid	50	63	44	100	61
Offered, Cost Shared	33	13	22	0	18
Offered, Not Paid	17	25	22	0	18
Not Offered	0	0	11	0	4
Meals, When Working					
Offered, Fully Paid	67	71	56	100	69
Offered, Cost Shared	33	14	11	0	15
Offered, Not Paid	0	14	11	0	8
Not Offered	0	0	22	0	8
Meals, When on Call					
Offered, Fully Paid	83	88	78	100	86
Offered, Cost Shared	17	13	11	0	11
Offered, Not Paid	0	0	0	0	0
Not Offered	0	0	11	0	4

Table 23

Other Housestaff Benefits by Region
Church-Owned Hospitals
1993-94

CHURCH-OWNED HOSPITALS	REGION Northeast	South	Midwest	West	All
Life Insurance					
Offered, Fully Paid	100%	88%	93%	*	89
Offered, Cost Shared	0	13	0	*	3
Offered, Not Paid	0	0	7	*	6
Not Offered	0	0	0	*	3
Disability Insurance					
Offered, Fully Paid	100	71	82	*	79
Offered, Cost Shared	0	14	9	*	7
Offered, Not Paid	0	14	9	*	10
Not Offered	0	0	0	*	3
Housing					
Offered, Fully Paid	0	0	7	*	3
Offered, Cost Shared	30	13	21	*	20
Offered, Not Paid	40	13	14	*	23
Not Offered	30	75	57	*	54
Parking					
Offered, Fully Paid	50	88	100	*	80
Offered, Cost Shared	10	13	0	*	6
Offered, Not Paid	20	0	0	*	9
Not Offered	20	0	0	*	6
Meals, When Working					
Offered, Fully Paid	22	14	62	*	34
Offered, Cost Shared	44	57	23	*	41
Offered, Not Paid	22	0	15	*	16
Not Offered	11	29	0	*	9
Meals, When on Call					
Offered, Fully Paid	80	63	79	*	74
Offered, Cost Shared	20	13	21	*	20
Offered, Not Paid	0	0	0	*	0
Not Offered	0	25	0	*	6

* *too few respondents to report data*

Table 24

Other Housestaff Benefits by Region
Other Non-Profit Hospitals
1993-94

	REGION				
OTHER NON-PROFIT HOSPITALS	Northeast	South	Midwest	West	All
Life Insurance					
Offered, Fully Paid	94%	91%	95%	86%	93%
Offered, Cost Shared	5	9	5	0	5
Offered, Not Paid	1	0	0	0	1
Not Offered	0	0	0	14	1
Disability Insurance					
Offered, Fully Paid	79	75	87	80	80
Offered, Cost Shared	7	20	3	0	8
Offered, Not Paid	5	0	3	0	4
Not Offered	9	5	6	20	8
Housing					
Offered, Fully Paid	5	0	5	0	4
Offered, Cost Shared	23	5	19	13	19
Offered, Not Paid	11	18	11	25	13
Not Offered	61	77	65	63	64
Parking					
Offered, Fully Paid	46	88	71	75	60
Offered, Cost Shared	40	13	21	13	30
Offered, Not Paid	9	0	3	13	6
Not Offered	5	0	5	0	4
Meals, When Working					
Offered, Fully Paid	14	19	26	38	19
Offered, Cost Shared	43	52	24	13	38
Offered, Not Paid	15	14	16	13	15
Not Offered	28	14	34	38	28
Meals, When on Call					
Offered, Fully Paid	65	78	79	100	73
Offered, Cost Shared	26	13	21	0	22
Offered, Not Paid	2	0	0	0	1
Not Offered	6	9	0	0	5

Table 25

Other Housestaff Benefits by Region
Veterans Affairs Hospitals
1993-94

	REGION				
VETERANS AFFAIRS HOSPITALS	Northeast	South	Midwest	West	All
Life Insurance					
Offered, Fully Paid	60%	70%	50%	71%	62%
Offered, Cost Shared	27	25	25	0	22
Offered, Not Paid	7	5	6	14	7
Not Offered	7	0	19	14	9
Disability Insurance					
Offered, Fully Paid	50	69	56	43	57
Offered, Cost Shared	7	6	0	0	4
Offered, Not Paid	0	0	6	29	6
Not Offered	43	25	38	29	34
Housing					
Offered, Fully Paid	7	0	0	0	2
Offered, Cost Shared	7	0	13	0	5
Offered, Not Paid	14	10	7	50	16
Not Offered	71	90	80	50	77
Parking					
Offered, Fully Paid	57	75	44	44	58
Offered, Cost Shared	14	10	13	11	12
Offered, Not Paid	7	10	19	44	17
Not Offered	21	5	25	0	14
Meals, When Working					
Offered, Fully Paid	29	11	0	0	11
Offered, Cost Shared	21	16	13	40	19
Offered, Not Paid	14	5	25	40	17
Not Offered	36	68	63	20	54
Meals, When on Call					
Offered, Fully Paid	63	95	87	78	82
Offered, Cost Shared	25	5	13	22	15
Offered, Not Paid	0	0	0	0	0
Not Offered	13	0	0	0	3

Table 26

Additional Data on Long-term Disability Insurance for Housestaff 1993-94

Question	Response	N	%
Are other hospital employees covered under the same disability insurance plan as housestaff?	Yes	120	38.7%
	No	156	50.3
	N/A	34	11.0
	Total	310	100.0
Is the disability insurance portable when house officers leave?	Yes	155	50.5%
	No	118	38.4
	N/A	34	11.1
	Total	307	100.0
If the policy is portable, can additional coverage be obtained when house officers leave the hospital and earn a higher income?	Yes	130	83.9%
	No	21	13.5
	Not Stated	4	2.6
	Total	155	100.0

ORR 1993-1994 "Telephone Tree"

Administrative Board Contact	ORR Representatives
Joseph Auteri	Susan C. Vaughan Joyce M. Paterson
Michele Parker	Natalie Ayars Laurel Leslie
Denise Dupras	Kelly Roveda J. Kevin Smith Daniel Vincent Edward McNellis
Deborah Baumgarten	Peter Bach Brijit Reis Rayvelle Barney John T. Comerci
Fernando Daniels,III	Reid B. Adams Joseph Schwartz Alan Scott Zacharias David R. Jones John R. Biglow
William Fortuner, III	Stephen Ripple Kishore Tipirneni Theodore Wells Alicia Zalka Deanna Haun
Nicholas Gideonse	Judith Hoover Kimberley Aaron Geronimo Sahagun Mark Epstein
Michael Greenberg	Marci Roy Dai Chung Charles Lewis Dan Boyd
Cathy Halperin	Raynor Casey Kathryn Mallak Julia Corcoran Kurtis Martin Christina Gutierrez

1994 Meetings

February 23-24	ORR Administrative Board Meetings/AAMC Executive Council, AAMC Headquarters and ANA Westin Hotel, Washington, DC
June15-16	ORR Administrative Board Meetings/AAMC Executive Council, AAMC Headquarters and ANA Westin Hotel, Washington, DC
September 21-22	ORR Administrative Board Meetings/AAMC Executive Council, AAMC Headquarters and ANA Westin Hotel, Washngton, DC
October 28-November 3	AAMC Annual Meeting, Marriott Hotel at Copley Place, Boston, Massachusetts [ORR Activities Friday thru Sunday, October 28- October 30]
December 12-14	AAMC Officers Retreat for Chairs and Chairs-elect, Queenstown, Maryland

Organization of Resident Representatives
February 23, 1994
Administrative Board Meeting Minutes

The meeting was called to order by ORR Chair Michele Parker, M.D. Members present were: Michele Parker, M.D., Chair, Denise Dupras, M.D., Chair-elect, Deborah Baumgarten, M.D., William Fortuner, M.D, Michael Goldberg, M.D., and Nicholas Gideonse, M.D. (Fernando Daniels, III, M.D., attended the afternoon portion of the meeting.) Dr. Parker reviewed the minutes of the 1993 ORR Annual Meeting; the minutes were approved.

Next Drs. Parker and Dupras discussed the AAMC Officer's Retreat last December. A major topic at the retreat was the theme for the 1994 Annual Meeting, which is, "Pushing the Boundaries of Traditional Medical Thinking." Dr. Parker noted that the ORR should begin planning its annual meeting as well, whose activities should preferably tie-in to the AAMC's theme. Dr. Dupras explained that the retreat's priority was strategic planning as a whole for the Association and preparation for the new AAMC President.

One objective the ORR leaders developed during the retreat is to establish other network lines for resident communication. Drs. Parker and Dupras are assembling a mailing list of resident groups and intend to contact state residencies and other medical specialty groups for assistance.

The next agenda item was production of the ORR newsletter. The administrative board formed deadlines for this year's production and distribution of the newsletter. ORR members will have three weeks to submit articles after each administrative board meeting; the newsletter will be distributed six weeks after the meeting. As a reminder, future ORR administrative board meetings will held June 15-16, September 22-23, and October 29-30. **The deadline to submit articles for the next issue has been extended to April 15.** All articles should be sent with a diskette to Dr. Denise Dupras. The board also discussed the possibility of using electronic mail and Internet systems, as well as an ORR "bulletin board" to communicate information to the membership.

Dr. Parker explained the role of the ORR/OSR liaison and called for a volunteer to fill the position. Dr. Michael Greenberg, former OSR administrative board member was chosen to represent the ORR as liaison.

The administrative board discussed possible joint projects with the OSR for the year. The board is also reviewing AAMC policy on student mistreatment.

Robert Dickler, AAMC Vice President for Clinical Services, was present to discuss the issue of resident representation on the Accreditation Council for Graduate Medical Education (ACGME). He gave a brief history of the ACGME and explained the components of its governance. The ACGME is comprised of five parent organizations: The American Medical Association (AMA), The American Hospital Association (AHA), The Council on Medical Specialty Societies (CMSS), the American Board of Medical

Specialties (ABMS), and the AAMC. Mr. Dickler further explained that the resident representative to the ACGME has been appointed by the American Medical Association Resident Physician Section (AMA-RPS). There have been numerous proposals to modify resident representation on the ACGME; the AMA has previously objected to every proposed modification. The latest proposal recommends the ACGME appoint one resident to the Council, selected through nominations submitted by each of its parent organizations. At its recent meeting, the Council passed the latest proposal; now each parent organization must approve the recommendation. If one parent organization vetoes, the entire process will be discontinued.

The administrative board then discussed the 1994 ORR topics for discussion and the interest groups which were formed during the past annual meeting. Reference materials on each topic were distributed; a board member was designated to "steer" each interest group. (A revised list of interest group members and chairs is attached.) Dr. Dupras suggested the focal point of each group should be to stimulate discussion of the specific topic and produce results of the discussion at the annual meeting. Dr. Gideonse recommended that group progress reports be included in each ORR newsletter. Consequently the board concluded each group should periodically produce an update on current events, definition of ORR interests regarding the topic, and a final report at the annual meeting.

Steve Northrup and Mary Beth Bresch White provided the board with an update on legislative issues affecting medical students, residents and physicians. Steve distributed a publication produced by the Governmental Relations office on NIH biomedical research initiatives. He also discussed the Health Education Lending Program (HELP), designed by Rep. Pete Stark (D-Calif.), which will allow medical students to access up to $60,000 to finance their education in return for a payment tax of 1% on the total lifetime income. Northrup explained that the bill offers an "income sensitive" repayment plan for borrowers. He further stated that loan forgiveness is available to those students who practice in underserved regions of the country. The key issue is whether students and residents prefer to keep the current HELP system or have a higher tax imposed on a lower income. Further discussion of the bill and a meeting with Stark staff members during the next ad board meeting in June is possible.

Mary Beth Bresch White discussed recent health care developments with the board and provided a comparison of reform proposals. (Copies of the comparisons are available through the AAMC Governmental Relations office.) She also noted the publication produced by the AAMC's Advisory Panel on Health Care Reform concerning graduate medical education reform.

The administrative board reviewed and voted on the Executive Council's agenda items (The proposed revision to the ORR bylaws was approved by the Council). The board also reviewed the 1993 ORR Annual Meeting evaluation results and noted the need for more time for small group/resident issues discussion during the next Annual Meeting.

The meeting was adjourned by Dr. Michele Parker.

Organization of Resident Representatives
1994 Interest Groups

Residents as Teachers

Fernando Daniels (chair)
Denise Dupras
Michele Parker
Julia Corcoran
Susan Vaughan
Judy Hoover
Dai Chung
Joe Schwartz
Christina Gutierrez
Deborah Baumgarten
Brijit Reis

Cost Containment

William Fortuner (chair)
Kelly Roveda
Alan Zacharias
Nicholas Gideonse

Communication

Michael Greenberg (chair)
Michele Parker
Kevin Smith
Gernimo Sahagun
Nicholas Gideonse
Alicia Zalka

Tort Reform

Cathy Halperin (chair)
Marci Roy
Brijit Reis
Raynor Casey
William Fortuner

Working Conditions, Disability

Deborah Baumgarten (chair)
Geronimo Sahagun
Marci Roy
Kishore Tipirneni
Steve Ripple
Joe Schwartz
Christina Gutierrez
Rayvelle Barney
Fernando Daniels

GME Funding

Nicholas Gideonse (chair)
Geronimo Sahagun
David Jones
Joe Schwartz
William Fortuner