

AGENDA

FOR

ORGANIZATION OF STUDENT REPRESENTATIVES

ADMINISTRATIVE BOARD MEETING

January 13, 1975

7:00-10:00 p.m.

January 14, 1975

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

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.

January 13, 1975
7:00-10:00 p.m.
January 14, 1975
9:00 a.m.-4:00 p.m.

- I. Call to Order
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- IV. ACTION ITEMS
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- VII. Old Business
- VIII. New Business
- IX. Adjournment



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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

September 13, 1974
AAMC Headquarters
Washington, D.C.

<u>Chairperson</u>	-- Dan Clarke-Pearson
<u>Vice-Chairperson</u>	-- Mark Cannon
<u>Secretary</u>	-- Dave Stein
<u>Regional Representatives</u>	-- Cindy Johnson (Western) Stan Pearson (Southern)
<u>Representative-at-Large</u>	-- Ernest Turner
<u>AAMC Staff Participants</u>	-- Robert Boerner Diane Mathews Bart Waldman
<u>Invited Guests</u>	-- Phil Aaron, Chairman, AMA Student Business Session Ted Norris, President, SAMA

I. Call to Order

The meeting was called to order by Dan Clarke-Pearson at 7:00 P.M.

II. Consideration of Minutes

The minutes of the June 15 meeting were approved with the following changes:

- A. Page 2, Item II B. The last sentence was changed to read, "The OSR Administrative Board felt strongly that the AAMC should have input to this Commission and supported the recommendation for AAMC representation."
- B. Page 2, Item III. The last sentence was changed to read, "In general, the OSR Administrative Board reached no definitive agreement since they felt that they were not well informed on this issue and that they were not prepared to adopt a policy regarding all Americans."
- C. Page 7, Item D. The second sentence was changed to read, "Cindy Johnson will chair the session on Women in Medicine, and Amber Jones of the AAMC will assist in planning the session and act as a resource person during the discussion."

- D. Page 17, Addendum #4. The second page of the proposed amendment to the AAMC Statement on Moonlighting by House Officers was omitted in the original minutes. The entire amendment is included as Addendum #1 with these minutes.

III. Chairperson's Report

Dan Clarke-Pearson summarized for the board the status of his discussions with Dr. Schofield of the AAMC Division of Accreditation on student participation in the accreditation process. He reported that Dr. Schofield is in agreement with the idea that student leaders at schools visited by accreditation teams be given adequate notice of the visit but is not very receptive to the suggestion that students serve on accreditation teams due to concern that students could not spend sufficient time away from classes to fully participate. Dan also related that he has surveyed student leaders at 30 schools that were visited by accreditation teams this year. Response to this survey, based on a 40% return of questionnaires at this point, indicates that students are notified approximately 1-3 weeks in advance of the visit, that the students notified are representatives of the student body, and that students are generally not aware of the actual purpose of the visit by the accreditation team. Dan and Serena Friedman are preparing a list of items for Dr. Schofield's consideration related to students which they feel should be considered by accreditation teams.

Dan also reported on the GSA Steering Committee meeting which he attended on September 9. One item discussed by the Steering Committee which was of particular interest to students was the amendment to the Omnibus Higher Education Act entitled "Family Educational Rights and Privacy Act of 1974." Bob Boerner explained that although the regulations to the amendment have not yet been written and it is unclear whether the amendment is applicable to medical schools, the act requires institutions receiving federal funds through the Office of Education to make available to parents of students or, upon attaining the age of majority, to students themselves the contents of any official school records about them. The amendment also implies that an educational institution will be required to make available its records only to students attending that institution and thus applicants to a medical school will be allowed access to their application file only after matriculation at that medical school.

The GSA Steering Committee also discussed their input to the newly appointed AAMC Task Force on Groups. The Task Force will be meeting on September 18 with the National Chairman of the five AAMC groups--Group on Business Affairs, Group on Medical Education, Group on Public Relations, Group on Student Affairs, and Planning Coordinators Group--to discuss the role of the groups and their relationship to the governing structure of the Association.

Dan also stated that he had met with Ted Norris, SAMA President, and Phil Aaron, Chairman of the AMA Student Business Session, and plans were discussed for more effective liaison between the various student groups.

IV. Committee Nominations

Cindy Johnson, who had been nominated to serve as the student representative to the AAMC Committee on Admissions Assessment, declined the nomination due to the time constraints of her M.D.-Ph.D. program.

ACTION: On motion, seconded and carried, the Administrative Board nominated Hal Strelnick to serve on the AAMC Committee on Admissions Assessment.

V. Rules and Regulations

The Administrative Board reviewed two sets of proposed revisions to the OSR Rules and Regulations, one prepared by AAMC staff and one prepared by Mark Cannon. The board was in general agreement that certain items relating to operational policy such as recommended length of office of OSR representatives should be included in a set of guidelines rather than in the Rules and Regulations.

Two items in the proposed revisions which were discussed at length were the selection process of OSR representatives and provisions for alternate representatives. The board felt that OSR representatives should be representatives of the student body rather than appointees of the Dean and therefore agreed that only students should vote in the selection process at the local institution. It was suggested that staff contact those schools at which OSR representatives are appointed by Deans to determine the reason for the lack of student input in the selection process. The board also reached consensus on the issues of alternate representatives and adopted the provision that alternate members may attend OSR meetings but that, due to problems which arise in determining a quorum and counting ballots, alternate members may not vote.

VI. The meeting was recessed at 10:15 with discussion of Rules and Regulations revisions to be continued the following day.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

September 14, 1974
AAMC Headquarters
Washington, D.C.

PRESENT: Chairperson -- Dan Clarke-Pearson
Vice-Chairperson -- Mark Cannon
Secretary -- Dave Stein

Regional Representatives -- Serena Friedman (Northeastern)
Cindy Johnson (Western)
Stan Pearson (Southern)

Representative-at-Large -- C. Elliott Ray
Ernest Turner

AAMC Staff Participants -- Robert Boerner
John A. D. Cooper, M.D., Ph.D.
Diane Mathews
John Sherman, M.D.
August G. Swanson, M.D.
Bart Waldman

VII. The meeting was reconvened by Dan Clarke-Pearson at 9:00 A.M. on September 14.

VIII. Executive Council Agenda

A. AAMC Policy Statement on New Research Institutes and Targeted Research Programs

The original policy statement which was first presented to the Executive Council at their June 21 meeting was reworded to be more specific according to action taken at that meeting. (Addendum #2)

ACTION: On motion, seconded and carried, the Administrative Board endorsed the revised AAMC Policy Statement on New Research Institutes and Targeted Research Programs.

B. Student Representation on the CCME, LCME (Addendum #3)

In response to concern expressed by board members about the recommendation by the Chairman of the Executive Council that the Executive Council consider rather than approve the OSR request, Dr. Swanson explained that the CCME is a relatively new organization and that the AAMC is only one of five parent bodies comprising the Council. Dr. Swanson stated that the Executive Council would possibly consider the request for student representation in light of these two factors and that a potential consideration in the Executive Council's discussion will be whether now is the time to request student representation on the LCME and CCME.

C. GME Resolution of NBME Rankings

The Administrative Board agreed with the GME Resolution (Addendum #4) and expressed the concern that medical school rankings of student performance on Parts I and II of the National Board exams may exert pressure on institutions to structure curricula according to those rankings.

ACTION: On motion, seconded and carried, the board approved the GME Resolution on NBME rankings.

D. Report of the COTH Ad Hoc Committee on COTH Membership Criteria

In a discussion of the recommended revisions of COTH membership criteria, concern was expressed by board members that such considerations as the proportion of internships and residencies which are filled by foreign medical graduates may restrict certain hospitals from establishing a teaching program. Dr. Swanson pointed out that COTH plays no role in defining which hospitals may have teaching programs other than in their role on the LCGME.

ACTION: On motion, seconded and carried, the board approved the Report of the COTH Ad Hoc Committee on COTH Membership Criteria and the recommendations contained therein.

E. Report of the COTH Ad Hoc Committee on JCAH Standards

In an effort to clarify this report and the specific problems that teaching hospitals encounter in the accreditation process, Dr. Swanson explained that the Joint Commission on Accreditation of Hospitals accredits all hospitals--both teaching and community. Teaching hospitals have encountered problems in a process which accredits all hospitals by the same standards and procedures due to the dual education and service role of the teaching hospitals. A question arose concerning house officer representation in the accreditation process, and it was pointed out that such representation would be more appropriate on the Residency Review Committees which evaluate teaching programs.

ACTION: On motion, seconded and carried, the Administrative Board approved the Report of the COTH Ad Hoc Committee on JCAH Standards.

F. CCME Report: Physician Manpower and Distribution

ACTION: On motion, seconded and carried, the Administrative Board approved the CCME Report: Physician Manpower and Distribution.

IX. OSR Administrative Board Input to Retreat Agenda

Bart Waldman explained that the Retreat is essentially an opportunity for AAMC officers and certain members of AAMC Executive Staff to identify Association policy and appraise Association resources and their directions for the coming year. The Agenda for the Retreat is developed by the Chairman of the AAMC and staff, and this year the Administrative Boards are being requested to provide input to the Retreat Agenda.

Cindy Johnson suggested that one major issue that the Retreat should consider as a priority during the coming year is the issue of identifying and addressing the Association's role in the medical education process for women. Since one of the OSR discussion groups at the Annual Meeting will be dealing with Women in Medicine, it was suggested that the potential retreat topic could be further expanded after the Annual Meeting.

Another suggestion for the Retreat Agenda was an examination of the Association's efforts to obtain house staff input into the AAMC program and policy development process.

X. Report of the AAMC GAP Task Force

Dr. Swanson explained that because of logistical problems centering primarily around Dr. Doris Howell's departure from the Association, the GAP Task Force will not be presenting their report at the September Executive Council meeting. The GAP Task Force Report is currently being developed and will appear on the agenda of the three Councils and on the agenda of the OSR at the Annual Meeting. The Executive Council will then consider the Report at their January meeting. The Administrative Board agreed that since the report of the GAP Task Force will be discussed at the Annual Meeting, one of the OSR discussion groups could address that issue.

XI. Health Manpower Legislation

Dr. Cooper and Dr. Sherman discussed with the Board the various bills being considered by Congress regarding Health Manpower Legislation. SAMA has been represented as supporting two year, mandatory, national service for all medical students, and it was agreed during the discussion that SAMA's position needs to be clarified since it is not evident whether SAMA supports mandatory national service for all Americans or for all medical students. Dr. Cooper stated that one possible outcome of emerging Health Manpower Legislation is the elimination or the reduction of capitation grants to medical schools. With this possibility it is likely that some medical schools would raise tuition, and the board expressed the concern that medical school populations might revert to representing only the students from the higher socio-economic background. One member of the board pointed out that financial assistance programs requiring service commitments would be particularly restrictive to women medical students since they generally lack the mobility of male medical students.

Dr. Cooper expressed the AAMC position that increasing the scope of the National Health Service Corp is a viable alternative since national service can establish a practice with adequate support personnel and can have access to basic facilities so that they are making a genuine contribution to underserved areas. Dr. Sherman pointed out that a possible compromise emerging in Congress is to continue the voluntary approach with an increase in funds to NHSC with the provision that if the voluntary approach does not succeed in recruiting a national percentage of students agreeing to service commitments, a quota requirement would then become mandatory for all medical schools.

XII. Resolutions

The following resolutions, referred to the Administrative Board by the OSR regions, were considered:

- A. "Objectives and expectations of the faculty for student performance should be clearly stated at the onset of a course or clerkship with ongoing feedback throughout the course or clerkship."

ACTION: On motion, seconded and carried, the board approved this resolution as amended above and referred it to the Executive Council and the Group on Student Affairs.

In addition of the above disposition, it was recommended that the resolution be included in the list of accreditation factors to be submitted to Dr. Schofield, that an article on this subject be included in the Bulletin Board, and that a letter expressing the content of the resolution be submitted to the Journal of Medical Education.

- B. "All evaluation reports should be available for inspection by the student."

ACTION: On motion, seconded and carried, the board decided not to approve the resolution since it reflects what has already been established as an OSR policy statement.

- C. "All evaluations and reports should be available for inspection by the student and should be released only with permission of the student."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve the resolution since its purpose is contained in other resolutions and in HR-69.

- D. "OSR recommends to the Council of Deans that the directors of medical education of the various clinical rotations instruct their teaching residents to provide to the incoming group of students at the beginning of each rotation written clarification of all parameters taken into consideration in the compilation of the evaluations of the students' performance during that rotation; further, that the incoming students be provided with a written description of their duties and obligations during that rotation."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve the resolution since its purpose is contained in other resolutions.

- E. "Faculty objectives and expectations for student performance should be clearly defined and stated at the outset of a course. During a course or clerkship faculty should provide ongoing feedback including at least one discussion, sufficiently in advance of the end of the clerkship, on a student's performance, especially if the performance is inadequate to date."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve the resolution since its purpose is contained in other resolutions.

- F. "No person outside the Dean's office may review the student's records without that student's permission."

ACTION: On motion, seconded and carried, the board approved the resolution as amended above and referred it to COD Administrative Board, the CAS Administrative Board, the GSA Steering Committee, and the GME.

- G. "To adequately provide funding of Medical Education for those students requiring financial assistance the following plan should be adopted: An Educational Opportunity Bank shall be created whereby: (1) Money can be allocated to needy students to provide for educational and living expenses during the 3 or 4 years of medical school; and (2) such funds will be reimbursed by a determined percentage of their annual income commencing upon graduation and continuing until such time as this said loan and appropriate interest have been reimbursed. (3) Initial funding is to be paid from federal sources and when possible can be supplemented from state sources."

ACTION: On motion, seconded and carried, the board endorsed the previous disposition on this resolution since it had already been referred to Craig Moffat of the AAMC Committee on Financing of Medical Education for informational purposes.

- H. "The Health Professions Scholarship Program should not be terminated as it is a vital encouragement to economically underprivileged medical school applicants."

ACTION: On motion, seconded and carried, the board approved this resolution in principle but took no further action since it has already been established as AAMC policy.

- I. "At the present time, the Public Health Service does not permit participation in its programs as recipients of Public Health Professional Scholarships by individuals who seek classification I-O from the Selective Service System, whereas persons classified as I-A-O are eligible for participation. The OSR requests the AAMC to use its influence in order to have the Public Health Service correct this policy."

ACTION: On motion, seconded and carried, the board approved the resolution as amended above and referred it to staff.

- J. "Since only an hour is usually devoted to meeting with students in on-site visits by members of the LCME Accreditation Team, the OSR requests that (1) at least one month advance notice be given to Student Council or student body representatives through the Dean's office prior to Accreditation Team visits to allow for development of student input to the Accreditation Team; (2) students be permitted to submit materials prior to on-site visits for preliminary consideration by the Accreditation Team; (3) student(s) be included on Accreditation Teams."

ACTION: On motion, seconded and carried, the Administrative Board approved the resolution as amended above and referred it to Dr. Schofield, Director of AAMC Division of Accreditation.

- K. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."

ACTION: On motion, seconded and carried, the Administrative Board approved the resolution and referred it to the Steering Committees of the GSA and GME and the Administrative Boards of the Council of Deans, Council of Academic Societies, and Council of Teaching Hospitals as an information item. The content of the resolution will also be included in the list of accreditation factors to be submitted to Dr. Schofield.

- L. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."

ACTION: On motion, seconded and carried, the Administrative Board approved the resolution and referred it to the Steering Committees of the GSA and GME and the Administrative Boards of the Council of Deans, Council of Academic Societies, and Council of Teaching Hospitals as an information item. The content of the resolution will also be included in the list of accreditation factors to be submitted to Dr. Schofield.

- M. "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."

ACTION: On motion, seconded and carried, the Administrative Board approved the resolution and referred it to the CAS Administrative Board and to the Executive Council.

- N. "The AAMC should consider with other concerned groups the feasibility of a uniform application form for programs in graduate medical education."

ACTION: On motion, seconded and carried, the Administrative Board approved the resolution and referred it to the CAS Administrative Board and to the Executive Council.

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

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve this resolution.

- P. "Each medical school should employ a Pass-Fail record system. Each evaluation should include a full description of the student's clinical experience and performance."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve this resolution.

- Q. Since it is the concern of medical students that health care in prisons is often inadequate, it is recommended that information be gathered regarding the quality of care in prisons and the possible role of medical schools and teaching centers in providing care."

ACTION: On motion, seconded and carried, the board approved this resolution and referred it to Health Services Advisory Committee as a request for information on the status of the work of that committee.

- R. "An annual listing of medical positions available in communities throughout the United States with some description regarding the medical needs in those communities should be provided to medical students and house staff in an attempt to alleviate the maldistribution of medical doctors."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve this resolution since the information is available through other sources.

- S. "Once the National Board Scores reach the individual medical schools: (1) Listing of these scores must be kept anonymous; (2) Scores may only be released in listings and on transcripts with the written permission of the student involved."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve this resolution.

- T. "Within the framework of the academic medical center we recognize that there are roles for primary educators. On this assumption, we urge that the university strive to hire and promote individuals on the basis of their ability and interest in teaching, in addition to more traditional criteria. Further, we urge that departmental and student evaluations be the basis for promotion of primary educators."

ACTION: On motion, seconded and carried, the Administrative Board voted not to approve this resolution.

XIII. Report on Uniform Grading System

At the November, 1973, OSR Business Meeting, the OSR approved the following resolution:

BE IT RESOLVED that the OSR study the feasibility of instituting a pass-fail system in an effort to equalize the post-graduate application process.

In response to that resolution, Joel Daven prepared a Position Paper on Uniform Grading (Addendum #5) which recommends that the AAMC survey

medical students, administrators, faculty, and post-graduate selection committees to determine a consensus on the desirable evaluation system for medical students. The Administrative Board reviewed the Position Paper and agreed to refer it to the GME for their review and comment. Further action will be considered after receiving advice on the matter from the GME.

XIV. OSR Activities at 1974 Annual Meeting

Since the CAS/COTH Joint Program will be held in the morning rather than the afternoon of Tuesday, November 12, the OSR Regional Meetings were rescheduled for Tuesday afternoon at 2-4 P.M. An informal meeting of the newly elected Administrative Board will be planned for Tuesday evening.

A. OSR Program Session

Final plans were made for the OSR Program Session entitled "Medical Education: Directions for the Next Decade." (Outline attached as Addendum #6) Bob Boerner reported that Dr. Hillard Jason, Director of the AAMC Division of Faculty Development, has agreed to discuss current innovative programs in medical education in Segment III; Dr. August G. Swanson, Director of the AAMC Department of Academic Affairs, will discuss current trends in medical education curricula in Segment II. Dr. Christopher C. Fordham III, Dean of the University of North Carolina School of Medicine, will be requested to speak on Medical Education and Societal Needs in Segment I. The basic format for the program will also include opportunity for audience reaction and discussion following each segment.

B. Discussion Sessions

Four topics for Discussion Sessions at the Annual Meeting have been specified and include the GAP Report, chaired by Mark Cannon; National Health Insurance and Health Manpower Legislation, chaired by Ernest Turner; Peer Review, chaired by Elliott Ray; and Women in Medicine, chaired by Cindy Johnson. The board members responsible for organizing each of the discussion sessions were reminded that all written material to be distributed to OSR members prior to the Annual Meeting must be submitted to staff by October 4.

XV. Rules and Regulations

After the discussion on Friday evening regarding revisions to the OSR Rules and Regulations, Dan Clarke-Pearson and Mark Cannon presented a new draft of revisions to the Administrative Board. Because of time limitations, the board reviewed the new draft and agreed to forward additional suggestions or comments to staff for preparation of a final set of revisions to be presented at the OSR Business Meeting in November and to be circulated to all OSR members 30 days in advance of the business meeting.

XVI. OSR Bulletin Board

The Administrative Board reviewed and approved the mock-up copy of the proposed OSR Bulletin Board which was prepared by staff. The first issue of the Bulletin Board will be distributed as an insert in the October issue of STAR. One copy of STAR will be sent to the OSR representative and five copies of the insert will be bulk mailed to Student Affairs Deans for posting.

XVII. OSR Expenses

Bob Boerner reported that as a result of increased activity of the Administrative Board and rising costs, it is no longer possible for the AAMC to underwrite incidental expenses such as telephone, xeroxing, and postage for OSR business conducted by board members. AAMC staff will negotiate with Student Affairs Deans at the institutions of those OSR board members elected in November, 1974, to have the medical schools assume responsibility for these expenses. As an interim measure it was agreed that minimum, necessary expenses of this type for the current board members will be paid by the AAMC until the Annual Meeting.

XVIII. The meeting was adjourned at 5:30 pm.

Organization of Student Representatives
Association of American Medical Colleges

AAMC STATEMENT ON MOONLIGHTING BY HOUSE OFFICERS

AMENDMENT:

1 The Association of American Medical Colleges is concerned
2 about the quality of graduate medical education and any activity
3 which might compromise the quality of this experience.

4 The timely debate regarding house officer "moonlighting"
5 involves a number of considerations which include:

- 6 a. The rights of an individual to engage in whatever legal
7 activities he chooses during the time when his services
8 are not required by his primary full-time employer.
- 9 b. The dependence that has developed in some sections of the
10 country upon physicians from training programs for the
11 provision of primary and emergency care during their off-
12 duty hours.
- 13 c. The financial dependence of some married house officers
14 with children, and other house officers with large previous
15 debts, upon incomes larger than those offered while
16 employed in training status.
- 17 d. The broadening educational experience for the house officer
18 who practices some medicine outside the graduate medical
19 education institution.
- 20 e. The possible injury to the health of the house officer
21 by working excessive numbers of hours.
- 22 f. The possible impairment of the caliber of training
23 opportunities experienced by a house officer whose free
24 time is not available for study and recreation.
- 25 g. The relationship of the educational institution that has
26 primary responsibility for recruitment and training of house
27 officers to the larger consumer community when its
28 employees serve in a secondary capacity as a part of a
29 health care system outside the aegis of the primary employer

30 In creating a statement regarding house officer "moonlighting"
31 the AAMC recognizes that there is no documentation which suggests

32 that the very occasional time spent pursuing additional work
33 opportunities for income has diverted house officers from their
34 primary responsibilities to their own education and to the patient
35 charged to their care by the training institution.

36 THEREFORE, as a matter of general principle, the Association
37 of American Medical Colleges urges that institutions of graduate
38 medical education and house officers recognize the importance of the
39 graduate medical education experience both for the individuals'
40 professional development and for the development of the nation's
41 medical resources. Further, the AAMC believes that the house
42 officer, as a medical graduate qualified and accepted by an
43 accredited American graduate medical education program, is a mature
44 individual capable of being responsible for his/her own educational
45 development but urges that the house officer consider the following
46 matters before engaging in additional work opportunities:

- 47 a. The capacity of the house officer to fulfill his/her
48 educational objectives while, at the same time, pursuing
49 additional work opportunities for income;
- 50 b. The nature of the work opportunity, including its educational
51 value;
- 52 c. The needs of the community, and
- 53 d. the financial need of the individual.

AAMC POLICY STATEMENT ON NEW RESEARCH INSTITUTES
AND TARGETED RESEARCH PROGRAMS

The Association of American Medical Colleges reaffirms its strong belief that a key element in the past and future success of our national effort to conquer disease is a strong, diverse, balanced program of high quality biomedical research.

NEW RESEARCH INSTITUTES

The present organizational structure of the National Institutes of Health provides specific attention to various disease categories, organ systems, basic science and the particular needs of various age groups in our population. It is thus a rational arrangement embodying the essential characteristics of diversity and balance. While we recognize that the current structure is not without potential for improvement, we believe it imperative that any modification recognize that an effective national program of support for biomedical research requires an organizational structure with reasonable stability comprised of a limited number of component entities. The fundamental nature of scientific inquiry involves the potential for substantial overlap among projects and programs, thus, the orderly management of scientific programs requires a high degree of coordination. Such coordination would be made more difficult by the proliferation of organizational entities devoted to increasingly narrow concerns. Furthermore, the administrative support required for each new organizational entity imposes new financial burdens and creates additional management complexities for which there is little offsetting benefit. Thus, the Association opposes, as a matter of considered principle, the establishment of additional categorical disease institutes or institutes dedicated to one or more organ systems at the NIH or NIMH. However, the Association recognizes that to accomplish objectives not presently identified it may be necessary to add new responsibilities to existing programs of the various institutes of the NIH/NIMH.

TARGETED RESEARCH

Legislative proposals mandating the establishment of biomedical research programs directed toward specific disease entities should be evaluated in the context of the following considerations.

1. The relative priority of the new programmatic focus in relation to ongoing programs. During a period of constrained budgets, the legislation will increase the emphasis on the identified disease to the detriment of pre-existing programs.
2. An appropriate distinction between research and non-research components of the proposal. The almost insatiable resource demands of service-oriented activities require built-in safeguards if the research activities are to share appropriately in the allocation of resources.
3. The status of the scientific understanding of the disease and the potential for significant progress through a targeted approach. An essential prerequisite for any national program targeted toward the conquest of a specific disease is the

existence of an understanding of the fundamental biological processes underlying the disease in question. In the absence of such knowledge, the search for specific therapeutic treatments must not be over-emphasized to the detriment of investigating the underlying biological phenomena.

4. The suitability of existing legislative authorities for the accomplishment of newly identified objectives. The array of existing authorities provides ample bases and great flexibility for more intensive effort in specifically designated areas.

Finally, the Association believes that the key to our Nation's ability to achieve long-term biomedical research goals is the maintenance of a strong program of fundamental research such as is supported under the aegis of the National Institute of General Medical Sciences. Great care should be taken that our long-term investment in the solution of health problems not be undermined through speculation on short-term and potentially illusory objectives.

For the immediate future, any new legislation dealing with the establishment of new research institutes or targeted research programs should await the comprehensive review of national biomedical research and recommendations of the Biomedical Research Commission, which has been established at the direction of Congress with the passage of the National Cancer Amendments of 1974, PL-93-352.

STUDENT REPRESENTATION ON CCME, LCME

The OSR Administrative Board has asked that the Executive Council approve the following statement:

The AAMC Executive Council supports the concept of medical student participation and representation in the CCME and in the LCME. The Executive Council requests that the AAMC representatives to these two groups transmit this recommendation to the CCME and to the LCME and propose Bylaws changes to this effect.

The LCME is currently composed of six members of the AAMC and six representatives from the AMA. The Coordinating Council on Medical Education is currently made up of three representatives of each of the five parent organizations. In addition, both groups have public and federal representatives.

RECOMMENDATION

It is recommended that the Executive Council consider the OSR request.

GME RESOLUTION ON NBME RANKINGS

The resolution which appears below was passed unanimously by the Steering Committee of the AAMC Group on Medical Education. They have asked that it be considered by the Administrative Boards and by the Executive Council.

The GME Steering Committee recommends that the Executive Council request the AAMC representatives appointed to the National Board of Medical Examiners to request the Board to cease publishing, confidentially or otherwise, information regarding medical school comparisons (rankings) of student performance on Parts I and II of the National Board examination.

This resolution was offered out of concern for what is considered to be an inappropriate application of test information. National Board examinations Parts I and II have as their objective providing certifying information for the licensure of the physician, not the evaluation of programs of instruction or curricula of the various medical schools. The relevant institutional information from the performance of students on these exams is only the proportion of students who fail to meet the certifying standards of the National Board and thus may not meet state licensing requirements.

Significant concern has been expressed within the GME regarding the influence these examinations exert on curricula. Therefore, there is not only a question about the appropriateness of the examinations for the purpose used, but also a more general question concerning the desirability of a national examination for evaluating curricula. Providing the ranking of mean performance on Parts I and II of the NBME examination is not a sufficient data base upon which to modify curricula. Schools utilizing externally generated exams should employ item analyses to determine the extent to which their educational objectives are being met.

RECOMMENDATION

It is recommended that the Executive Council approve the resolution of the GME Steering Committee which appears above.

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 to correct 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 agreed, though, that uniform 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 foreseeable 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 OBR by Joel Daven, Rebecca Backenroth, and Alice Rothchild.

OSR PROGRAM SESSION

Monday, November 11
7-10 PM

Medical Education: Directions for the Next Decade

- Segment I - *Medical Education and Societal Needs*
Christopher C. Fordham III, M.D.
Dean, University of North Carolina School of Medicine

Audience Reaction and Discussion

- Segment II - *Present Trends in Medical Education*
August G. Swanson, M.D.
Director, AAMC Department of Academic Affairs

Audience Reaction and Discussion

- Segment III - *Innovative Programs in Medical Education*
Hilliard Jason, M.D., Ed.D.
Director, AAMC Division of Faculty Development

Audience Reaction and Discussion

December 10, 1974

If such a policy is not followed, serious questions concerning the Association's tax-exempt status may arise. Moreover, the OSR rules and regulations as well as the AAMC Bylaws and the OSR guidelines require that the OSR be composed of one student representative from each institution that is a member of the Council of Deans. To permit individuals who are not at all times the official student representative of their respective institutions to serve in the OSR, its Administrative Board, the Assembly or the Executive Council is in direct conflict with those governing documents.

Since the Chairperson of the OSR is, ex officio, a member of the Executive Council, implementation of the foregoing policy would preclude any individual who is not a designated representative of his school from filling this position on the Executive Council. We believe this is the desirable result since no one who is not a student or who is not a member of OSR should occupy this position.

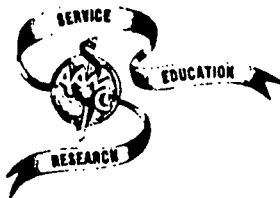
I shall be pleased to discuss any of these matters with you or others who are interested.

With best regards, I am,

Sincerely,

(signed) Joe

cc: Mr. J. Trevor Thomas
Mr. Bart J. Waldman



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

DATE December 31, 1974

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

TO: Robert Boerner
FROM: Joseph Keyes
SUBJECT: OSR Rules and Regulations Revisions

As per our discussions, this is to provide you with the material I propose to include in the COD Administrative Board Agenda on the OSR Rules and Regulations revisions.

COPIES TO:

OSR Rules and Regulations Revisions

On November 11, 1974, the OSR voted to revise its Rules and Regulations. The AAMC Bylaws (Section III) require that the Rules and Regulations be approved by the Council of Deans. Because of the time constraints, this Board determined on November 12, 1974, not to bring the matter to the full Council, but rather to consider the revisions at its own January meeting and to act on behalf of the Council with respect to this matter.

The attached document provides a comparison of the Rules and Regulations as they had been previously approved with the revised version as voted by the OSR on November 11, 1974.

Subsequent review of the changes by the Association's legal counsel has disclosed the necessity of certain changes to bring this document in conformity with the AAMC Bylaws and to preserve the AAMC's tax status. Two of these changes relate to the necessity of assuring that the officers and voting board members of the OSR are, at the time that they serve, "institutional representatives," that is, officially designated by their medical schools as the schools' representative to the OSR. Thus, Section 4. D will need to be revised to include this requirement and Section 4. F to specify that the immediate past chairperson of the Organization will have only non-voting status on the Administrative Board. Section III of the AAMC Bylaws also provides that the OSR shall "recommend to the Council of Dean the Organization's representatives to the Assembly." Thus the OSR Rules and Regulations Section 5 should be revised to account for the COD role in the approval of Assembly members from the OSR.

The necessity of these changes have been brought to the attention of the OSR officers and presumably they will be made by the OSR Board at its meeting on January 14, 1975.

The revisions pose certain additional policy issues which the COD Administrative Board may wish to consider prior to approving the document.

Section 3. A, specifying the process by which members of the OSR are to be selected, previously provided that "The selection should facilitate representative student input." The proposed additional language, "and only students may vote in the selection process," would appear to preclude selection by an action of a committee which included faculty and/or members of the school administration. This appears to be in direct conflict with the COD Guidelines (attached) which provides that the process of selection should "facilitate representative student input and be appropriate to the governance of the institution." This comment also applies to the last phrase in Section 3. D.

Section 4. A 4) provides for an Administrative Board with a minimum of 10 members and a maximum of 10 percent of the total

OSR membership. The COD Administrative Board may wish to consider the policy and fiscal implications permitting the OSR Board to expand in this open ended fashion.

Finally, the Board may wish to consider the desirability of according "formal action" status to the results of regional meetings implicit in Section 7. E(2). No other component of the AAMC provides for formal business sessions at regional meetings. Additionally, while it may be viewed as unlikely that an identical motion will be passed by three of four regions, this mechanism would permit the accord of formal status to a motion which has less than majority support. This is a possibility of even greater likelihood in the case of regional meetings which attract a small attendance.

The OSR Board is in receipt of this background paper. This, it may consider these matters at its meeting and provide additional proposed revisions to its Rules and Regulations for the COD Board review.

Recommendation: To consider the OSR Rules and Regulations and to approve the document if satisfied that the legal and policy questions are appropriately resolved.

Proposed OSR Rules and Regulations Revisions 12/31/74

The following revisions in the OSR Rules and Regulations as revised November 11, 1974 are proposed to reconcile differences between these rules and regulations and the AAMC Bylaws and between these rules and regulations and the limitations upon the AAMC as a result of its status as a tax-exempt public charity under the Internal Revenue Code.

Section 4.D. Presence at the Annual Meeting shall be a requisite for eligibility for election to office. Each officer shall be an official representative of his or her institution to the OSR throughout his or her entire term. The Chairperson shall in addition have attended a previous meeting of the Organization, except in the event that no one satisfying these conditions seeks the office of Chairperson, in which case this additional criterion shall be waived.

Section 4.F. There shall be an Administrative Board composed of the CHairperson, the Vice-Chairperson, the Regional Chairpersons, the Representatives-at-Large, and as a non-voting member, the immediate past Chairperson of the Organization.

Section 5. The OSR is authorized the number of seats on the AAMC Assembly equal to 10 per cent of the OSR membership, the number of seats to be determined annually. Representatives of the OSR to the Assembly shall have the prior approval of the Council of Deans; shall include only current, official OSR members and shall be determined according to the following priority:

- 1) The Chairperson of the Organization of Student Representatives;
- 2) The Vice-Chairperson of the Organization of Student Representatives;
- 3) Other members of the Administrative Board of the Organization, in order of ranking designated by the Chairperson, if necessary.

Section 7.E. Delete



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

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

December 6, 1974

WASHINGTON: 202: 466-5175

MEMORANDUM

FROM: Executive Staff
TO: Office of the President
SUBJECT: Committee Appointments

For discussion at the staff meeting on Tuesday, December 10, please bring names of people whom you might suggest to fill the committee vacancies listed below:

<u>Deans</u>	<u>Faculty</u>	<u>Hospital</u>	<u>Students</u>
Audit	Audit	Flexner	Data Development Liaison
Borden	Borden		
LCGME	LCGME	LCGME	Flexner
LCME	LCME		Health Services Advisory
Flexner	Data Development Liaison		
MAP			CIRME
Nominating	Flexner		Resolutions
	Nominating		

cc: Diane Mathews
(for OSR Adm. Bd. consideration)

REHABILITATION TRAINING IN UNDERGRADUATE
MEDICAL EDUCATION FOR THE PRIMARY PHYSICIAN

Holly Doyne
University of Minnesota

WHEREAS, It has been estimated that 10% of the United States population is in need of various rehabilitation services and it is estimated that less than one-third are able to obtain needed services, and

WHEREAS, The common problems of arthritis, cerebral palsy, hemiplegia, peripheral vascular disease, cardiorespiratory diseases, as well as the problems of amputation and spinal cord injury, all require comprehensive care of the involved patient including rehabilitation services, and

WHEREAS, These problems are among the most common treated by the primary physician, especially the family practitioner, and

WHEREAS, At present, undergraduate medical education in most institutions devotes little time to instruction or consideration to including rehabilitation in the comprehensive care of patients with these problems, and

WHEREAS, The primary physician needs to be familiarized with the services of allied health professions, such as Physical Therapy, Occupational Therapy, Social Services, etc.

BE IT RESOLVED THAT:

Undergraduate medical education, primary-physician-oriented, include formal training in Physical Medicine and Rehabilitation, and

BE IT FURTHER RESOLVED THAT:

should
This training include no less than sixty (60) hours of classroom and clinical time in the undergraduate medical curriculum, including combined teaching with other disciplines, and

BE IT FURTHER RESOLVED THAT:

This training should be sufficient to give the future primary physician an adequate data base to:

- 1) differentiate problems which can be managed by the primary physician from those requiring services of a Physiatrist or other specialist;
- 2) recognize the amount of disability and its effects;
- 3) be acquainted with the range of therapeutic measures available; and
- 4) be aware of the roles and services which are available through the allied health professions, such as Occupational Therapy, Physical Therapy, Speech Therapy, Social Services, etc.

R E S O L U T I O N

Primary Care Practice of Medicine

BE IT RESOLVED that admissions incentives
and priorities be given to qualified students from
areas of physician shortage.

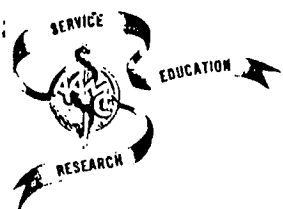
Dan Miller
University of Louisville

CHAIRPERSON'S RECOMMENDATIONS

*Presented by Dan Clarke-Pearson at the
AAMC Annual Meeting
November 10, 1974

1. The AAMC bylaws be changed to include the OSR as a full council; the OSR be independent from the Council of Deans; and the OSR be given voting privileges on an equal basis with the other councils.
2. Houseofficers be included in the governance of the AAMC and that this representative houseofficer input come from the existing houseofficer organizations--the Physicians' National Housestaff Association and the Interns and Residents Business Session of the AMA.
3. The OSR staff must be fully aware of AAMC policies, must be in touch with the issues, and must keep the OSR and its Administrative Board informed of developing issues so that we can make our input before, not after, AAMC policy is established.
4. The AAMC bylaws be amended so that student appointments to AAMC committees are made only by the OSR.
5. In terms of OSR budget:
 - a) the OSR should be given the right to discuss our financial needs with the AAMC budget committee.
 - b) that the budget be clearly defined for the OSR and that the OSR Administrative Board be informed monthly of expenditures and balance.
 - c) that the OSR be given the right to spend the budgeted funds as it sees fit.
6. The OSR, as an advocate of pre-medical students, ask that the AAMC clearly define the costs of administering MCAT and AMCAS so that the net income from these services can be determined. In addition, I recommend that the OSR review the cost to the pre-med student to apply through AMCAS to determine whether AMCAS is worth the service the student receives.
7. The OSR develop a feedback mechanism so that other OSR members can make input to the individual OSR members on AAMC committees. The OSR develop a means of communication between and among its committee members and all OSR members about the issues the committees are addressing.
8. During the coming year, the means be developed so that the OSR Chairperson elected at next year's annual meeting will be required to take on the responsibilities of OSR leadership on a full time basis. This means, of course, that a reasonable stipend must be found to support the OSR Chairperson.
9. The AAMC in cooperation with other national medical student groups such as SNMA and SAMA sponsor an institute and workshops aimed at developing better medical student government at each medical school with the primary purpose of stimulating more representative student input on national issues.
10. The leaders of the various medical student groups meet periodically to discuss common problems and to develop unified student policy.

*Full text of the address is available upon request from AAMC, One Dupont Circle, NW, Washington, D.C. 20036.



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

December 6, 1974

MEMORANDUM

TO: OSR Administrative Board

FROM: Dan Clarke-Pearson

SUBJECT: OSR Project on Accreditation of Medical Schools

The purpose of this memo is to solicit your help in reviewing some materials which are preliminary to a report which I will make to the Administrative Board in January.

Over the past 12 months, the OSR Administrative Board has expressed concern about the accreditation process--especially as it relates to medical students. Highest on our list of priorities have been to insure (1) that students are informed in advance of a site visit to their school, (2) that the students who meet with the site visit team are representative of the student body, (3) that the students understand the nature of the visit, and (4) that the criteria used in writing the report is complete and that the report is sufficiently detailed so that reviewers (members of the AAMC Executive Council and AMA Council on Medical Education) can understand the school.

It is to this last point that this memo addresses itself. In reviewing reports this past year, it was apparent to me that no format or standardized information was included regarding student affairs. Usually, the information was scant, and often times trivial.

Enclosed are a series of questions which Serena Friedman and I have drawn up. These questions are intended to be included in the student affairs section of the team's site visit materials and are intended to be a minimum standard format which should be reviewed at each school.

Would you please review these questions and then contact me in writing with any changes, deletions, and/or corrections which you would make?

Thanks in advance for your help.

Accreditation Criteria
Review Factors
Student Affairs

EVALUATION:

How are students evaluated in the (1) pre-clinical and (2) clinical years?

Are definite criteria and/or objectives clearly stated for students prior to a course or clerkship?

What is the grading system? (ie. Grades, Pass-Fail-Honors, etc.)

Do students feel there is enough (adequate) feedback from their instructors, especially on the clinical clerkships?

How are National Board Scores used at the school? Are they required for promotion or graduation?

Are students permitted to review and/or correct their written evaluations?

Are students given the opportunity to offer feedback on a course or clerkship? What mechanism is established so that this feedback can be used to modify the courses?

TEACHING:

Are there adequate tutorial programs for students who need remedial work? Are there summer remedial courses?

Are the students happy with the mode of teaching? ie. would they prefer to have more of one type than another?

Is there opportunity for self-instruction? Are there any computer courses?

Do the students feel their time could be better spent in some other type of study or learning activity than they are offered at present?

Are advisors assigned or arranged for each student? During the pre-clinical years? During the clinical years? Is there a post-graduate counseling system?

Are there areas in the curriculum which the students feel should receive more or less time? eg. Nutrition, human sexuality

Is there a course/clerkship in primary care/family practice?
Is it required of all students? Is it integrated or part of the
Family Practice post-graduate program at the University?

How much of the pre-clinical and clinical years are offered as
"elective" or "option" time?

Are there adequate conference room facilities on the clinical
services?

Do the residents take an active and adequate part in the teaching
program?

Do students on internal medicine and pediatrics (especially) work
on general wards or in sub-speciality rotations?

Is there any organized exposure to the out-patient and emergency
room services?

Are student:patient ratios small enough to allow an adequate
teaching/learning experience?

In the obstetrical rotation, do students deliver enough babies?

Is there a combined MD-PhD program?

How is the curriculum evaluated at the school? Do students have
input to this process? Is the "process" actually influential in
bringing about needed changes?

FACILITIES:

Is there adequate student housing?

Are the on-call rooms on the wards adequate? Do they also pro-
vide rooms for female students?

Are there adequate and convenient athletic facilities for the
students? Are these facilities open at times when students can
use them?

Is there a student lounge?

Are there adequate cafeteria and eating facilities? Do students
get a free meal when on-call?

Is the library adequately supplied and does it provide study
space for students?

Are the lecture halls adequate? Are labs adequate in size and staff?

Are there adequate student health care facilities? Do students pay a health service fee? Is it required?

Is there adequate student parking? Is there convenient public transportation to out-lying hospitals where students have clerkships?

Is psychiatric care and counseling available?

FINANCIAL AID:

What was the amount of financial aid requested last year? How much financial aid was actually provided?

Are there adequate work-study programs at the school?

MINORITIES AND WOMEN:

What is the percentage or total # of minority students in the school and in each class? What is the ratio of male:female students?

Does the school have an active and effective recruiting system in academic "trouble"?

Do women feel that they are excluded from certain specialities?

Do women feel there is discrimination overt/covert against them and do they have some means of rectifying the situation?

Are there child-care facilities at the school?

Is the curriculum flexible enough to allow a student time off without being penalized? Does the student have to miss a whole year if he/she takes time off?

Is there a dean or office for minority and/or women's concerns?

Are facilities for women (ie. rest rooms, on-call rooms, etc.) equal to those for men and are they adequate?

Are women with children accepted?

Is there adequate female student health care?

ADMINISTRATION:

Are students given seats with vote on the school's committees? eg. curriculum, exams and evaluation, judicial council, admissions, etc.?

Is there a student council or student government?

Do students have a voice in the selection process for department heads and new administrators?

How is the admissions process handled at the school? Do students have input?

Is there any attempt to integrate the clinical and pre-clinical sciences in the first years?

Do students feel they are asked/required to do too much "scut" work? ie. drawing blood, running for blood, starting IV's, other routine lab work?

How do the students feel about their school? What are their major criticisms?

What speciality fields do the students at the school eventually go into? ie. % in Surgery, Medicine, Peds, Family Practice, OB-GYN, Pathology, Anesthesiology, etc. A breakdown of this information for the past 2 or 3 years would be helpful.

Is the student body heterogeneous? How many states and colleges are represented in the freshman class?

Are students required to do a research project and/or paper for graduation?

Is time set aside in the curriculum for teaching of such things as medical economics, ambulatory medicine, public health, preventative medicine social aspect of medicine, and legal medicine?

Is time devoted to ethical and moral issues in medicine? Are students required to participate in such courses?

What is the distribution of undergraduate majors in the freshman class?

Is credit given for courses taken in other departments of the university? Is there cross-registration?

Are medical students, nursing students, physicians assistants, etc. taught in any formal "team" type courses? How do the students feel about these courses?

Are students taught by physicians whose primary career is in the private or community practice of medicine?

Describe the admissions process. What are the criterion used to select a student?

Does this school participate in COTRANS? Does it accept students in transfer? Does it accept students from other schools for elective courses? Does it charge students from other schools a tuition?

Are students allowed to take elective courses at other medical schools or institutions?

Are students given advanced standing and/or allowed to skip courses if they demonstrate adequate preparation and skill?

Is the academic system such that students may proceed at their own pace?

Are there "tracks" which students may enter for early career specialization?

Report of OSR discussion group on the GAP Report

Thirty students participated in this discussion. We began with a free discussion of the GAP Report itself and of the report of the AAMC Task Force on the GAP Report. Later, we moved into a point-by-point review of the "summary of recommendations" of the AAMC Task Force. A copy of this summary is included with this report, as is the "GAP background material" that was also distributed in advance of our convention.

Our general discussion focused on several concerns. One concern was that the present system of National Boards is a constraining influence upon curriculum, especially in the sense that it encourages a dichotomy of basic science and clinical science. We agreed unanimously that any new system that encourages an integration rather than a separation of these would be preferable, even if not optimal.

Another general concern was that the GAP Report and also the AAMC Task Force Report propose to severely limit the options of medical students and physicians. We felt that a valuable aspect of medicine is its pluralism and flexibility, and that this orientation must apply to licensure as well. But the GAP Report (and, to a lesser degree, the AAMC Task Force Report) aims to force all physicians into a single licensure path.

A third - and related - concern was whether there should be any qualifying exam for entrance into residency. Such an exam, we felt, would render the M.D. degree functionless. Years ago it was decided by the medical profession that the M.D. degree in itself does not qualify a physician for independent practice. Now, the GAP Committee and the AAMC Task Force are saying that it is not even a sufficient qualification for entering graduate medical education. Phrased naively but tellingly, "Won't the M.D. degree mean anything any more?" If a qualifying exam will be required in order to begin a residency, we think not. The suggestion of such a qualifying exam seemed to us to be so illogical and unnecessary from the standpoint of public accountability or educational objectives, that we could only assume that the idea was conceived merely with the intent of being a convenient "solution" to the FMG (foreign medical graduate) issue.

We were aghast at the GAP Report's recommendation that physicians be required to complete their residency training and pass specialty boards before being fully licensed. We were pleased that the AAMC Task Force clearly rejected this view, but were disappointed that the Task Force's stance represents a compromise, in that its recommendation is that physicians complete a "core portion" of graduate medical education in order to be eligible for full licensure. This core portion would probably be two years for most residencies, instead of the present one-year requirement that exists in most states (some require none). We felt that it has never been shown that physicians who have completed just one year of post-M.D. training are not sufficiently competent to be licensed, and recognized that such physicians are presently providing much-needed medical care in many

American communities. The "core portion" stipulation seems inappropriately arbitrary.

We discussed the special impact upon minorities that the present and future licensing exams have. It was felt that because of cultural differences among groups within the population, it is extremely difficult to find or create a single licensing exam that can be fairly applied to all candidates - another argument in favor of the existence of multiple options. It was pointed out that there is a lack of constructive minority input sought for these tests; if anything at all is done, it is generally in the area of deciding what kinds of material to leave out, rather than investigating what might be put in to make the exams fairer.

Our positions, point-by-point, regarding the Task Force's "summary of recommendations," are as follows:

1. We support the Task Force's position on this item.
2. We support the Task Force's position, but we would like the intent to be made more specific. Further, we feel that every exam should be as much of a learning experience as possible for the student, and this end is facilitated by providing feedback to the student that is as specific as possible. Therefore, we recommend that the following two sentences be added to the Task Force's response on this item:

Students should receive their normed scores on these tests, but schools should only be provided with the overall mean score of its students on each test. Furthermore, whenever possible, the data reported to both school and students should be broken down by sub-subject areas, so that areas of relative strength and weakness may be indicated.

3. We support the Task Force's position.
4. We oppose the Task Force's position, and propose the following substitute recommendation:

A qualifying exam should not be made a requirement for entrance into graduate medical education. The M.D. degree itself should remain a sufficient qualification.

5. We support the Task Force's position on limited licensure, but oppose the phrase regarding a qualifying exam. We propose that this recommendation be amended to read as follows:

The Task Force opposes the establishment of such a category of licensure.

6. We support the Task Force's position.
7. We concur in the Task Force's opposition to the GAP Report on this question, but propose that the recommendation be amended to read as follows:

The Task Force recommends that specialty certification be only one mechanism by which individual physicians may gain licensure; it should not be the prime or sole mechanism. The Task Force recommends that physicians should be eligible for full licensure after the satisfactory completion of one year of a graduate medical educational program.

We also recommend that an eighth recommendation be added to the Task Force's Report, to read as follows:

8. The Task Force recommends that the input and review by minority group representatives be obtained for every medical licensing examination.

It is noteworthy that in spite of our many points of agreement with the position of the AAMC Task Force, there was sufficient disgruntlement with it and with the GAP Report itself, that we felt, unanimously, that it would be worthwhile to form a committee of medical students and house staff personnel to study the whole question of evaluation in medical education, and to make suggestions and recommendations with a completely open mind, rather than with a point-by-point reference to the GAP Report.

Submitted by Mark Cannon
(OSR representative,
The Medical College of Wisconsin)

REPORT OF THE AAMC OFFICERS' RETREAT

December 11-13, 1974

Officers Present:

Dr. Sherman M. Mellinkoff (Chairman)
Dr. John A.D. Cooper (President)
Dr. John F. Sherman (Vice-President)
Dr. Ivan L. Bennett, Jr. (Chairman, COD)
Dr. John A. Gronvall (Chairman-Elect, COD)
Dr. Jack W. Cole (Chairman, CAS)
Dr. Rolla B. Hill (Chairman-Elect, CAS)
Mr. Sidney Lewine (Chairman, COTH)
Mr. Charles B. Womer (Chairman-Elect, COTH)
Mr. Mark Cannon (Chairperson, OSR)
Dr. Cynthia B. Johnson (Vice-Chairperson, OSR)
Dr. Kenneth R. Crispell (Distinguished Service Member)

Staff Present:

Mr. Charles Fentress
Dr. H. Paul Jolly
Dr. Richard Knapp
Dr. Emanuel Suter
Dr. August Swanson
Mr. J. Trevor Thomas
Mr. Bart Waldman
Dr. Marjorie Wilson

The retreat of the Association's officers was held December 11-13 at the Belmont Conference Center, Elkridge, Maryland. Individuals invited to attend included the Chairman and Chairman-Elect of the Association and of each Council, the OSR Chairperson and Vice Chairperson, the "coordinator" of the Distinguished Service Members, and the Executive Staff.

The discussion and recommendations of the retreat participants are presented below in the outline format in which each issue was considered.

I. AAMC Organization and Governance

A. COTH Membership Criteria

Membership criteria proposed by a COTH task force had been presented to the Executive Council and referred back to the COTH Administrative Board to provide for the inclusion of affiliated community hospitals having only a family practice residency. COTH representatives felt that a strong commitment to medical education must be shown by a hospital in order to qualify for COTH membership. The view was expressed that the nomination of an affiliated hospital by a dean might be considered to be sufficient evidence of this commitment. The issue of COTH size was also considered, since it was agreed that COTH should never try to include the over 1500 hospitals having graduate training programs and since some deans had previously expressed the view that COTH had grown too large. It was agreed that hospitals having a significant commitment to medical education should not be excluded and that a new task force which would include deans should be appointed to review the mechanics of accomplishing this.

B. Housestaff Representation

The question of including housestaff representation in the Association was discussed by the retreat participants. The OSR had suggested this item, expressing the belief that house officers should have a voice in Association affairs. A number of alternate methods by which house officers could be included in the Association, either as a governing organization such as the OSR, or in a less formal status, were presented.

Since no formal request had been presented to the Association by any group representing house officers and since a representative of the Physicians National Housestaff Association had expressed some opposition to the idea, the retreat participants felt that no action should be taken at this time. They specifically indicated that the AAMC should avoid, at all costs, giving recognition to any group which might function as a union. In discussing further alternatives, it was emphasized that if residents were to be included, the Association should seek only to represent them as teachers and students. Employee interests of house officers should never be served through the AAMC.

Doctor Bennett expressed the strong feeling that the Association should observe the housestaff situation, waiting until employee issues, which dominate the house officers' interests, calm down. He also felt that the AMA/housestaff relations should be observed for a period of time.

The retreat participants agreed that formal housestaff representation should be postponed, but that the Association should seek qualified housestaff input to appropriate committees and explore the possibility of having the deans or program directors invite house officers to the annual meeting.

C. Report of the Task Force on Groups

A task force of the Executive Council had been appointed to consider the appropriate role of the five existing groups within the AAMC, the most desirable relationship of the groups to the staff and to the Councils, and the appropriate level of staff and financial resources which should be devoted to supporting groups. The task force's report supported the existing organizational structure and allocation of resources. It went on to recommend a formal mechanism by which groups could recommend items to be considered by the Executive Council and the constituent Councils.

The retreat participants expressed their full support for the recommendations of the task force and agreed that the task force report should be circulated immediately to the group chairmen with invitations to the January meeting of the Executive Council.

D. Distinguished Service Members

Doctors Mellinkoff and Crispell discussed the first meeting of the Association's Distinguished Service Members which had been held at the annual meeting in November. The minutes of this meeting were distributed for information.

The retreat participants felt that the role which had been identified by the Distinguished Service Members was appropriate and should be pursued with enthusiasm. It was also agreed that some limit on the size of this group be sought in discussions with the Councils which recommend their election. It was also felt that editorials for the Journal of Medical Education should be sought from members of this group.

II. Relationships with Other Organizations

A. CCME, LCME and LCGME

The retreat participants discussed the general structure and function of these three bodies and then addressed specific issues raised in the retreat agenda. It was agreed that Dr. Cooper should be appointed as an AAMC representative to the CCME. It was also felt that expansion of the LCME membership, beyond the current AMA-AAMC composition, should be addressed on the merits of participation by other organizations and should not be handled as a political question. Strong feelings were expressed that at least one, and maybe all of the additional groups being proposed, should not be added on the merits of their contributions to the accreditation of undergraduate medical education.

The question of staffing the CCME was discussed but it was felt to be an issue which should not be confronted until some problem arose regarding the staffing by the AMA. It was also felt that the question of which policies should be forwarded to the CCME and which policies should be considered independently by the AAMC should be addressed on an individual issue-by-issue basis.

B. Association for Academic Health Centers and Federation of Associations of Schools of the Health Professions

Relationships with groups representing schools of other health professions were reviewed. It was agreed that the Association's close liaison with the AAHC should be continued as in the past. Special relationships with groups representing dentistry, nursing and public health were strongly supported. It was felt that the Federation should only serve as a forum for discussion and should not be used to advance positions on national legislation.

III. Staff Activities

A. Resource Allocation

Doctor Sherman reviewed in detail the process by which the staff was attempting to identify component activities and assign dollar allocations on an actual time and dollars spent basis. He outlined the methodology for this process which included the establishment of a Program and Budget Review Committee and would eventually include a system of evaluation of each of the component staff activities. The retreat participants were presented with an array of 148 distinct activities, along with a description of each and the number of person years devoted to each. Doctor Sherman also presented the dollar allocations devoted to four of the aggregate categories of activities, as well as an array of the percentage of Association manpower being assigned to each general classification.

The retreat participants supported the concept of the program budgeting and expressed the view that this activity would be more useful as an internal educational tool than for any other purpose. It was stressed that the figures would never be accurate and should not be relied on too heavily. Mr. Lewine indicated that if the figures were within ten percent of the actual numbers, the Association would be doing well. He also expressed a strong feeling that any attempt to determine priorities through a mechanism of program assessment would be futile.

The mechanics of the study were reviewed and the feeling expressed that the personnel figures presented needed to reflect dollar expenditures and not simply person years. The treatment of Federal Liaison activities by including them in the substantive areas was supported.

Doctor Bennett reminded the retreat that priorities must also be looked at in terms of which activity, when reduced, will save the most dollars. This meant that a decision to cut back an activity would be meaningless unless the number of people and/or the travel funds could be reduced.

It was agreed that the January Executive Council meeting would be presented with the process being undertaken. Representatives of each Council would be asked to assess the expectations of the Council members regarding this display and its ultimate effect on the setting of priorities. The retreat participants also discussed inconclusively the concept of asking a management consultant to work with the Association on this activity.

B. Space Requirements

Doctor Cooper and Mr. Thomas discussed the activities of the Building Committee, the expanded space requirements of the Association, and the Washington, D.C. real estate market. The Building Committee had recommended that the staff actively seek either the outright purchase of an existing facility or the leasing, with option to buy, of office space where the staff activities could be consolidated. Mr. Thomas indicated that market conditions in the Washington area were extremely unfavorable to this type of action. It was recommended that the AAMC continue to lease space at One Dupont Circle and elsewhere as needed. More favorable market conditions are anticipated within two to three years.

The retreat participants concurred in this recommendation, adding that it would be psychologically disadvantageous to purchase office space at a time when general economic conditions affecting the constituency were so restricting.

IV. Physician Production and Distribution

A. Federal Support of Medical Education

The retreat participants reviewed the steps which had been taken since the meeting of the Assembly to reconsider the Association's position on health manpower legislation. They agreed with the appointment of a Task Force on Health Manpower, chaired by Dr. Daniel Tosteson, and reviewed the questionnaire which had been sent to the full AAMC membership. It was felt that the substantive consideration of health manpower policies should be left to the task force with recommendations to come before the Executive Council.

In anticipation of the task force report, it was recommended that meetings be arranged with potentially influential individuals. The discussion then turned to suggestions of people who would be appropriate contacts with House and Senate leaders. It was also suggested that deans and hospital directors be encouraged to visit nearby, underserved areas to establish the basis for future outreach programs.

B. Output and Adequacy

The question of expanding and improving staff activities in the area of assessing the output and adequacy of physician supply was discussed. The retreat participants felt that the two issues should be separated--that output measures and predictors be improved, but that any attempts to measure adequacy be dropped. It was recommended that staff stay aware of studies of needs conducted by others and to also be familiar with the methodologies used. The maintaining of a bibliography of such studies was recommended.

It was also recommended that the schools be encouraged to analyze their local areas and work within these regions to alleviate identifiable shortages. It was felt, however, that any Association statement relating to physician needs of the Nation would fail to convince Congressional leaders that shortages do not exist and that more physicians are not the solution.

C. Specialty Distribution

The retreat discussed various proposals which had been advanced to regulate and reallocate residency training positions. In particular, they reviewed the proposal contained in the House health manpower legislation which would designate the CCME as the body to regulate both the numbers of residency programs and their distribution by specialty.

It was generally felt that by enforcing stricter accreditation criteria, the number of residencies could be reduced to an acceptable amount. In addition, the introduction of a uniform qualifying examination would limit the demand for marginal residency programs. It was felt that these qualitative controls should be attempted before any absolute limits were placed.

On the issue of supporting the particular provisions of the House bill, the retreat did not reach a consensus. It was generally agreed that the development of an Association policy on this should be the work of the Task Force on Health Manpower. The political expectations of both Mr. Rogers and Senator Kennedy in this area were discussed. It was agreed that any discussions with them should emphasize the overall approach of changing the income differences of primary care physicians and specialists through a national health insurance mechanism.

D. Geographic Distribution

The retreat participants briefly considered an appropriate position on geographic distribution and again felt that specifics of this issue relating to legislation should be reviewed by the Task Force on Health Manpower. They reiterated their support for voluntary programs by which the schools and hospitals would work within their regions to alleviate manpower problems. In addition, support was expressed for a tracking program by which the Association would assist the schools to develop a data base tracing ultimate career and residence choices of their students.

V. Replacement of NIH Director

It was reported that the Washington Post had just published a story saying that NIH Director, Dr. Robert Stone, had been asked to resign. A general discussion of the process by which the NIH director would be selected ensued and strong feelings were expressed that this not be a political appointment. It was agreed that the Association would ask that a career NIH'er be appointed as the director and would specifically request that the new director be someone with scientific qualification who could provide continuity of leadership.

VI. Consideration of the House Health Manpower Bill

During the course of the retreat, Dr. Cooper was informed that Mr. Rogers' health manpower bill had passed the House under a suspension of the rules by an overwhelming margin. The specific provisions of this bill were reviewed with the retreat participants and it was felt that if Mr. Rogers would agree to modifying several provisions of his bill in conference, the Association would support his bill and ask the Senate to go to conference. Provisions singled out for modification were mandatory service, enrollment increase waivers, and the requirement that 25 percent of capitation money be spent in remote educational sites.

VII. Study of Medical Practice Plans

Doctors Cooper, Sherman and Jolly reviewed a proposed study of practice plans in effect in all U.S. medical schools. The sensitivity and viability of the study were reviewed by the retreat. Although the retreat participants agreed that this information would be useful to the Association in establishing credibility on matters of medical school financing, it was strongly felt that this would be information which the schools and the faculty members would be reluctant to divulge. In some cases, individual salary information was not even available to the institutions.

It was agreed that a qualitative study of the practice plans themselves would be acceptable, but a quantitative study of how much medical practice income is involved would be impractical.

VIII. Multimedia Learning Materials Project

Doctor Swanson reviewed the Association's collaborative activities with the National Library of Medicine in the area of cataloging and evaluating multimedia learning materials. One component of this project was to identify areas in which improved multimedia educational materials are needed. As a follow-up to this activity, the Association conducted a feasibility study of establishing a Multimedia Learning Advancement Program as a mechanism for the Association to develop the capability of influencing the production and distribution of these materials.

Support for this project would be sought from foundations and the Federal agencies. Approximately \$500,000 per year would be needed to support the Association's core activities exclusive of any project support. Doctor Swanson described the feedback loop which would enable the program to become self-supporting once distribution of the materials began.

The retreat participants agreed that this was a worthwhile project and that the Association should proceed to explore the possibility of generating outside funding. Caution was recommended over accepting a large portion of the funding from any agency which provides support for other Association activities. It was felt that these other activities should not be jeopardized in order to develop the substantial support required by this program.

IX. 1975 Annual Meeting

Doctor Mellinkoff suggested that the theme of the 1975 annual meeting be "Quality in Medical Education and Care." The retreat participants agreed but felt that it should be modified to cover only "Quality in Medical Education." By narrowing the theme in this way, the "continuum of medical education in the post-Flexnerian era" could be considered.

A format by which one plenary session would be devoted to this theme and one plenary session devoted to political speakers and issues was accepted. It was also agreed that the Assembly meeting should come earlier in the week and that the joint Council program should follow the final plenary session.

X. National Health Insurance and Its Effect on Medical Education

Doctor Mellinkoff proposed that the Association might wish to appoint a task force to look specifically at the educational component of national health insurance and to recommend provisions which might optimize the effect that national health insurance would have on medical education. It was suggested that each council might wish to have a task force to consider these broad questions with some provision made for coordination. The retreat participants agreed that further consideration of this would take place at the January meeting of the Executive Council.

CALENDAR OF 1975 OSR REGIONAL MEETINGS

<u>REGION</u>	<u>DATES</u>	<u>LOCATION</u>	<u>CONTACTS</u>
South (Joint with GSA, AAHP)	March 23-26	Hyatt House Winston-Salem, NC	Local Host: C. Douglas Maynard Bowman Gray Program Chairman: Suydam Osterhout Duke
West (Joint with GSA, AAHP)	April 6-8	Asilomar Pacific Grove, CA	Chairman: John P. Steward Stanford Program Chairman: Martin A. Pops UCLA
Northeast (Joint with GSA)	April 20-23	Motor House Williamsburg, VA	Chairman: James L. Curtis Cornell
Central (Joint with GSA, AAHP)	May 1-3	Clayton Inn St. Louis, MO	Chairman: John C. Herweg Washington-St. Louis