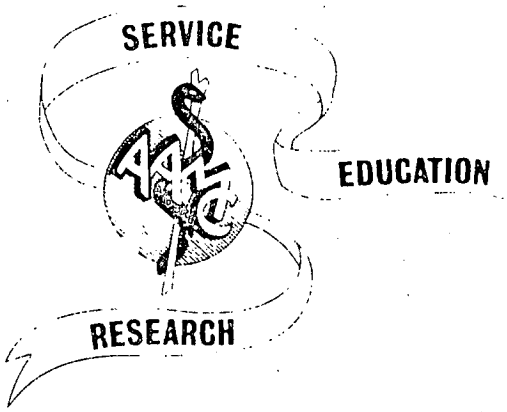

AGENDA

FOR

ORGANIZATION OF STUDENT REPRESENTATIVES

ADMINISTRATIVE BOARD MEETING

JUNE 15, 1974

9:00 a.m. - 4:00 p.m.

LUNCH

CONFERENCE ROOM

AAMC HEADQUARTERS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D.C.

OSR ADMINISTRATIVE BOARD AGENDA

Conference Room
AAMC Headquarters
Washington, D.C.

June 15, 1974
9:00 a.m. - 4:00 p.m.
LUNCH

I. Call to Order

II. Consideration of Minutes 1

III. Report of the Chairperson

IV. Action Items

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- E. Liaison with Other Student Organizations
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- G. National Board of Medical Examiners Annual Meeting
- H. OSR Communication through AAMC Publications
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VII. Reports of Regional Chairpersons

VIII. Old Business

IX. New Business

X. Adjournment

ORGANIZATION OF STUDENT REPRESENTATIVES

of the

Association of American Medical Colleges

MINUTES:

ADMINISTRATIVE BOARD MEETING

March 16, 1974

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

1. Call to Order

Daniel Clarke-Pearson, Chairperson of the OSR, called the meeting to order at 9:40 AM.

2. Roll Call

PRESENT:	Chairperson	Dan Clarke-Pearson
	Vice chairperson	Mark Cannon
	Secretary	David Stein
	Regional Representatives	Serena Friedman (Northeastern)
		Stan Pearson (Southern)
		Lisa Bailey (Central)
		Cindy Johnson (Western)
	Representatives-at-Large	Ernest Turner
		Elliott Ray
	AAMC Staff Participants	Bob Boerner
		Joe Keyes
		Diane Mathews
		August G. Swanson
		Bart Waldman

3. Discussion with AAMC Staff

In an effort to establish better communication between the AAMC staff and the OSR Administrative Board, the following topics were discussed:

A. Plans for the OSR Administrative Board meetings: Dan Clarke-Pearson explained that Executive Council meetings will be requested. The COD, COTH, and CAS presently hold their Administrative Board meetings prior to each Executive Council meeting, and rescheduling of OSR meetings to interdigitate with the other councils would facilitate communication and rapport between the OSR and each of the other AAMC councils.

B. OSR Development: Dr. Swanson spoke of the rapid maturation of the OSR, its increasing scope of activities, and the need to cycle OSR meetings with sessions of the Executive Council. He reiterated that the OSR Administrative Board meetings should immediately precede the Executive Council meetings and should be held in conjunction with the COTH, CAS,

and COD Administrative Board meetings. Such scheduling would permit topics under consideration by the Administrative Boards of the various councils to be included on the OSR Administrative Board Agenda and vice versa.

C. OSR Executive Session: Dr. Swanson commented on the desire of the OSR Administrative Board to hold part of its meeting in executive session without the presence of AAMC staff. He informed the Board that no other facet of the AAMC constituency conducted such sessions and that it was undesirable to conduct AAMC business without staff present. He pointed out that the OSR is unique among student organizations such as SAMA and SNMA in that it is an integral part of the parent organization, the AAMC. It is through this affiliation that the OSR has its role in medical education. As with any other portion of the constituency of the Association, all OSR activities evolve within the AAMC. In short, the strength of the OSR lies in its ties to the AAMC and its ability to provide the incorporation of student opinion in the formulation of AAMC policy.

D. Required lines of communication: All actions of the OSR must be reported to the COD, but need not receive COD approval. (See Addendum #1.) Mark Cannon proposed that the OSR be made a fourth council equal to the COD, CAS, and COTH, though it now can make proposals directly to the Executive Council without COD approval.

Dr. Swanson pointed out that the reality is that OSR ideas considered favorably by the COD have a greater chance of acceptance by the Executive Council than ideas submitted directly from the OSR to the Executive Council, just as any idea submitted by only one of the councils to the Executive Council has less of a chance of acceptance than if the other councils approved it.

E. Proposed OSR bulletin: Dr. Swanson questioned the feasibility of such a publication and raised the question of its future if the incoming OSR Administrative Board were to assign it a low priority this November. He also questioned whether it would accomplish its objective of increasing student awareness of and interest in the OSR. He indicated also that the AAMC is reluctant to finance another publication when it is presently assessing the value of those already in print.

Dan Clarke-Pearson and Serena Friedman stressed the importance of an informed constituency and the need for feedback from that constituency. Dan Clarke-Pearson also noted that the cost estimate as calculated by the COD was greater than that calculated by the OSR Administrative Board.

Dr. Swanson suggested use of a section in the Student Affairs Reporter (STAR) already in print. Opposition was raised on the grounds that this publication was not geared strictly for students and would fail in its objective of stimulating student interest. The Board agreed that the proposal for an OSR bulletin be transmitted to the Executive Council for consideration.

F. OSR Budget: The fundamental concern of the Administrative Board was that financial allocations for this year were decided upon by the Executive Council last year and did not anticipate greater OSR activity in the current year.

In an effort to minimize financial problems in 1974-75, the Administrative Board presented an "OSR Budget Request" to the AAMC staff.

Dr. Swanson explained that the overall AAMC budget, once approved by the Executive Council, is allocated to the various councils, organizations and groups on the basis of the projects which that segment plans to undertake in the upcoming year. No council, organization, or group has a specific yearly budget other than its allowance for meeting expenses, and none reviews the monies available to it for the next fiscal year. In other words, the AAMC finances projects and programs, not councils and organizations.

G. OSR Administrative Board Agenda: Dan Clarke-Pearson pointed out that the agenda for the Administrative Board meetings of each council and the OSR are developed by AAMC staff to coordinate the activities of all the councils, organizations, and groups within the AAMC.

Dr. Swanson reemphasized that each Administrative Board within the AAMC must be informed of the activities of the other Administrative Boards. This coordinates efforts on each problem and heightens overall efficiency.

H. OSR representatives to AAMC/GSA Committees: Craig Moffatt rather than Paul Romain was confirmed to be the official OSR nominee to the AAMC Committee on Financing Medical Education.

Dr. Swanson made the point that OSR members on AAMC committees should be free to vote on issues according to their own inclinations and should not feel that they must represent the feelings of their Administrative Board. However, the Board may wish to request reports from its committee representatives for its meetings.

OSR representation on the Borden Award Committee has been discontinued upon request of last year's OSR delegate who felt that student participation on this committee was not appropriate.

I. Student Representatives to the NBME: The Executive Committee of the National Board of Medical Examiners recently indicated that it will present the OSR request for student representation to the Board at its meeting on March 23. Mark Cannon will attend this meeting as an invited guest. Any OSR member nominated to the NBME would have to receive the approval of the AAMC Executive Council.

Dr. Swanson pointed out that the AAMC presently appoints three people to the NBME which has 59 members. He suggested that the OSR request that the AAMC appoint a student to one of these three positions in addition to other possible student representation to the NBME.

Mr. Keyes stated that segments of the AAMC should not deal directly with outside agencies, and that any delegate from the OSR to any outside organization represents the AAMC, not the OSR.

Dr. Swanson suggested that the current AAMC delegates to the NBME be consulted by the OSR Administrative Board for suggestions on the number of student positions to seek.

J. GAP Report: The AAMC recently created a task force to examine and make recommendations regarding the GAP Report. This task force will probably consist of members from each of the three councils (COD, COTH, CAS), the OSR, and the GME. The Administrative Board agreed to seek representation on the task force equal to that of the other councils.

The decision of the OSR to establish its own task force on the GAP Report has been pre-empted by the general AAMC Task Force. In lieu of the above, the original plan to develop a single OSR position paper from four regional papers has been discarded in favor of presenting all four regional papers to the AAMC Task Force via Bob Boerner.

4. Minutes of the previous meeting: Approved as read with the following corrections:

   A. Section 8, paragraph B: GME Committee: delete "and who was formerly the student representative."

   B. Section 16, introductory sentence: change "appointed" to "elected".

   C. Section 18, paragraph H: delete: "The objectives of this proposal are already integrated in a pilot study under way in California and Michigan."

5. Chairperson's Report:

A. Dan Clarke-Pearson's request to Dr. Mellinkoff to add a house officer to the AAMC Committee on Moonlighting was not approved since the OSR Administrative Board will have the opportunity to review the report of the committee prior to its presentation to the Executive Council.

B. Admission and Grading: Jerry Zeldis has been asked to prepare a position paper on the feasibility of a limited random admissions policy, and Joel Daven has been requested to investigate the feasibility of a nationwide pass-fail system. Both papers are anticipated in June.

C. Senior Electives Catalogue Committee: Vicki Williams submitted a progress report and discussed the activities at her committee recently with Mr. Boerner. Present plans call for the AAMC Curriculum Directory next year to include an indication of whether each school will accept outside students into elective programs, whether these students are charged tuition, and whether housing is available for them.

6. Regional Reports:

A. Southern Region: Stan Pearson commented that the Southern Regional Meeting will be April 11 - 13. Topics of discussion are:

1. The GAP Report
2. Minority Affairs
3. Women in Medicine
4. NIRMP violations
5. The OSR role on campuses
6. Financial aid

B. Western Region: Cindy Johnson stated that the issue of women in medicine will be discussed during the Western Regional Meeting. Ms. Amber Jones of the AAMC will lead this discussion.

The "mini" senior electives catalogue will be completed in about two weeks but the decision to allow nationwide distribution of it is still pending.

C. Central Region: Lisa Bailey mentioned that the Central Region will meet with the GSA in May and will consider the topics of women in medicine, the GAP Report, and the Bill of Student Rights which was discussed during their Chicago Subregional Meeting.

D. Eastern Region: Serena Friedman stated that after some reluctance due to the location of the Northeast GSA meetings the Northeast Region OSR agreed to hold their regional meeting with the Northeast GSA. They then discovered that the Northeast GSA wished this year to meet separately from both the OSR and the AAMC.

AAMC staff suggested a separate OSR meeting and the sending of an OSR delegate to the Northeast GSA meeting. Dr. Swanson urged that this attitude of the Northeast GSA be brought to the attention of the COD.

It was reported that the Southern Subregion of the Eastern Region has cultivated alumni input into OSR issues and has established a healthy exchange of ideas.

7. Committee Reports:

The following are reports of GSA national and committee meetings which included OSR representation.

A. Summary of the February 4 Steering Committee Report from the GSA National Planning Conference (Addendum #2).

B. Minutes of the meeting of the GSA Committee on Relations with Colleges and Applicants at the National Planning Conference (Addendum #3).

C. Report of Susan Stein on the meeting of the Subcommittee on the Letter of Evaluation of the GSA Committee on Relations with Colleges and Applicants (Addendum #4).

8. Executive Council Agenda:

The Agenda of the Executive Council Meeting held March 22, 1974 was considered by the Administrative Board with the following comments:

1. Dr. Swanson commented that he thought that the OSR request to meet four times per year in conjunction with the other Administrative Boards would probably be approved by the Executive Council.

2. The Executive Council and COD recommended an alteration in bylaws which would allow greater flexibility in scheduling the December Executive Council Meeting which presently must be held within eight weeks of the Annual Meeting. The December meeting does not allow sufficient time both to hold the Officer's Retreat and to plan for this meeting. Scheduling the Executive Council Meeting in January would allow more time to prepare the agenda and to review the topics of discussion. Thus, the first OSR Administrative Board meeting after the election of officers would occur in January if this change is approved.

3. Mark Cannon pointed out a recommendation before the Executive Council to request representation on the National Commission on Certification of Physician's Assistants. Mark questioned whether the AAMC should participate in such an organization. The OSR Administrative Board strongly felt that AAMC representation on it was desirable.

4. The OSR resolution on "Safeguarding Data Systems" will be considered by the Executive Council in March. SAMA has agreed to work with the OSR in promoting this resolution nationally.

5. Dan Clarke-Pearson pointed out that the IOM (Institute of Medicine) Report on Costs of Education in the Health Professions is completed and parallels the report of the AAMC Committee on Financing Medical Education. The level of capitation

for medical education recommended by the I. O. M. report is $2,450 - $3,900 per year, and the IOM Report favors on-going support by the federal government for medical education.

6. The Board endorsed the recommendation to the Executive Council (Addendum #5) on modification of the Hill-Burton Program.

9. OSR Activities at the Annual Meeting

Discussion was held on which days to hold the OSR functions at the Annual Meeting at the Conrad Hilton in Chicago on November 12-15. It is necessary to schedule the OSR business meeting prior to the COD business meeting so that OSR actions may be reported to the COD. Since the plenary session and COD meetings begin on Wednesday, it was tentatively decided to hold the OSR functions on Monday and Tuesday of the Annual Meeting week.

A suggestion was made that each OSR representative attending the Annual Meeting be given information on the structure and function of the OSR. Ideas on methods to handle OSR resolutions at the annual business meeting were entertained. An OSR Resolutions Committee was considered along with the feasibility of requiring a deadline 30 days prior to the meeting for submission of resolutions. An overhead projector to allow immediate display of resolutions under consideration was suggested.

Cindy Johnson proposed the topic of women in medicine for discussion at the Annual Meeting. Since final scheduling of the Annual Meeting will not be completed until June, it was decided to test the general interest in this topic by noting the level of concern generated during the Western Regional Meeting.

10. The following OSR representatives to the MCAAP Review Committee were nominated:

1. Ernie Turner

2. Tessa Fischer or Paul Pitel) to be nominated by the Chairperson after being contacted to ascertain interest in the Review Committee

11. NIRMP Monitoring Committee and the Student Administrative Listing:

Elliott Ray informed the Administrative Board that he has received no feedback on the OSR-GSA NIRMP Monitoring Program and that 24 schools have returned the Administrative Listing to date which provides only questionable validity to this study.

12. Committee Nominations:

A. Bob Rosenbaum was nominated to replace Jan Weber as the OSR representative on the Editorial Board of the Journal of Medical Education.

B. Janet Schlechte was nominated to the Study Committee on Continuing Medical Education.

13. Liaison with SNMA and SAMA:

Mark Cannon has communicated with representatives of SNMA informing them of our desire to have a delegate from SNMA present at the OSR Administrative Board meetings. The SNMA displayed only moderate interest in this proposal and indicated that it would not be possible for them to invite an OSR member to their meetings.

Dr. Swanson cautioned again that liaison with outside organizations such as SNMA should take place through AAMC channels and not independently by the OSR.

Elliott Ray stated that communications with SAMA are adequate but that confusion exists within SAMA about the OSR. SAMA tends to consider the OSR a rival organization. Efforts will be made to inform SAMA about the role of the OSR within the AAMC.

14. Regional Meetings:

Topics for consideration at the Regional Meetings were offered by Dan Clarke-Pearson and include:

1. NBME - GAP Report
2. Resolutions
3. NIRMP
4. OSR rules and regulations: suggestions from Russ Keasler were distributed
5. Student administrative listing
6. Women in medicine

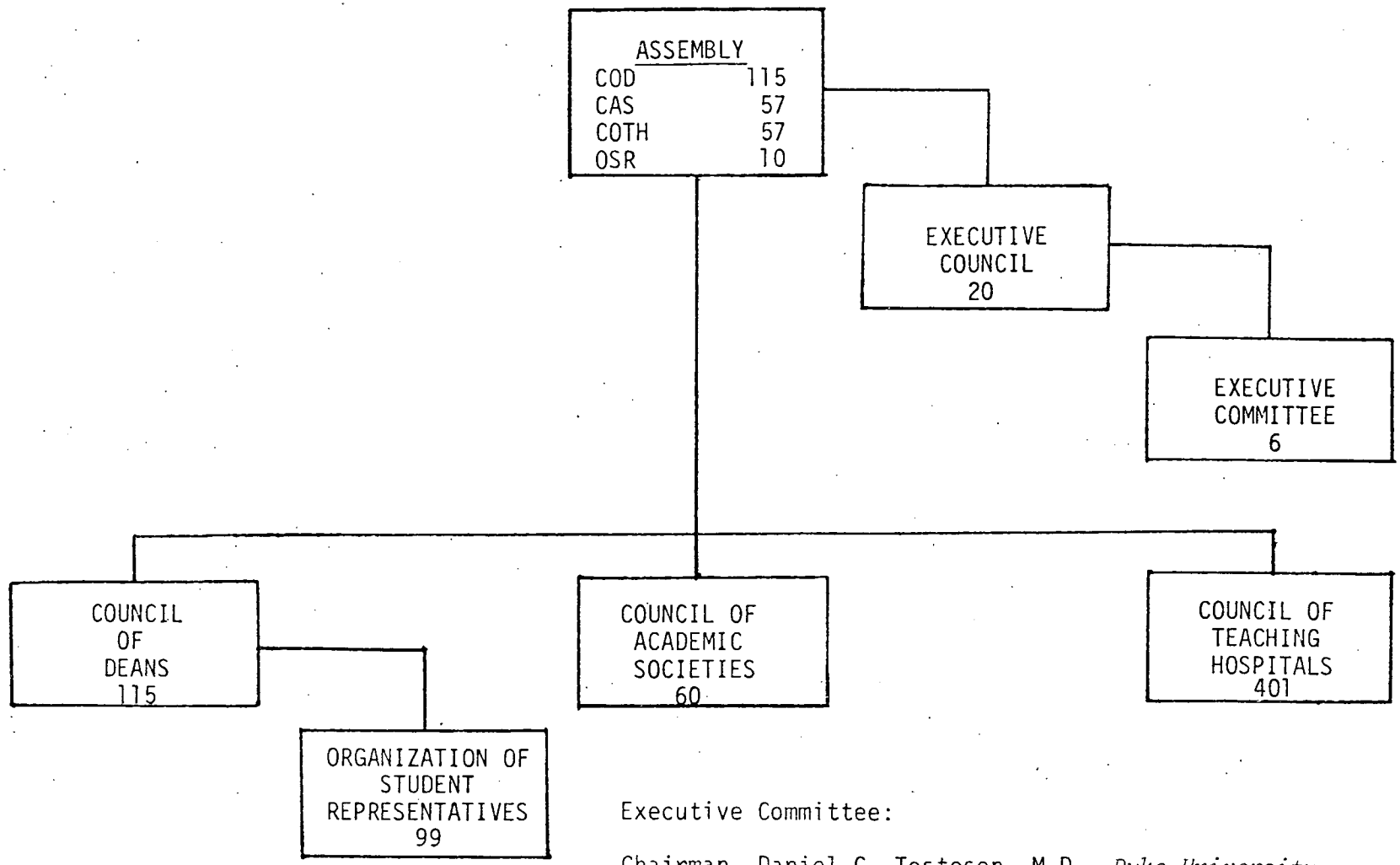
15. The meeting adjourned at 5:00 PM.

Respectfully Submitted,

David Stein
OSR Secretary

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

GOVERNING STRUCTURE



Executive Committee:

Chairman, Daniel C. Tosteson, M.D., *Duke University*
Chairman-Elect, Sherman M. Mellinkoff, M.D., *UCLA*
Chairman, COD, Emanuel M. Papper, M.D., *University of Miami*
Chairman, CAS, Ronald W. Estabrook, Ph.D., *U of Texas, Dallas*
Chairman, COTH, Robert A. Derzon, *University of California*
John A. D. Cooper, M.D., *President, AAMC*

ADDENDUM # 2

FEBRUARY 4 STEERING COMMITTEE REPORT

The morning of February 4 was spent in small group discussions of the topic areas listed on the previous page. Reports of these discussion groups were presented verbally at a meeting of the GSA Steering Committee on the afternoon of February 4. It is evident from those reports that GSA membership worked very diligently at the identification of focused goals and objectives within their special interest area. Since many of the discussion groups were parallel to related GSA committees, they also took time to refocus their continuing committee functions.

The following is a summary of the discussion of the Steering Committee meeting following the planning conference. The full written reports of the special interest discussion groups were not incorporated in this Planning and Procedures Handbook due to space limitations. Copies of these reports can be obtained on request from Bob Boerner, GSA Executive Secretary, AAMC, Washington, D.C.

1. Recommendation for Action by AAMC

   Obtain AAMC approval for the new GSA Committee on Professional Career Development and Advising (NIRMP, Internship, Postgraduate Education, Career Counseling, etc.)

2. Recommendation for Continuing Study or Action by GSA Committees:

   a. Relations with Colleges and Applicants:
      - uniform application, acceptance and non-acceptance dates
      - uniform letter of recommendation
      - legal implications of admissions decisions

   b. Medical Education of Minority Group Students
      - appointments of minority representatives to other GSA committees
      - credibility of preprofessional advisors with minority group students (with AAHP)
      - increased participation of minority representatives on the MCAMP project
      - updating of the Sloan Task Force Report on admission of minority group students
      - financial aid for minority group students (relationship to military, NHSC, USPHS)

   c. Financial Problems of Medical Students:
      - update the bibliography on financial aid
      - work with the proposed task force on the development of a comprehensive medical student aid program
      - develop workshops on financial aid administration
      - increase communication on new approaches to financial aid documentation, records, sources, etc. (workshops)
      - develop workshops for new financial aid officers
      - develop a systematic approach for data collection with an aggregate base

d. Professional Career Development and Advising:
   - since this is a newly proposed committee (developed from the proposed Ad Hoc committee on NIRMP), its continuing studies are nonexistent. Its purpose is to develop materials and exchange information which will improve the skills of individual members of the GSA in the professional development and advising of medical students in the areas of NIRMP, Graduate Programs Advising and Processing, Academic and Personal Advising and Processing, Student Evaluation and Promotions, Use of Elective Time, and Student Health Facilities and Career Alternatives in the Uniformed Services.

e. - develop a medical student data elements dictionary
   - communication to GSA members of current information and data collections systems (STAR)
   - study the problems of confidentiality of records and use of data elements (individual or in aggregate)

ADDENDUM # 3

GSA National Planning Conference
Palmer House
Chicago, Illinois
February 3-4, 1974

Summary of Minutes of Meeting: Admissions and Relationship to Colleges and Applicants

February 4, 1974

Chairman: Roger O. Lambson, Ph.D.
Associate Dean for Student Affairs
University of Kentucky College of Medicine

The meeting entitled "Admissions and Relationship to Colleges and Applicants" was attended by 30-40 persons representing Admissions Offices, Student Affairs Offices, Preprofessional Advisors, and Medical Students. A lively and productive discussion ensued covering only a portion of the issues generated at the Plenary Session for lack of time. The discussion resulted in the following recommendations:

I - Establish an Admissions Task Force

A - General Purposes

1. To define more accurately the applicant pool.
2. To define the types and numbers of physicians wanted and needed by the public.
3. To define the factors affecting physician distribution.

B - Specific Questions:

1. What type of student wants to go to medical school?
   a) ACT scores
   b) SAT scores
   c) High School Grades
   d) College Grades
   e) Major Taken
2. How many students want to go to medical school as basis for predicting applicant pool?
   a) at High School level.
   b) At College level, by year.

3. How significant is the older-applicant pool?

   a) What type of applicant undergoes a career change?

   b) Can this group be predicted?

4. What is the need for physicians?

   a) Defined by state and region, urban and rural.

   b) Defined by specialty type.

5. What factors affect physician distribution?

   a) Where do medical graduates of particular schools locate to practice?

   b) What influence does geographic origin, biographic factors, and postgraduate training location have on practice location?

6. Can these factors be predicted?

C - Suggested Approach

Collect existing data and develop, where appropriate and feasible, new information on these questions from such sources as:

NIH

HEW

AMA

State Medical Associations

AAMC

AAHP

Longitudinal Studies

High Schools

Colleges

Medical Schools

II - Improvement of Premedical Counseling

A - General Purpose:

1. To help alleviate the discrepancy between number of applicants

and number placed.

B - Suggested Approaches

1. Encourage further development and distribution of detailed characteristics of successful applicants for each medical school.
2. Encourage development and broader availability of practical health-related experiences for preprofessional students.
3. Develop guidance counseling materials for high school counselors.
4. Develop advising and counseling materials for preprofessional counselors.
5. Develop and provide admissions workshops for preprofessional counselors, e.g., simulated admissions meetings.

III - Improvement of Admissions Mechanics

A - General Purpose:

To decrease paper shuffling work load and simplify task of pre-professional advisors.

B - Suggestions and Problems:

1. AMCAS
   a) General reaction to AMCAS was favorable.
   b) Could a mechanism be worked out with AMCAS Staff wherein applicant could be motified by AMCAS that application was not forwarded to a particular school because the application did not meet the schools cut-off requirements.
2. Uniform Notification Dates
   a) Group agreed that this principle must be "All or None", probably at the 75% level, to be effective.
   b) Group agreed that, before this idea is scrapped, it should be tried for at least another year.
   c) Suggested that all schools should be polled for their reactions and suggestions to the question of uniform

notification dates, how has it worked, positive and negative, and what could be done to improve the system? Results should be synthesized and problems corrected, in so far as possible, and the system continued for one more year before resolving this issue.

d) Closing dates: Group was split and no agreement was derived. Some wanted earlier closing dates, premedical advisors wanted the dates extended.

3. Confidentiality of Student Records and Release of Information

a) Group was concerned about communication between medical schools and preprofessional advisors in light of the release statement on the AMCAS application. It was agreed that school's hands were tied, in so far as notifying advisors of action taken, if student objects.

Suggestion: Would AMCAS staff obtain a legal opinion, for distribution to medical schools, on what information, if any, can a medical school release against a student's wish. Can a medical school inform an advisor that an applicant has applied and state the action taken if the student checks No on the release statement?

b) Suggestion: Would AAMC extract appropriate passages from HEW document, Computors, Confidentiality and Rights of Citizens and distribute this to GSA constituency?

c) Student Records: The group strongly urged the development of guidelines for dealing with the general issues of student record confidentiality and access.

ADDENDUM #4

Report on the Meeting of
The Subcommittee on the Letter of Evaluation

On March 18 the Subcommittee on the Letter of Evaluation of the GSA Committee in Relations with Colleges and Applicants met in Washington. Essentially we met to comment on the Letter of Evaluation which Mr. Angel and his staff have been developing through the American College Admission Assessment Program. The OSR will be presented with the final form of this letter at the regional meetings and will be given the opportunity to comment on it at that time.

I, unfortunately, was not sent a draft of the letter until a weekend before the meeting so I could not get student comments before the meeting. The sample letter of evaluation which the Committee agreed on, however, is pretty good. It is meant to be used by an individual rather than a committee. A separate form is going to be developed for use by a premed. committee.

The purpose of this letter is to try to devise a form which will help guide college instructors in what is important for a medical school committee to know about the candidate. In schools with a pre-med. committee this form will be useful for the committee to use to gather information from individual faculty members. Hopefully this form will provide standardized information for admissions committees.

I do not have a final copy of the Letter of Evaluation yet; however, I assume the AAMC staff will forward one to the OSR Administrative Board as soon as it is typed and printed. I do have the latest revision of the letter which I have included.

The letter is composed of two main parts: one is a rating scale, and the other is a narrative. There was some argument on the need for a rating scale; however, it was felt that it would be better to include the scale for those medical schools who have found it valuable.

On the whole, I feel that the letter we agreed upon is very good. After you have had the chance to review the letter I will be happy to explain the reason behind any of the topics included.

Submitted by

Susan Stein
Medical College of Pennsylvania
OSR Representative

To Be Completed By Student:

I request that you complete this evaluation form which is to be sent to medical schools to which I am applying. I understand that your candid evaluation of me and information from school records is being sought, and that the completed form will be sent to professional schools and that it will be held in confidence both from me and the public by those professional schools, to the extent permitted by law.

Name (Print)_____ Signature _____

S.S. #_____ Date_____

****

LETTER OF EVALATION

In selecting applicants to medical school, the Admissions Committee depends very much on evaluations of the applicants supplied by undergraduate faculty members. Since the number of qualified applicants to medical schools far exceeds the number of first year class positions available, we are anxious to select those individuals whose accomplishments, personal attributes, attitudes, and abilities indicate that they have the greatest potential for medical training and practice. Therefore, we ask you to provide a thoughtful and completely frank appraisal of the applicant in relation to other students you have known at your institution. Your early reply is appreciated since the applicant will not be evaluated without your appraisal.

1. In what capacity have you been associated with the student?

   A. Instructing: /_/ Lecture /_/ Laboratory /_/ Seminar
   Specify course(s): _____

   B. /_/ Academic Advising

   C. /_/ Socially

   D. /_/ Other (Please specify) _____

   E. /_/ Not Acquainted

   How well do you know the applicant?

   A. /_/ Very Well B. /_/ Fairly Well C. /_/ Slightly

   B. How long have you known the applicant? _____

2. To your knowledge, has there ever been any disciplinary action involving this student?

   /_/ Yes /_/ No If yes, please provide full explanation in Narrative Comments Section or in a letter.

3. What would be your attitude toward having this student in a position under your direction?

   /_/ Definitely would want him; /_/ Would want him;

   /_/ Would be satisfied to have him; /_/ Would prefer not to have him;

   /_/ Definitely would not want him; /_/ Unable to judge.

4. Please indicate with a check (✓) for each factor below your opinion of this applicant's position on that factor relative to other students at your institution.

	OUTSTANDING Top 5%	EXCELLENT Next 10%	VERY GOOD Next 20%	GOOD Next 40%	FAIR Next 20%	POOR Bottom 5%	NO BASIS for Judgment
MOTIVATION for MEDICINE: genuineness and depth of commitment.							
MATURITY: personal development, ability to cope with life situations.							
EMOTIONAL STABILITY: performance under pressure, mood stability, constancy in ability to relate to others.							
INTERPERSONAL RELATIONS: ability to get along with others, rapport, cooperation, attitudes toward supervision.							
EMPATHY: sensitivity to needs of others, consideration, tact.							
JUDGMENT: ability to analyze a problem, common sense, decisiveness.							
RESOURCEFULNESS: originality, skillful management of available resources.							
RELIABILITY: dependability, sense of responsibility, promptness, conscientiousness.							
COMMUNICATION SKILLS: clarity of expression, articulateness.							
PERSEVERANCE: stamina, endurance							
SELF CONFIDENCE: assuredness, capacity to achieve with awareness of own strengths and weaknesses.							

GUIDELINES FOR NARRATIVE COMMENTS ON APPLICANTS

The following has been suggested by admissions committee members as important information they would like to have included in narrative comments on each applicant, in addition to elaboration on the qualities described on the rating scale.

1. *Personal attributes:* Please emphasize assets and liabilities particularly those qualities which would indicate special promise or potential problems for medical education. Description of the applicant's actions in particular situations would help to clarify your appraisal.

2. *Academic achievement:* Comments should amplify the information on the applicant's academic record including the following:

   A. Academic achievement relative to current applicants from your college or university or those from previous academic years, i.e. class rank or distribution of science and other grades at your college.

B. Consistency of performance.

C. Extenuating circumstances which might account for atypical grades or course loads.

D. Degree of strenuousness of classes and overall course loads. (honor sections, etc.)

3. *Employment, extra-curricular or avocational activities:* Since this is given on the application, list only if you can elaborate meaningfully on them. Any activities which indicate motivation for medicine or concern for others are of special interest. If involvement was extensive, what was the effect on academic achievement?

4. *Honors received, academic or nonacademic:* Specify the competition or degree of selectivity of such awards, e.g. how many were awarded in what student population?

NARRATIVE COMMENTS (Please include extra pages if you wish.)

Please check your overall evaluation of the applicant for medical school.

- ☐ Outstanding Candidate (Top 5%)
- ☐ Excellent Candidate (next 10%)
- ☐ Very Good Candidate (next 20%)
- ☐ Good Candidate (next 40%)
- ☐ Fair Candidate (next 20%)
- ☐ Poor Candidate (Bottom 5%)
- ☐ No Basis for Judgment

Name (print) _____ Title _____

Signature _____ Department _____

Date _____ School _____

City/State/Zip _____

ADDENDUM #5

MODIFICATION OF THE HILL-BURTON PROGRAM

Legislative authority for the Hill-Burton hospital construction assistance program is to expire June 30, 1974. The President's fiscal 1975 budget requested no new funds for the program, and the Administration is not currently proposing to request extension or modification of the program. Nevertheless, Congress is almost certain to consider legislation to modify and continue some form of federal assistance in hospital construction.

Because of the importance of the Hill-Burton program in the past to some Association constituents, it is thought the Association may wish to take part through testimony or other means in Congressional action extending and modifying the program. The guidance of the Executive Council is being sought.

Present options available through pending legislative proposals, budget recommendations and past AAMC staff suggestions include the following:

1. Extend the present program without change.

2. Let the program expire, as proposed by the Administration.

3. Extend and modify the program as proposed in a 1972 AAMC staff memorandum: shifting the emphasis from construction of new hospitals to modernization of existing facilities and construction of outpatient facilities; replacing the rural-biased allotment formula with a more equitable formula based on need; increasing the emphasis on assistance for teaching hospitals and outpatient facilities; calling for priority assistance to projects for facilities which will promote the use of innovative and experimental methods of construction and methods of providing hospital and outpatient care.

4. Convert the program from a formula to a project-grant basis, with or without priorities for urban versus rural hospitals or for certain kinds of facilities, as proposed in legislation (S 2983) introduced February 7, 1974, by Senator Javits, and supported by the Council of Urban Health Providers.

5. Convert the program to a DHEW-administered direct loan and loan guarantee program, as proposed in legislation (HR 12053) introduced December 20, 1973, by Congressman Rogers as part of his RMP-CHP proposal.

RECOMMENDATION: The Executive Council select one of the above options or propose an additional option and authorize the AAMC staff to participate appropriately in any legislative process necessary to carry out the designated option.

Western Region Recommendations

The members of the Western Group of the Organization of Student Representatives who met at Asilomar on March 31 - April 1, 1974, considered the list of resolutions submitted for possible consideration at the regional meetings. The members observed that a number of resolutions dealt with the problems and process of undergraduate and graduate medical education. The following points emphasize the major issues contained in these resolutions which the members of the Western Region of the Organization of Student Representatives wish to recommend for the consideration and possible approval of the other regional groups for transmittal to the Administrative Board of the OSR.

I. Undergraduate Medical Education

A. Evaluation: pre-clinical and clinical
Objectives and expectations of the faculty for student performance should be clearly stated with ongoing feedback throughout the course or clerkship

B. Grading System
The grading system should be a comprehensive system which is adequately descriptive of the course or clinical experience which will insure a more equitable evaluation for selection into programs in graduate medical education

C. Open Records
All evaluation reports should be available for inspection by the student

II. Graduate Medical Education

A. The AAMC should consider developing a program for providing information about the characteristics of individual programs in graduate medical education and the criteria for selection of participants in these programs

B. The AAMC should consider with other concerned groups the feasibility of a uniform application system for programs in graduate medical education

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Ad Hoc Committee on Professional Development and Advising

PURPOSE: To develop materials and exchange information which will improve the skills of individual members of the GSA in the professional development and advising of medical students in the areas of NIRMP, Graduate Programs Advising and Processing, Academic and Personal Advising, Student Evaluation and Promotions, Use of Elective Time, Student Health Facilities, and Career Alternatives in the Uniformed Services.

MEMBERSHIP FOR 1973-74:

1. Chairman, Mitchell Rosenholtz, Missouri-Columbia
2. Joshua S. Golden, California-Los Angeles
3. Wilbert Jordan, Washington, D.C. Public Health Department
4. Paul Palmisano, Alabama
5. William Van Huysen, Rochester
6. OSR Representative to be appointed

Tentative Outline of OSR Activities

at 1974 AAMC Annual Meeting

SUNDAY, Nov. 10, 1974

6 - 8 PM	OSR Administrative Board meeting
	We cannot afford to serve dinner to the Board at this meeting.
8:30-10:00 PM	OSR General Reception, Cash bar.

MONDAY, Nov. 11, 1974

9 - 11 AM	Business and Orientation Meeting
11 AM	Coffee break
11:15 AM-12:30PM	Regional meetings
2 - 5 PM	Task Force sessions
	I have put the Task Force sessions here, since their reports should be made at the second half of the business which will take place Tuesday morning. I have presently requested four rooms seating approximately thirty each for the Task Force sessions.
7 - 10 PM	OSR Program session

TUESDAY, Nov. 12, 1974

9 AM - 12 noon	OSR Business meeting, election of officers
10:30 AM	Coffee break
2 - 5 PM	CAS program
7 - 9	Regional meetings and election of regional officers

April 28, 1974
DRAFT
OSR Annual Meeting 1974
Proposed Program Session

HEALTH SCIENCE EDUCATION-
Directions for the next decade

I. Priorities of Health Science Education in the Next Decade

- Needs of society and how medical education will fulfill them
- Needed Changes in the present system
- Primary Care and health care delivery
- Minority group physicians
- Women in Medicine
- Maldistribution of physicians: geographically and in specialities
- Continuum of undergraduate and graduate training

II. Medical Education in 1974 and discussion of present trends

- Integration in Curricula
- Grading systems
- Primary Care teaching/delivery
- FMG influx

III. Constraints which presently limit innovation and growth

- Grades
- NBME
- Speciality orientation
- The University Hospital v. Community Hospital Training

IV. A Case Study: One approach to innovative Medical Education (University of Missouri-Kansas City)

V. The AAMC's Role, Committment and Involvement
Present efforts, Future plans,
How the AAMC fits into the picture

VI. Discussion between panel and audience

Draft 5/31/74

Organization of Student Representatives -- 1974-75

Orientation Materials

General Introduction*

A. Introduction to the AAMC

1. Annual Report
2. AAMC Bylaws
3. Organization Chart
4. Governance Chart
5. Publications Available from the AAMC*
6. Common Acronyms*

B. Introduction to the OSR

1. Rules and Regulations
2. Guidelines
3. Current Roster of Membership
4. List of Committees with Student Representation
5. Minutes of 1973 Business Meeting
6. Minutes of September 1974 Administrative Board Mtg.

* Draft attached

ORGANIZATION OF STUDENT REPRESENTATIVES

What is the Organization of Student Representatives?

The OSR was established in 1971 as the mechanism through which medical students participate in the governance of the Association of American Medical Colleges. OSR is one of the three governing councils of the AAMC, and its membership consists of medical students representing institutions with membership on the Council of Deans. During the 1973-74 academic year, 106 medical schools were represented in the OSR.

How does the OSR operate within the AAMC?

Each medical school with membership on the COD is entitled to name one voting representative to the OSR. The selection process for OSR representatives is defined by each individual medical school, but each member must be certified by the dean of the institution. During the year the OSR meets in conjunction with the AAMC Annual Meeting to make recommendations and elect officers and administrative board members to govern its affairs.

The OSR Administrative Board is the governing committee of the OSR and consists of the chairperson, the vice-chairperson, the secretary, four regional chairpersons, and three representatives-at-large. The OSR Administrative Board meets four times a year prior to each Executive Council meeting to consider OSR business items. The chairperson of the OSR serves on the AAMC Executive Council, as do representatives from the Council of Deans, the Council of Teaching Hospitals, and the Council of Academic Societies. The OSR also has voting representation on the AAMC Assembly, AAMC's highest legislative body. Voting representation of the Assembly at this time is COD--115 votes; CAS--57 votes; COTH--57 votes; and OSR--10 votes.

What is the AAMC?

The AAMC is the only organization that speaks with a single voice for the entire community of academic medicine. It represents 115 U.S. medical schools and its medical students; 400 U.S. teaching hospitals; and 60 U.S. academic and scientific societies in the biomedical field.

What is AAMC's focus?

Among important areas of activity is maintainling federal liaison. The AAMC keeps members informed of legislative activities on national issues such as National Health Insurance; Comprehensive Health Manpower Training Act; Ethical Aspects of Biomedical Research; Research Training; National Cancer Act; and Appropriations. The

AAMC also provides testimony and consultation upon request to the Congress and federal agencies such as the Health Resources Administration, National Institutes of Health, Social Security Administration, and Veterans Administration.

Other ongoing programs include the following areas:

Academic Affairs--Biomedical Research and Research Training; Continuing Medical Education; Curriculum and Instruction; Educational Resource Development Program; and Graduate Medical Education.

Student Affairs--Applicant Study; Centralized Application Services (AMCAS); Coordinated Transfer Application System (COTRANS); Financial Assistance; Minority Affairs; and Student Records.

Educational Measurement and Research--Biochemistry Special Achievement Test (BSAT); Longitudinal Study; Medical College Admission Test (MCAT); and Research in Medical Education (RIME) Conference.

Health Services--Health Maintenance Organization Resource Development; National Health Services Corps; Primary Care; and Quality of Care.

Teaching Hospitals--Costs of Health Care in the Teaching Setting; Executive Salary Survey; Financing of University-Owned Hospitals; House Staff Survey; and Sources of Capital Financing.

Institutional Development--Graduate and Undergraduate Accreditation; Management Advancement Program; and Women in Medicine.

Operational Studies--Cost Allocation Project; Data Collection; Faculty Roster; Financing Study; and Salary Studies.

International Medical Education--Foreign Medical Graduate; Health Care in Guatemala; and Medical Education in Latin America.

How Does AAMC communicate with OSR?

AAMC President Dr. John A. D. Cooper communicates with AAMC constituents weekly by means of his Weekly Activities Report. This goes routinely to the OSR Administrative Board, and WAR is available to all OSR members for the price of postage involved. The AAMC maintains a mailing list of OSR representatives, and mailings are issued to advise the OSR of actions taken at Administrative Board meetings and to address other items of interest to medical students.

What do AAMC's Programs cost?

AAMC program for F/Y 1973 cost $6,318,139. The Audited Treasurer's reports is published each year in the Proceedings of the AAMC which appear in the Journal of Medical Education each spring.

OSR Orientation Materials - Item A-6

AAHP - Association of Advisors for the Health Professions

AAMC - Association of American Medical Colleges

AMA - American Medical Association

AMCAS - American Medical College Application Service

CAS - Council of Academic Societies

COD - Council of Deans

COTH - Council of Teaching Hospitals

COTRANS - Coordinated Transfer Application Service

DEMR - Division of Educational Measurement and Research

DIME - Division of International Medical Education

ECFMG - Education Council for Foreign Medical Graduates

FMG - Foreign Medical Graduates

GME - Group on Medical Education

GSA - Group on Student Affairs

HPEA - Health Professions Education Act

LCGME - Liaison Committee on Graduate Medical Education

LCME - Liaison Committee on Medical Education

MCAAP - Medical College Admission Assessment Program

MCAT - Medical College Admission Test

Med-MAR - Medical Minority Applicant Registry

MSAR - Medical School Admission Requirements

MSOUSMS - Minority Student Opportunities in U.S. Medical Schools

NBME - National Board of Medical Examiners

NIRMP - National Intern and Residency Matching Program

NMA - National Medical Association

OEO - Office of Economic Opportunity

OSR - Organization of Student Representatives

RIME - Research in Medical Education

SAMA - Student American Medical Association

SNMA - Student National Medical Association

STAR - Student Affairs Reporter

WAR - Weekly Activities Report

AAMC Curriculum Directory

The annually updated AAMC Curriculum Directory provides basic objective data on the curriculum of all U.S. medical schools. The individual two-page entries for each school cover the semester starting dates, total hours required in basic science courses, duration of required clerkships, and time allotted to elective programs. The Curriculum Directory also contains listings of schools with special programs and special medical education opportunities.

Medical School Admission Requirements: U.S.A. and Canada, 1975-76. Edited by Vickie Wilson, 1974.

An official source of information on premedical preparation and admission to medical school which is revised and distributed annually. Includes comprehensive discussion on premedical planning, choice of medical school, the admissions process, financial information, the nature of medical education, information for minority students and foreign applicants, and alternatives for rejected applicants. The balance of the publication is a summary of admission requirements for each medical school in the U.S. and Canada.

AAMC Periodicals

The Advisor--Articles concerning premedical advisory activities, health careers counseling, undergraduate premedical programs, reports of application and admission statistics, innovative curricula,

MCAT and other testing data. Published four times during the academic year by the AAMC Division of Student Studies. Distribution free to premedical advisors of undergraduate colleges and to deans and student affairs officers of U.S. and Canadian medical schools. (6-8 pages)

President's Weekly Activities Report--A weekly summary of major activites at AAMC headquarters and of Congressional and governmental actions of interest to the constituency of the Association. Published weekly except August and the last two weeks of December. Individual subscription: $10.00 per year. (2-4 pages)

STAR (The Student Affairs Reporter)--News items of interest to members of the Group on Student Affairs and deans of U.S. and Canadian medical schools concerning accerlerated, M.D./Ph.D., special, and transfer programs; AMCAS; COTRANS; financial aid; MCAAP; MCAT; minority student affairs; publications; personnel changes; reports on GSA and AAHP meetings; summer makeup courses; and workshops. Published quarterly by the AAMC Division of Student Studies. Distribution: free to medical school deans, GSA members, and by request. (6-8 pages)

AAMC Bulletin--News items on AAMC affairs, Congressional and government actions pertaining to medical education, and medical school faculty and administrative appointments. Published monthly except July and August. Distribution: Multiple copies are distributed to each constituent school; OSR representatives should arrange with their dean to obtain copies of the Bulletin. (8-12 pages)

AAMC Education News--Reports on instructional innovation, assessment, and curriculum within the medical schools. Published five times

during the academic school year. Distribution: free to all full-time faculty members. (8 pages)

WORKSHEET

OSR Rules and Regulations
Suggested Topics for Discussion

1. Selection of OSR member at the local institution.
2. Length of office of an OSR member.
3. Provisions for an alternate member.
4. Resolutions. Should they be submitted prior to the Annual meeting? Should we have a resolution's committee?
5. How should AAMC and GSA committee members be chosen?
6. How should ad hoc task force and committee members be chosen?
7. What should be the term of a committee member?
8. Provisions for regional meetings?
9. Continuity in the administrative board or OSR leadership.
10. Provisions for continued participation of past members.

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

DIVISION OF STUDENT PROGRAMS

SUMMARY OF ADMISSIONS ACTION REPORTS
RECEIVED TO DATE, APRIL 26, 1974
FOR THE CLASS ENTERING IN SEPTEMBER, 1974

	Total Number Action Reports Received (To Date)	% of Total	Total Number Accepted (To Date)	% of Total Accepted
ALL CATEGORIES	39,986	100%	11,245	28%
FEMALE	8,135	20.3	2,487	22.1
MALE	31,851	79.6	8,758	77.9
BLACK AFRO AMERICAN	2,073	5.2	748	6.6
AMERICAN INDIAN	113	.3	55	.5
WHITE CAUCASIAN	33,643	84.1	9,468	84.2
MEXICAN/AMER OR CHICANO	406	1.0	174	1.5
ORIENTAL/ASIAN	1,109	2.8	266	2.4
PUERTO RICAN/MAINLAND	109	.3	35	.3
PUERTO RICAN/COMMONWEALTH	129	.3	12	.1
CUBAN	161	.4	55	.5
OTHER	1,052	2.6	156	1.4
NO ANSWER	1,191	3.0	276	2.5

NOTE: This summary reflects only those admissions actions which have been reported to date from the medical schools. A total of 43,000 applicants are expected to apply for admission to the class entering in September, 1974.

POSITION PAPER ON UNIFORM GRADING

Prepared for OSR Administrative Board Meeting June 15,1974

At the OSR national meeting in November, 1973, I proposed that the OSR study the feasibility of instituting a nation-wide uniform grading system among American medical colleges. This system would be based on the pass/fail-written evaluation concept. Since that time, Dan Clarke-Pearson the chairperson of OSR, has asked me to write a position paper concerning this proposal.

NEED FOR THE SYSTEM

The need for a uniform grading system has become evident recently as medical schools experiment with pass/fail variations, and post-graduate selection committees are consequently confronted with constantly changing patterns of undergraduate medical evaluation.

It's important to look at the question of student evaluation within the context of medical education as a whole and the goals of such an education. Medical education should entail both the sharing of information between faculty and students and the development of an approach towards medical workers and patients that creates the best medical care system possible. The importance of absorbing factual information, developing cooperation, internal motivation and responsibility are obviously part of the necessary development of a physician. Such qualities can either be encouraged or discouraged by the educational process and are very much affected by the type of communication that exists between the faculty and students, and among students themselves. The method of student evaluation forms an important framework within which such communication functions.

Unfortunately, within much of medical education the process of evaluation tends to rely on external grading pressures, to foster a competition that discourages cooperation and to encourage an approach towards subject matter that places testing over the relevance of the information for the practice of medicine. This is similar to the unhealthy atmosphere in pre-medical courses engendered by the highly competitive and selective medical school admissions process.

In terms of grading, giving a number or a letter to an evaluation lends it scientific credibility; yet, there is a tremendous amount of subjectivity in determining numerical or letter grades, especially in the clinical years. Not only are the grading categories hard to define, but the

same grades mean different things among different departments and among various schools. A written evaluation system which deals with all aspects of a student's performance would favor more careful assessment by faculty, increase communication, and enable students tocorrect deficiencies which may otherwise go unrecognized in a letter grade system.

CRITICISM OF SUCH A SYSTEM

One objection that is often raised is that students will have trouble when applying for competitive internships if the school is on a pass-fail system. This is not necessarily true. Many departments are already choosing interns and residents without regard to grades.

Recently a survey was conducted by Associate Dean William F. McNary of Boston University School of Medicine. He sent letters (appendix 1.) to approximately 65 medical and surgical intern and resident selection committees, chosen in alphabetical order from the Directory of Approved Internships and Residencies (1971-72). In these letters he asked for their candid opinions concerning pass/fail grading and its relationship to their screening of applicants for post-graduate training.With 33 programs responding, the consensus was that pass/fail grading had made the selection of prospective house officers more time consuming and subjective. However, the majority agreed that the quality of house officers that they ended up with had not changed because of pass/fail grading. Opinions varied from strongly in favor of letter grading to strongly in favor of only written evaluations. Most agrred, though, that unifrom grading would make their jobs much simpler.

Another criticism that has been expressed is that any move towards a pass/fail system is a step towards mediocrity. We believe that mediocrity is determined not by the system of evaluation but by the faculty, students, and their interactions within the school. The superior medical student will stand out no matter which grading system is used.

Lastly, a forseable difficulty in implementing such a system would be obtaining agreement among the individual medical colleges. We feel that a system that is well planned and thought out---- taking into consideration the feelings and desires of all people concerned----will have an excellent chance of being adopted by all American medical colleges.

PROPOSAL

As a uniform pass/fail grading system is desirable for American medical colleges, we propose that the AAMC conduct

opinion surveys among medical students, administrators, faculty, and post-graduate selection committees in order to achieve a consensus on the evaluation of medical students. And, if such a consensus is achieved, to develop a plan for the implementation of a uniform pass/fail grading system on a nationwide basis.

Prepared for OSR by Joel Daven, Rebecca Backenroth, and Alice Rothchild.

APPENDIX 1.

BOSTON UNIVERSITY MEDICAL CENTER

BOSTON UNIVERSITY SCHOOL OF MEDICINE

80 EAST CONCORD STREET, BOSTON, MASSACHUSETTS 02118

OFFICE OF THE DEAN

Dear Sir:

As I am sure you are aware, there has been a move in medical education to change the usual grading systems of medical schools to pass-fail (S/U) sysdtems. At the present time over 40 medical schools in the United States have adopted some modivication of these systems. I have been attempting to collect some data on the effect a P/F grading system has on intern or resident selection committees and find that available data is extremely limited. Because of this, I am requesting of several such committees an expression of their experience, handling and general feelings when confronted with a student transcript expressing all or some P/F grades. It is usual to send a form or check list in such a survey, but having faced survey after survey form during the past year, I am sure that you will find it easier to simply compose a short paragraph expressing your feelings. I also believe that one can slant and direct check-list reports by carefully constructing their contents and I am much more interested in your honest and personal feelings concerning this matter. I hope to use the data collected as a source of my own and our students education, but will, if you so wish, collate the results and forward them to you.

Sincerely,

William F. McNary, Jr., Ph.D.
Assistant Dean for Student Affairs

WFM/mgf

viewpoint

continued from page 35

THE NEW PHYSICIAN, MAY 1974

why the match must survive

by C. Elliott Ray

Reliable sources tell me that every psychiatry program in the country is violating the National Intern and Resident Matching Program (NIRMP), although facts to back up the claim are scarce. I also hear that if you are a junior in medical school beginning to think of ophthalmology as a career, you "may as well forget trying to get a position, because they are gone for your class."

The NIRMP has been matching senior medical students with postgraduate training programs since 1953. And although its services are used by at least 96 percent of the graduating students and more than 98 percent of the hospitals approved for intern training, it has been under attack by several specialties. The Association of Professors of Psychiatry sponsored a matching program in 1967, but found it too troublesome and abandoned it. The Association of Medical School Pediatric Department Chairmen started a match in 1968, but gave it up quickly too. The American Academy of Orthopedic Surgeons and the American Orthopedic Association sponsored a matching program in 1969, 1970, and 1971, but like the others, returned to the NIRMP. It seems to have been found the most workable program. So, who is violating it and why?

A survey conducted by the Group on Student Affairs (GSA) of the Association of American Medical Colleges (AAMC) at the request of the NIRMP offers some clues to the culprits. Sent to the 94 medical schools that had four-year graduating classes in June, 1972, with questions based on the 1972 matching program, the survey produced a 100 percent response. Among its disclosures was that an estimated 783 students — nine percent of the 9,014 graduates — obtained appointments to the first year of graduate training outside the NIRMP. Twenty-six percent of this group made arrangements in violation of the NIRMP.

In addition, of the 822 seniors that reportedly went on to residency training, 173 appointments — 21 percent — were obtained outside the NIRMP. By 1975, a majority of the first-year appointments will be residencies, and that could increase the number of violations from 1973 to more than 1,000. Forty-one schools answering the survey cited psychiatry as the discipline most frequently violating NIRMP guidelines; 13 schools cited OB-GYN and six, surgery.

For well over a year, I have heard program directors, students, interns and residents tell me the inadequacies of the NIRMP. Certainly, many of the complaints are justified. First, it does not help anyone to know in mid-April who is going where and for what in June. Students cannot make adequate moving and housing arrangements, and program directors cannot possibly prepare for the arrival of their new trainees.

Second, the program is being hindered by the AMA, which hasn't been able to publish its *Directory of Approved Internships and Residencies* on time and in time for students to make their choices; this year's directory wasn't issued in time for the match.

And third, program directors who demand early commitment and the trainees who capitulate to them are undermining the program and all of postgraduate medical education. Medical educators, deans of our medical schools, the AMA and the NIRMP itself also are at fault for not dealing with the violators harshly enough.

Fortunately, help for the program seems forthcoming. The NIRMP announced this year's results in early March, a full month ahead of the previously established date. I hope to see

continued on page 43

viewpoint

continued from page 37

this date moved even earlier, but not at the price of forcing final career decisions back into the third or even second year of medical training. The Organization of Student Representatives (OSR) has developed a nationwide network to monitor and report violations of the NIRMP. (Violations include signed contracts secured outside NIRMP guidelines and dates as well as signed reports from a student or hospital that either party is using pressure to receive a contractual commitment). Under the network almost every medical school has a committee that receives complaints and channels them to the appropriate officials. The NIRMP acts on behalf of the accusing party. The final recourse is to expel the training program and all other programs at the same institution or expel the student from the matching program. The principle of such a monitoring system received the unanimous approval of last year's SAMA House of Delegates.

If we really want the match to survive, as I believe it must, what happens next? First, the NIRMP must tool itself into a smoother and faster operation. It must explore new areas, such as two separate matches during the year. An early match might occur in the first or second month of the senior year with participating seniors allowed to match for one program each and program directors permitted to offer a maximum of 25 percent of their positions.

Second, the status of the internship must be clarified. The decision to move away from it is becoming a nightmare; after all, it offers an excellent way to solidify one's medical education, a means to delay long range career decisions to a time when one can make a more intelligent decision, and a smoother mechanism for blending pre- and post-M.D. training.

Third, programs that are forcing early commitments must be exposed by us, the medical students. If your school is one of the few without a monitoring committee, approach your dean and ask that he appoint one.

The author is a third-year student at the University of Kentucky College of Medicine in Lexington. He is SAMA's liaison to the NIRMP board of directors and the author of the NIRMP Monitoring Committee system developed by the Organization of Student Representatives.