

OSR ADMINISTRATIVE BOARD AGENDA

Conference Room
One Dupont Circle
Washington, D.C.

January 12 and 13, 1976
9:00 a.m. - 4:00 p.m.

- I. Call to Order
- II. Consideration of Minutes
- III. Report of the Chairperson
- IV. ACTION ITEMS
 - A. Executive Council Agenda
 - B. Nominations for AAMC Committees 1
- V. DISCUSSION ITEMS
 - A. Orientation to AAMC
 - B. Curriculum and Evaluation
 - C. Discrimination Against Students with Service Commitments 7
 - D. Housestaff Issues 8
 - E. Health Manpower Legislation 18
 - F. Medical Student Stress 21
 - G. NIRMP and the Transition from Undergraduate to Graduate Medical Education 42
 - H. Women In Medicine 43
- VI. INFORMATION ITEMS
 - A. AAMC Activities Related to Primary Care Education
 - B. Non-Cognitive Assessment Program
 - C. OSR Accreditation Pamphlet 56
 - D. Reg. Mtg.*
- VII. OLD BUSINESS
- VIII. NEW BUSINESS
- IX. ADJOURNMENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

September 17, 1975
AAMC Headquarters
Washington, D.C.

Chairperson
Vice-Chairperson

-- Mark Cannon
-- Cindy Johnson

Regional Representatives

-- Stevan Gressitt (Southern)
-- Richard Seigle (Western)
-- Frederick Waldman (Northeast)

Representatives-at-Large

-- Serena Friedman
-- Stanley Pearson
-- Elliott Ray

AAMC Staff

-- Robert Boerner
-- John A.D. Cooper
-- Paul Jolly
-- Joseph Keyes
-- Julie Lambdin
-- Diane Mathews
-- August G. Swanson

Guests

-- John Barrasso
-- Laurel Cappa
-- Robert Nickeson

I. Call to Order

The meeting was called to order by Mark Cannon at 9:30 a.m.

II. Consideration of Minutes

The minutes of the June meeting were approved as distributed.

III. Chairperson's Report

Mark Cannon reviewed with the Administrative Board the actions taken at the June Executive Council meeting. He reported that the proposed amendment to the AAMC Bylaws which would allow participation in the OSR by two students from schools with an Administrative Board member was approved and forwarded to the Assembly for action at the Annual Meeting.

At the Executive Council meeting, Dr. Cooper outlined the various activities related to women's affairs being undertaken by the Association divisions and departments. Impetus for the discussion of this issue stemmed from an OSR resolution that AAMC create an office of women's affairs. It was the conclusion of AAMC staff that rather than duplicate the efforts being carried out in the various parts of the Association, a more efficient means of creating an identifiable focus would be for the President's office to function as a clearinghouse to refer inquiries and communications about women's affairs to the appropriate department or division. The board members expressed the concern that this solution may prove to be inadequate in terms of providing a national focus for women's issues and requested that Mark continue to ask for feedback from the Executive Council and staff about whether the decentralized approach is an effective way to address this issue.

Mark brought to the attention of the board the suit which medical students from George Washington have filed against the medical school to block tuition increases. The GW medical students are filing the suit on the basis of breach of contract since the school catalogue indicated an approximate tuition increase of \$200 and tuition was raised from \$3200 to \$5000.

At the GSA Steering Committee, the OSR resolution about admission of students from areas of physician shortage was discussed and forwarded to the GSA business meeting at the Annual Meeting for information. Mark also reported that he presented a proposal for a project to study the psychological environment of medical education to the Steering Committee for their consideration (See Addendum 1). The board reviewed the proposal and agreed with the concept of a project aimed at increasing the awareness, both at the local and national level, of the impact the medical school environment has on medical students. Some board members thought, however, that the project outline as conceived was too broad and required an unrealistic amount of institutional support and interest. While the general objectives of such a project were deemed beneficial, the board decided to reach a final decision about the proposal after the joint OSR/GSA program on stress at the Annual Meeting.

Mark distributed to the Administrative Board a letter from him to Dr. Cooper expressing his concern about the manner in which AMCAS and MCAT fees are determined. Mark explained to the Administrative Board that the basis for his concern was the accounting procedure used to determine indirect costs which are charged to student services. Mark indicated that while he understood that this procedure was a legal and commonly-accepted method for determining indirect costs, he questioned whether it was appropriate for premedical students' application fees and testing fees to include overhead costs which may not be directly related to the operation of MCAT and AMCAS.

There was a considerable amount of discussion about this issue. Some board members agreed in principle with Mark's concern and advised him to raise the points outlined in the letter with the Executive Council. Others said that this should not be done because they felt that present fees are reasonable and that the amount of any decrease would not be great enough to warrant pursuing the issue further.

ACTION: On motion, seconded, and carried the OSR Administrative Board requested that concerns about the procedure for determining MCAT and AMCAS fee levels be referred to the Executive Council for further discussion and clarification.

IV. Executive Council Agenda

A. Ratification of LCME Accreditation Decisions

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommendation that the Executive Council approve the LCME accreditation decisions.

B. LCME Procedures for Levying Charges to Schools for Early Stage Accreditation Site Visits and Provisional Accreditation

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the principle of the LCME levying charges for a Letter of Reasonable Assurance site visits to developing medical schools.

C. LCME Voting Representation of the ACMC

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommendation that a representative from the Association of Canadian Medical Colleges be seated as a voting member of LCME.

D. Election of Institutional Members

ACTION: On motion, seconded, and carried, the OSR Administrative Board supported the recommendation that the University of South Florida College of Medicine and Southern Illinois University School of Medicine be elected to Institutional Membership in the AAMC by the Assembly.

E. Election of CAS Members

ACTION: On motion, seconded, and carried, the OSR Administrative Board supported the recommendation of the CAS Administrative Board regarding the election of CAS members to AAMC membership.

F. Election of Individual Members

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommended list of people for election to Individual Membership.

G. Election of Emeritus Members

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the list of recommended individuals for election to Emeritus Membership.

H. Amendment of the AAMC Bylaws to Establish a Category of Corresponding Members

ACTION: On motion, seconded, and carried, the OSR Administrative Board supported the recommended amendments to the AAMC Bylaws to establish a category of corresponding members.

I. Flexner and Borden Awards

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the nominations by the Flexner Award Committee and the Borden Award Committee for the recipients of these awards.

J. The Role of the Foreign Medical Graduate

The OSR Administrative Board discussed the staff recommendation that AAMC take exception to the portion of the CCME report which provided for the continuation of the Fifth Pathway Program. The board questioned the appropriateness of discontinuing the Fifth Pathway Program before U.S. medical school enrollment has increased to the extent that the U.S. is basically self-sufficient in terms of physician manpower. Mr. Keyes explained that the recommendation to not approve the continuation of the Fifth Pathway Program was based upon the conviction that all individuals entering the mainstream of U.S. medical practice should have received the M.D. degree. The Fifth Pathway Program enables students who have completed the didactic portion of medical education abroad and a nine-month clinical clerkship in a U.S. teaching hospital to practice medicine in some states without ever having received an M.D. degree.

The Administrative Board expressed the view that Recommendation B-6 stating that both FMGs and USMGs should complete two or more years of supervised graduate medical education before being eligible for licensure in any state should not be approved by the Executive Council. It was the consensus of the Administrative Board that the CCME Report is not the appropriate document for stipulating the length of graduate training programs. In addition, the board reasserted the view expressed in discussions about the GAP Report that students should not be required to spend more than one year in graduate training to be eligible for licensure.

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the CCME Report on Foreign Medical Graduates with the exception of recommendations B-6, B-11, and C-6. The OSR Administrative Board recommended that, in light of steps being taken to decrease the flow of FMG's into the U.S., AAMC continue to support efforts for increased U.S. medical school enrollment.

K. Report of the National Health Insurance Task Force

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the Report of the National Health Insurance Task Force.

L. Recognition of New Specialty Boards

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommended statement that authorization for the formation of new specialty boards and the development of accreditation programs for new specialties must be the responsibility of the CCME.

M. Modification of "Recommendations of the AAMC Concerning Medical School Acceptance Procedures"

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the GSA statement on the Early Decision Plan for inclusion in the "Recommendations of the AAMC Concerning Medical School Acceptance Procedures."

N. Proposed Recommendations of the AAMC Concerning the College Level Examination Program

ACTION: On motion, seconded, and carried, the OSR Administrative Board supported the Proposed Recommendations of the AAMC Concerning the College Level Examination Program.

O. AAMC Response to the Principal Recommendations of the GAP Committee Report to the NBME

During a discussion of this document, several board members expressed disagreement with certain portions of the AAMC's response to the GAP Report. It was pointed out by Mark Cannon and Dr. Cooper that endorsement of the response by the board would indicate that they agreed that the document was an accurate summary of the Executive Council's deliberations and not that the board agreed with every point. Since the AAMC response reflects a consensus of several constituent bodies, it is unlikely that any one council or group would completely agree with the entire response.

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the AAMC Response to the Principal Recommendations of the GAP Committee Report to the NBME.

P. Planning Agency Review of Federal Funds Under the Public Health Service Act

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommendation that the Executive Council approve the report.

Q. Recovery of Medicaid Funds and Sovereign Immunity

ACTION: On motion, seconded, and carried, the OSR Administrative Board recommended that the AAMC neither support nor oppose S. 1856.

R. U.S. Citizens Studying Medicine Abroad

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the recommendations about U.S. Citizens Studying Medicine Abroad subject to a revision of the third paragraph of Recommendation #2 to read, "In order to diminish the flow of students seeking access to

medicine by enrolling in foreign schools there should be a consensus that students enrolling in foreign schools after July 1, 1977 must meet the same criteria as other candidates seeking advanced standing admission to U.S. medical schools, and COTRANS should be phased out on a compatible schedule."

V. Financial Aid Survey Preliminary Results

Julie Lambdin, Research Associate in the AAMC Division of Student Studies, provided for the board preliminary results of the survey distributed in spring of 1975 of how students finance their medical education. A summary of those preliminary results is attached as Addendum #2.

VI. OSR Annual Meeting Plans

The Administrative Board finalized plans for OSR Annual Meeting Activities (See Addendum #3). In addition to the November 2 joint GSA/OSR program about medical student stress, the board agreed that discussion sessions should be planned for the morning of Monday, November 3 which will focus on various aspects of student stress. Staff will contact the speakers who are participating in the program session in order to arrange for discussion leaders for these sessions.

VII. OSR Accreditation Pamphlet

The board reviewed and approved a draft of the text of the proposed OSR Accreditation Pamphlet. (See Addendum #4). It was pointed out that in addition to these two sections there will be a short introduction and a list of suggested items for consideration which will be a distillation of the list prepared earlier in the year by Dan Clarke-Pearson and Serena Friedman. The pamphlet was referred to the Council of Deans Administrative Board for approval and to the OSR for information at the Annual Meeting.

VIII. Scholarship Programs with Service Commitments

Anecdotal data which has come to the attention of the OSR Administrative Board suggests that residency programs may discriminate against applicants to Post Graduate Year I who are participating in National Health Service Corps, military scholarship programs, and other programs involving a service commitment. The OSR Administrative Board agreed that in order to assess whether service commitments are viewed by program directors as a detrimental factor in the residency selection process, data should be collected. Staff will work with Richard Seigle in developing a proposal for a survey to explore this issue.

IX. Old Business

At the June Administrative Board meeting, Mark Cannon presented a statement reflecting his view of the Association's amicus curiae brief filed with the National Labor Relations Board. The Administrative Board voted to take no action on the statement at their June meeting, but a revised version (Addendum #5) was reintroduced for consideration at this meeting.

ACTION: On motion, seconded, and carried, the OSR Administrative Board approved a statement regarding the amicus curiae brief filed by AAMC with the National Labor Relations Board and referred the statement to the Executive Council.

In a related discussion, the Administrative Board considered a motion to establish an OSR committee on housestaff relations which would develop a proposal for housestaff representation within the Association. Several board members felt that until a decision is reached by NLRB on the issue of housestaff unionization, further consideration of housestaff representation in AAMC would not be productive.

ACTION: On motion, duly seconded, a proposal to create an OSR committee on housestaff relations was defeated.

X. New Business

Fred Waldman presented to the Administrative Board a proposal for a survey of housestaff designed to collect objective information on residency programs. The purpose of such a survey would be to provide medical students with more complete information about various programs to assist them in making choices about graduate training. The Administrative Board requested staff to distribute the survey on a pilot basis to OSR representatives in the Northeast Region who would in turn collect information from housestaff at their affiliated hospitals. After completion of the pilot study, the board will be better able to determine the usefulness of a similar national survey.

XI. The meeting was adjourned at 5:30 p.m.

STUDENT NOMINEES FOR AAMC COMMITTEES

The following committees currently have openings for student representatives:

Data Development Liaison
Flexner Award
GSA Committee on Financial Problems of Medical Students
GSA Committee on Medical Education of Minority Group Students
GSA Committee on Medical Student Information Systems
GSA Committee on Professional Development and Advising
Committee on International Relations in Medical Education
Health Service Advisory Committee
Resolutions Committee

The following students have expressed interest in serving on an AAMC committee:

Bell, David M., Class of 77, Harvard Medical School, Committee on International Relations in Medical Education

Current representative on CIRME; OSR representative since 1974-75. Attended 1974 and 1975 Annual Meetings and 1975 regional meeting. Special Qualifications: "I am currently actively involved in on-going projects of the committee. I have gradually learned where the real problems, loopholes, and red herrings are, as well as where the real power is. I have been involved in designing the international health course and have insisted on a heavy emphasis on local customs for students who are planning clerkships abroad. (This was not done in the past.) AAMC was planning an exchange program with Saudi Arabia until I pointed out that the Saudi Arabians have refused to permit Jews to enter the country in the past and were not guaranteeing to lift this restriction for our program. Consequently, plans for the AAMC program have been tabled. I am, however, agitating for more student exchange programs and am trying to find sources of funding for these programs.

I have a strong interest in international health problems. I have spent a year in France and Germany studying health economics, African politics, and political philosophy involving much contact with Arab, African, and Asian students (from former French colonies) with whom I continue to correspond. I speak French fluently, fair German, and am learning Spanish. I have also participated in an international health seminar at the Harvard School of Public Health. I shall take clerkships in rural Guatemala and in France, and am planning a career in infectious disease with special attention to international health.

Bernstein, Robert, Class of 77, University of Connecticut School of Medicine, Committee on International Relations in Medical Education

Current OSR Rep-at-Large; OSR representative since 1974-75. Attended 1974 and 1975 Annual Meetings and 1974 regional meeting. Ph.D. in biochemistry and post-doctoral research in neuropharmacology. Special interests include the pertinent concern about the need for the development of a U.S. health care delivery system. Special Qualifications: "For the past two years I have participated in a seminar on Cross-National Studies of Health Care Delivery which includes the continuum of education of professions, super-structure of health care (social, political, and cultural), and the financing and implementation of health care systems in an attempt to draw unifying principles from comparative studies of various national approaches to preventive and curative measures of health care delivery."

Diamond, David V., Class of 78, Brown University, Program in Medicine, GSA Committee on Medical Student Information Systems

X
OSR alternate representative 1974-75, OSR representative 1975-76. Attended Annual Meeting in 1975. AMSA member and AMSA news service liaison; founder and editor of SYNCYTIUM (student monthly newsletter); member of Committee on Community Relations of medical student council; programmer for college radio station (WBRU). Special Qualifications include a "continuing interest and ability to develop, maintain, and advocate those channels of information exchange which I see necessary to improve the coordination of, cooperation between, and understanding amongst the individuals in those organizations of which I am a member."

Frumin, Fred, Class of 77, Wayne State University, Health Service Advisory Committee

OSR alternate representative 1974-75, OSR representative 1975-76. Attended Annual Meeting in 1974 and 1975 and regional meeting in 1975. Special interests include social, cultural, and political trends and ideas and study in economics and alternative ways of sharing in society's resources. Special Qualifications: two periods of preceptorship with primary care physicians in an underserved area of Detroit and the Upper Peninsula of Michigan. Past research projects include study of specific areas of primary care and community health resources and delivery of health care.

Hardt, Nancy, Class of 77, Loyola University of Chicago, Stritch School of Medicine, GSA Committee on Medical Student Information Systems, GSA Committee on Professional Development and Advising

OSR alternative representative 1974-76. Attended 1974 and 1975 Annual Meeting and 1975 regional meeting. Class Secretary 1974-75, Admissions Committee-Full voting member 1975-77, Course Evaluation Committee 1975, Curriculum Revision Committee 1975. Special Qualifications: "I think my main qualification is a sincere interest in OSR as manifested by attendance at three consecutive meetings. I think I have sufficient understanding of the organization that I can now make a significant contribution as a committee member."

Harper, Richard J., Class of 77, University of Cincinnati, Committee on International Relations in Medical Education

OSR alternative representative 1974-75, OSR representative 1975-76. Attended 1975 regional and Annual Meeting. Member of Curriculum Committee and Admissions Committee at University of Cincinnati, Executive Committee at Cincinnati General Hospital. President, Medical Student Council. Special Qualifications: "As a Peace Corps volunteer (West Indies), as an undergrad (Stanford-in-Italy) and in my personal travel (South America, Europe, Asia Minor, Central America, and 48 states), I feel that the United States is educationally isolated; this seems especially true in medical education. Mature medical educators around the world clearly have much worthy of exchange."

Helm, Stan, Class of 77, Tufts University School of Medicine, Health Service Advisory Committee

Current member of Health Service Advisory Committee. Attended 1974 Annual Meeting and 1974 regional meeting. Tufts Committee on Primary Care Education. Past work for DHEW on evaluation of Medicaid. Special Interests include "primary care, stemming from undergraduate thesis work and volunteer activities. With a particular regard to this committee, I feel that important steps can be made to make NHSC programs more attractive to current participants and that by working with the Director of NHSC we can take some important steps to improve the quality of the NHSC experience and possibly affect physician distribution. . . I strongly believe that people will provide the best medical care when they are doing what they wish to do and that it is only by increasing exposure to primary care that increasing numbers will go into it with the attitudes which our patients deserve. Because I wish to see the current efforts continue and expand, I would appreciate being reappointed to this committee."

Jacobson, Mark L., Class of 78, University of Minnesota at Minneapolis,
Committee on International Relations in Medical Education

Member of AMSA. Currently on AMSA Committee on Legislative Affairs. University of Minnesota Student Council. Special Qualifications: "I am particularly interested in international medicine as a career. I spent three weeks in Africa last August during which I was visiting medical facilities and meeting with physicians in Ethiopia and Tanzania. I would like to work more toward getting electives in international health available. I am particularly concerned that we as American physicians need to be more aware of medicine as it is practiced in other parts of the world. This would include an understanding of the international interrelationships of health care."

Long, Adrian E., Class of 76, University of North Carolina, Data
Development Liaison

Attended 1975 Annual Meeting. President, University of North Carolina Student Body, Member-Student Faculty Advisory Committee, Human Values in Medicine Committee. Special Qualifications: "Interest and concern for applicants to various levels of the medical hierarchy having adequate information on which to make a rational decision as to the best programs available for them--be they medical school or housestaff applicants."

Ludmer, Charles H., Class of 78, Northwestern University Medical
School, Journal of Medical Education Editorial Board, Resolutions
Committee, GSA Committee on Financial Problems of Medical Students

Current OSR representative. Research Associate-Dept. of Anatomy. Ph.D. in Electrical Engineering. Hamilton Watch Award from University of Illinois College of Engineering. Previous experience as Editorial Asst. in the Engineering Publications Office at University of Illinois; Director of Technical Writing-Grubb, Graham, & Wilder, Inc.; free-lance technical writing and editing since 1969. Participated in the joint University of Illinois-University of Colorado B.U.I.L.D. Educational Development Program, Sloan Foundation and Kettering Foundation supported programs within University of Illinois dealing with the content of educational programs and the demands of society.

Meade, William, Class of 77, Hahnemann, GSA Committee on Professional
Development and Advising

Current OSR representative. President, Student Institute-Hahnemann. Special interests include National Board Exam, its relevance, and its use of internship letters.

Pittenger, Joyce A., Class of 77, University of Kansas Medical Center, GSA Committee of Financial Problems of Medical Students

Current member of GSA Committee on Financial Problems of Medical Students. Attended 1974 and 1975 Annual Meeting and 1975 regional meeting. Special interests include support for service scholarships, keeping in touch with the needs and problems of medical students and their concern for their financial future.

Repke, John, Class of 78, New York Medical College, Committee on Admissions Assessment

✓ Current OSR representative. Attended 1975 Annual Meeting. Special interests include New York Medical Student Senate, coordination of tour guides for interviewees, freshman orientation. Special Qualifications: 1974 graduate of Georgetown University. "I feel that I have a good grasp on the problems that are facing today's admissions process and hope to use my own experience, based on many talks I've had with both medical and pre-medical faculty, to make medical school admissions a fair, efficient, and hopefully an inexpensive process."

Smith, Ian Douglas, Class of 78, Medical University of South Carolina, Journal of Medical Education Editorial Board

Current OSR representative. Special Qualifications include news editor college paper; worked as Director of Public Relations for an educational agency. "I am a newcomer to OSR; service on this committee would quickly give me a perspective on issues confronting medical education."

Taylor, Derrick, Class of 78, Boston University School of Medicine, GSA Committee on Medical Education of Minority Group Students

OSR representative 1974-75 and 1975-76. Special interests include increasing application and improving medical counseling for minority students. Special Qualifications: "I am presently a member of SNMA chapter subcommittee working with the Office of Minority Affairs in our school's admissions committee. I have worked three years on the admissions committee at my undergraduate school (Johns Hopkins) while matriculating there. My main task on the committee was to recruit minority students into the university."

Wilkinson, William H., Class of 78, Albert Einstein College of
Medicine, GSA Committee on Medical Education of Minority
Group Students

Current member of American Sociological Association
Society for Study of Social Problems, Society for
Applied Anthropology, Assn. for the Study of African-
American Life and History, SNMA, Bronx Health Manpower
Consortium. Past Chairperson, Black Studies Program,
Dartmouth College, Past Counselor, Committee for the
Collegiate Education of Black Students (CCEBS),
University of Massachusetts.

DISCRIMINATION AGAINST STUDENTS WITH SERVICE COMMITMENTS

- S: There have been reports that some post-graduate training programs discriminate against students who have a service commitment who are applying to begin a residency or against students who have completed a service commitment who are applying to complete residency training.
- O: I spoke with half a dozen people in the central and regional offices of the National Health Service Corps. None of them had heard reports of any such discrimination. They pointed out that a student applying for residencies could request deferment of the service commitment until the completion of residency training and that essentially all such requests are being honored.
- A: I do not feel that we have any evidence that this problem is widespread or even anything more than one or a few isolated cases. On the other hand, the problem should be fairly easy to investigate further.
- P: Two alternate plans suggest themselves:
- 1) Do nothing further
 - 2) Devise a brief questionnaire and send it to people who are now completing or have recently completed service commitments. Follow this, if response indicates, with a poll of directors of residency programs.

Bob Cassell

HOUSESTAFF ORGANIZATION
An OSR Position Paper Prepared in
Conjunction with a Resolution Passed
at the 1975 Annual OSR Business Meeting

It is apparent from an analysis of the OSR resolution (Appendix I) that the sense of the organization was directed toward two distinct problems. For the sake of clarity, these will be considered separately.

PROBLEM 1. Without reference to the content of the AAMC-sponsored amicus curiae brief, the OSR feels the need to express its dissatisfaction at not having been consulted during the deliberations which led up to its formulation.

PROBLEM 2. The OSR expressed strong disagreement with the content of the AAMC brief, which contends unequivocally that housestaff are students rather than employees, and are, therefore, not protected by labor legislation.

With respect to problem #1, the subjective basis is clear, and is being considered in some detail by the working group on Structure and Function. There exists a strong feeling within the rank and file of OSR that the main function of the group is to give an air of legitimacy to AAMC decisions, by making it appear that these decisions are representative of all constituencies of the medical education community. This feeling of frustration, the basis of which is amply demonstrated by AAMC actions such as the commissioning of the brief, without OSR support or consultation, was expressed in two ways. First, the major resolutions of the OSR included clear provisions to "go public" because our views were accorded no respect within the AAMC. Second, the majority of OSR Administrative Board members indicated in their election campaigns a desire to end the rubber-stamp quality of OSR, even by ending OSR if this became necessary.

The objective basis of problem #1 derives from a survey of the

events leading up to the OSR resolution and this Paper. Repeated attempts by OSR officers to involve the Council of Deans in productive, open discussion of the substantive position expressed in the AAMC brief have failed. Mark Cannon's Statement Presented to the OSR Administrative Board (Appendix II) and the recent resolution would have provided an excellent backdrop against which such discussion could have taken place. Both of these documents, however, appeared ex post facto, and although Mark called for the Executive Council to "disclaim the brief as an enunciation of AAMC policy," even such a disclaimer would not have altered the fact that, as indicated by the existence of Problem #1, the OSR was never allowed to feel a part of the deliberations leading up to the AAMC position vis-a-vis housestaff. It is this unilateral development of policy which we found disturbing; the actual brief was only the legalized, official-looking statement of this policy.

A thorough assessment of the current status of Problem #1 is made difficult in that it requires, in fact, an inquiry into the role of OSR and into the possibility of altering this role into one which more satisfactorily serves the needs of OSR's student constituency. It presently appears that, with its single vote on Executive Council, the OSR lacks the ability to force discussion of its resolutions and positions. On the other hand, the Chairman of the Council of Deans and other officials have indicated a willingness to discuss, informally, any issues of interest to OSR. It is now necessary to question the validity and function of such discussions, when they exist in an artificial atmosphere. If official discussions of OSR motions made are denied us by a structural limitation of our ability to bring items to the floor, then unofficial discussions seem to be merely phatic. It appears, then, that Problem #1 can only be solved if AAMC takes official action to ensure that OSR has a more tangible role in the policy making processes of the organization. Short of this, it is not likely that the present feeling of alienation will be dispelled.

Finally, it is appropriate to suggest some steps in a plan whereby OSR might work toward the implementation of solutions to Problem #1. First, the seriousness of OSR purpose must be underscored by a careful fulfillment of resolutions passed at the Business Meeting. If the Administrative Board fails in this step, it will mean acceptance of an OSR role as a harmless sounding -board and rubber-stamp for decisions made at the level of the parent organization. Secondly, every effort should be made by the Administrative Board to assist in the creation of an organizational framework for increased input. This effort is best made by a unified Administrative Board, and by the pursuit of realistic goals such as an increased number of OSR votes on AAMC governing bodies. The third aspect of this plan, but perhaps the most important, recognizes that the only real power OSR has derives from its role as a voice of student opinion. From this point of view, all efforts to maintain the vitality of the OSR-constituency relationship are valuable.

It becomes apparent that Problem #1 cannot be solved since it refers to an event which has already taken place, and there is no way to undo that event. The best solution we can hope for, and the only one we should accept, is one which provides adequate protections that future AAMC decisions will only be made after full and open consultation with the student constituency.

PROBLEM #2

Subjectively, the question of OSR position regarding the AAMC brief derives from basic and essentially complete disagreement with the philosophical stance from which the brief issued. This is made clear in the resolution (Appendix I) which states that the brief "represents sentiments in conflict with the desires and best interests of the OSR," and goes on to cite "inaccuracies and distortions of fact" which are contained in the brief. The Representatives in their clinical years

were aware in a first-hand way of the clinical and teaching functions of housestaff, and it was apparent that the vast majority of delegates were conversant with aspects of the problem which had been thoroughly covered by articles in news journals such as New Physician. The strike in New York, and the gross inequities which had surfaced as a result of the publicity surrounding that strike, was familiar to all the delegates, as were the internal AAMC communications regarding the deliberations of the NLRB. Especially disturbing was the obvious sophistry inherent in the AAMC argument that housestaff are not employees because their service function is unimportant to the teaching hospitals (AAMC brief, pp 14 et seq.), but that even if housestaff are considered to be employees the NLRB ought not to extend to them the protection afforded by law (AAMC Brief, pp 16-18). The AAMC argument seems to rely on the proposition that housestaff (or "students" as they are referred to throughout the AAMC Brief) are not competent to fulfill their service role without continuous staff supervision, and that this supervision would in some mysterious way be impaired if the right of housestaff to bargain collectively were recognized. That the logic of this argument is weak at best must have been recognized by the writers of the Brief, since in their closing argument they find themselves forced to rely on hyperbole and ridicule in an effort to ingratiate themselves to the NLRB. The following statement is illustrative:

Even testing would become a mandatory subject of bargaining were the Board to assert jurisdiction. Never before in the history of American education has the student been an equal partner with the teacher in determining the content of tests and the manner in which he will be tested. The notion of a committee of law students [sic] sitting down with their dean and law professors to bargain over whether they will be tested on constitutional law, and, if so, in what manner, borders upon the ludicrous. Yet an analogous situation will be imposed upon graduate medical education if it becomes subject to the collective bargaining process.

AAMC Brief, p. 25, paragraph 2.

That law students perform no service function and pay tuition for

instruction received appears to have escaped the attention of the authors, as did the fact that law students are --in the same sense as medical students-- undergraduates in their chosen field.

Objectively, the weaknesses of the AAMC Brief reside in the way in which "facts" are presented, and in the conclusions drawn from this presentation. Dr. Cannon's Statement documents several of these apparent misrepresentations. He addresses principally the following:

1. The AAMC argument is based on the assertion that the NLRB may decline to assert jurisdiction over any class or category of employees. The actual wording of the Labor Relations Act (29, U.S. Code 164(c)1)) states that the discretion of the Board is limited to categories of employers. In earlier action, the Board has asserted jurisdiction over non-supervisory employees of voluntary hospitals.
2. In attempting to minimize the service aspect of the internship and residency years, the AAMC Brief cites a study undertaken at Hartford Hospital to prove its point that housestaff, rather than providing revenue, actually cost the teaching hospitals money (AAMC Brief, p. 11). The falsehood of this statement is amply demonstrated in the study cited, as reported in J. Am. Hosp. Assoc. 47: 65: 1973. In this article it is shown that housestaff save hospitals money in the performance of "hospital-essential" functions, and save the community a great deal of money in the performance of "medically essential" functions.

The AAMC argument that interns and residents were never intended to be included in the spirit of the recent labor relations legislation is shown to be erroneous by an examination of the debate in the Senate. There, Mr. Alan Cranston (D., Calif.), a sponsor and floor leader of the bill, specifically referred to the long hours and low salaries characterizing housestaff positions as one of the conditions to be addressed by the amendment. (Debate and Congressional Record citation obtained from PNHA Reply Brief). Further, interns, residents, fellows, and salaried physicians were expressly cited by the reports from both houses of Congress as groups which are not to be excluded from coverage under the legislation (Senate and House Report citations obtained from PNHA Reply Brief).

Assessment of the subjective and objective aspects of Problem #2 leads one to the conclusion that AAMC has designed a situation in which it places itself in an adversary role to a legitimate, legal and morally acceptable housestaff position. Ignoring the basic substantive issues of hours, salaries, working conditions, and input into patient-care related decisions, the AAMC chooses to see interns, residents, and fellows as an irresponsible group of students who do not really know what is good for them. In keeping with this position the AAMC has asked the NLRB to decline jurisdiction over housestaff labor disputes. The OSR assesses this as an incorrect position. We are familiar with the extensive service function of housestaff, as well as with their major teaching role, and support their efforts to develop programs which will provide them with adequate salaries, civilized working conditions, and input into policy-making groups concerned with the day-to-day quality of patient care. This familiarity comes both from our own personal experience as students (subjective), and from a study of the literature surrounding the current dispute (objective). It is apparent that as long as AAMC, and especially the Council of Teaching Hospitals (COTH), maintain an adversary position, housestaff will have to form groups to bargain effectively and gain a fair hearing.

Plans to implement the OSR position must take several tacks. First, it is essential that all available channels within AAMC be utilized in an effort to change policy and make it more acceptable to the student and housestaff constituencies. Second, the OSR Administrative Board must carry out the specific mandate contained in the Resolution, and communicate its dissenting position to the NLRB. Third, continued close communicative ties with housestaff organizations, especially the PNHA, should be fostered and maintained.

Finally, OSR representatives at each school should be encouraged to sample student and housestaff opinion concerning this issue, to educate concerned members of these constituencies regarding events at the national level, and to cooperate with housestaff in obtaining just redress of their grievances.

Respectfully submitted to the
Administrative Board of the
Organization of Student Representatives,

Thomas A. Rado
Vice Chairperson

TEXT OF A RESOLUTION PASSED
BY OSR
AT THE 1975 BUSINESS MEETING:

VI. Amicus Curiae Brief.

WHEREAS, an amicus curiae brief has been filed with the NLRB by AAMC on behalf of four hospitals supporting the contention that housestaff are purely students and not employees,
WHEREAS, this brief represents sentiments in conflict with the desires and best interest of the OSR,
WHEREAS, at present there is no housestaff representation within the AAMC,
WHEREAS, the OSR Administrative Board voted in opposition to the views and sentiments expressed in the brief,
WHEREAS, there are inaccuracies and distortions of fact contained in the brief,
BE IT RESOLVED, that the OSR communicate and clarify to its constituents, the NLRB, and the public a dissenting opinion which supports the position taken by housestaff before the NLRB.

STATEMENT PRESENTED TO THE OSR ADMINISTRATIVE BOARD
by Mark Cannon

On April 3, the AAMC was authorized by the Executive Council to file an amicus curiae brief with the National Labor Relations Board on the subject of housestaff unionization. The brief was prepared by a legal firm in conjunction with AAMC staff. The Executive Council in April made clear its philosophical inclinations on the issue, and the brief conveys these. Since the brief bears the name of the AAMC and has been disseminated in a booklet-form containing a foreward by John A.D. Cooper, President of AAMC, describing it as a "scholarly document" on the "role of interns and residents," the brief may be presumed by some to represent AAMC policy. However, the text of the brief has not been reviewed or discussed by the Executive Council. We feel that such a review is in order.

One point in question is the brief's assertion that the NLRB is at liberty to "decline jurisdiction over any labor dispute involving any class or category." The brief goes on to suggest that even if interns and residents are classified as "employees," the NLRB should decline jurisdiction over this category of employees. However, the true provision of the National Labor Relations Act is that the Board may "decline jurisdiction over any labor dispute involving any class or category of employers." In this case, the "class or category of employers" is the voluntary hospital, and the 1974 amendment to the Act precludes the declining of jurisdiction over this category. Yet, 40% of the text of the brief is devoted to arguments in favor of declining jurisdiction.

On page 9 of the brief, Section I(A)1 is headed, "The whole purpose of the relationship between interns and residents and hospitals is educational." The brief later concedes that the service role of housestaff cannot be denied, yet this hyperbolic heading is permitted to appear nonetheless. The statement that "graduate medical education is now a requirement for the independent practice of medicine" obscures the fact that no state requires more than one year. The statement that "virtually all states" require at least one year of graduate medical education does not accurately portray a situation in which 14 out of 50 states have no such requirement. The statement that "an individual cannot competently practice medicine on his own unless he has acquired the training offered by residency programs" would be challenged by the many communities that are served by moonlighting residents, and there has not been a documented claim that such service is not generally competent. In the following paragraph, the statement that medical students "engage in patient care and diagnosis under the supervision of medical school faculty" ignores the fact that the great majority of the students' work is done under the direct supervision of interns and residents, not faculty.

In Section I(A)3, the brief cites the Hartford Hospital study to create an impression that the cost of operating programs of graduate medical education is greater than the value of the services performed by interns and residents. However, an article in the Journal of the American Hospital Association (47:65, 1973) by two staff members of the Hartford Hospital (the head of the department of education and the associate executive director) interprets the results differently. They found that the housestaff provided services valued at two to four million dollars, which would have to be obtained from other sources, were it not for the interns and residents. The brief states that the Hartford study "demonstrated that were the graduate medical education program eliminated, 145 residents could be replaced

by 40 full-time doctors." This probably represents an oversight on the part of the brief's authors, since the study actually reported that 40 full-time physicians, plus 10 nurse practitioners and 14 surgical technicians, would be required to replace 145 interns and residents. In another study, sponsored jointly by the AAMC, AHA, and AMA (Program Cost Estimating in a Teaching Hospital: A Pilot Study, by A. J. Carroll), the following is stated: "(In the teaching hospital,) the hospitalized patient can receive competent medical care regularly, routinely, or in emergencies, as often as he may need it. This would not be possible without either an adequate number of interns and residents or a very large staff of full-time physicians... (With the present intern and resident system), the overall costs of this stand-by care are considerably lower than would otherwise be possible." And, "interns and residents are hospital employees!"

The OSR Administrative Board disagrees with the brief in spirit and also recommends that the Executive Council consider these points and disclaim the brief as an enunciation of AAMC policy.

Legislative Affairs Discussion Group
AAMC OSR Annual Meeting
November 2, 1975
Moderated by - John Barrasso, OSR Rep., Georgetown

Members of the OSR concentrated a great deal of effort at the AAMC Annual Meeting on Legislative Affairs, particularly health manpower legislation. Prior to the convention, all OSR members were sent a comparison of current health manpower legislation including the House passed bill, the Administration proposal, and the proposed AAMC bill.

The discussion centered around issues currently being heatedly debated by members of the Senate Health Subcommittee of the Committee on Labor and Public Welfare. The main concern of the Senate is to remedy the problems of geographic and specialty maldistribution of physicians in the United States. The thrust of most of the proposals in the Senate is to tie financial support for medical education to residency limitations and to obtain agreements from a percentage of graduating students to serve in physician shortage areas.

Considerable time was spent discussing the skyrocketing cost of attending medical school and the limited loan and scholarship funds available. The thrust of the discussion by the OSR showed a deep concern of the students for the health and welfare of the nation's citizens.

In attempting to find a solution to the problem of the geographic maldistribution of physicians, members of the OSR debated the options of requiring all medical graduates to serve, requiring a certain percentage of medical graduates to serve, or a voluntary program with lucrative incentives to encourage service. The participants favored an expansion of current Public Health and Armed Forces Health Professions Scholarship Programs which tie post-graduate service requirements to a grant of tuition and living expenses. By expanding these scholarship programs to a level which would provide scholarships for all interested students, we could avoid the previous year's problem of having many more scholarship applicants than available scholarships. Some students argued that the only fair way to solve the problem was to require two years of service from every medical graduate in order to avoid forcing only students in lower income brackets into service. In either case, it was agreed that some sort of a program should be established which would provide those students with a service requirement the opportunity to choose an area of the country appealing to them for repayment of their obligation.

With respect to physician maldistribution by specialty, the OSR agreed that more emphasis should be placed on primary care during undergraduate medical training. In order to facilitate this emphasis it was suggested that unrestricted capitation grants to medical schools be discontinued and that special grants be made available for the establishment of remote-site training and meaningful educational experiences in primary care. Additionally, members of the OSR favored the establishment of more primary care residency positions in communities designated as underserved areas.

Legislative Affairs Discussion Group (Cont.)

The entire discussion provided an opportunity to debate the same issues which the Senate is currently considering and enabled members of the OSR to be informed enough to report the issues to their respective student bodies. Following the discussion, a verbal report was made in the Business Session of the OSR at which time the following Statement was adopted:

"The OSR would like to make its assenting as well as dissenting views clear on the issues surrounding capitation. According to the resolution passed by our members at the National Meeting representing 85 out of 115 medical schools, 'capitation grants going directly to schools as unrestricted funds should be eliminated.' If capitation is partially contingent upon student service in NHSC then, if there were to be capitation funds, it should go to the students. The students feel that special funds should be continued to be made available to medical schools for 'special projects designed to 1) establish remote site training for all undergraduate medical students for a six week period, 2) provide meaningful primary care training for medical students, and 3) increase training of nurse practitioners and other physician extenders.' This is our major issue of dissent with the AAMC position.

We support the AAMC position that if a school is required to enlist a certain fixed percentage of entering students in NHSC scholarships, that that percentage can be filled from upper classes. In approximately a three to four year period, a fixed percentage of NHSC scholarship participants would be graduated yearly, which is the goal of the Bill. Before that time the NHSC would benefit from some participants who had signed up in the program as second or third year students. In the Administration proposal there would be no participants graduating for service for four years. More importantly, the total percent of the entering class would not be required to sign up for a full scholarship at the time of their admission. We feel the same goal can be achieved in a more effective and congenial manner.

On the issue of setting up a primary care and ambulatory care administrative unit, the OSR feels that schools should be setting up these programs, if they have not done so already. The AAMC believes that this position is a direct mandate on curriculum, whereas the student group feels this is a necessary step that should be voluntarily carried out by each medical school.

On the issue concerning regulating primary care residencies to be fifty percent of the total, the OSR agrees with the AAMC that the CCME should be the consulting body on determining residency positions. The Administration (HEW) should be an integral part of each step in this process and the CCME should be given a specified time limit to carry out successfully its duties. If this cannot be met, then another body should be designated.

Legislative Affairs Discussion Group (Cont.)

On the issue that some student loans be made available, the OSR feels that NHSC scholarships should not be the only available step for financially dependent medical students. At the National Meeting we passed a resolution that 'a limited number of low-interest loans be made available to individuals needing some financial aid but unwilling to sign a full support-for-service scholarship.' We support the AAMC position."

MEDICAL STUDENT STRESS

Stress in Medical Education - Robert Rosenbaum	21
Humanism in Medical Education - Sheryl Grove	24
Medical Student Stress	31
A Study of Three-year Curricula in U.S. Medical Schools	32
Reduced Schedule (Part-time) Residency Questionnaire	49

* * * * *

STRESS IN MEDICAL EDUCATION

The remarkable attendance of the GSA-OSR panel discussion at the Annual AAMC Meeting is evidence of the concern of those involved, in student affairs over the problem of stress in medical education. The participants raised many issues which merit consideration, scientific investigation and comment.

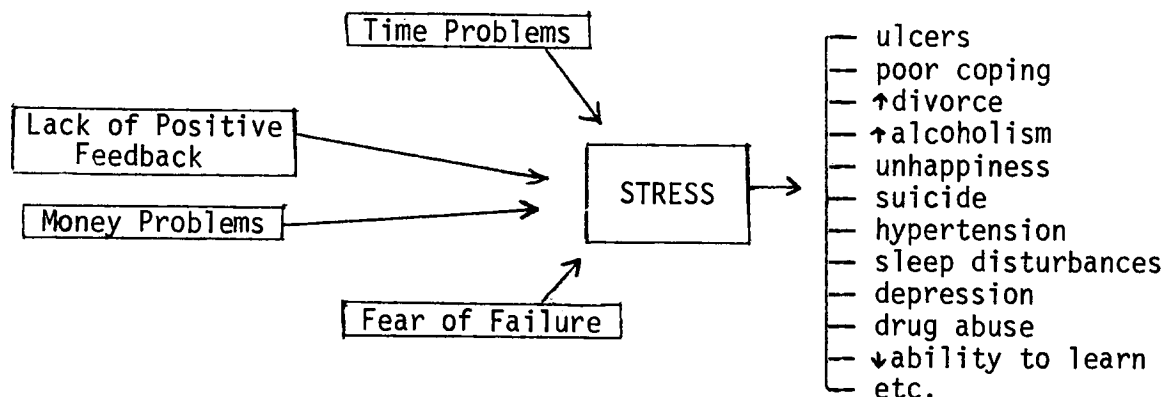
Questions were raised over the etiology of this problem. Some of the participants believed that medical students were particularly stress-prone and that it was their immature, anal compulsive, over-achiever personalities which, combined with premedical curricular conditioning, created the foundations for the psychopathology that emerges during medical school. Other participants felt that it was the medical school environment which was responsible for producing stress. They claimed that; the long hours per week, the large number of lectures per week, the lack of positive feedback, the lack of role models, sleep deprivation, information overload, excessive memorization, the infantilization of the student, and the fear of failure are responsible for the stress in medical education. Others believed that stress was the result of a complex combination of the above factors.

Questions were raised over the magnitude and scope of the problem of stress in medical education such as; what percentage of students experience significant stress? Is it true that 30-40% of medical students need psychiatric help during the four years of medical school, what are the rates of suicide, divorce, alcoholism, caffeine addiction, and drug abuse among medical students.

Robert Rosenbaum
OSR Central Region Representative

STRESS IN MEDICAL EDUCATION (CONT.)

Assessment



1. Medical school is stressful
2. Medical schools must be modified

Plan

AAMC Task Force

1. Composition

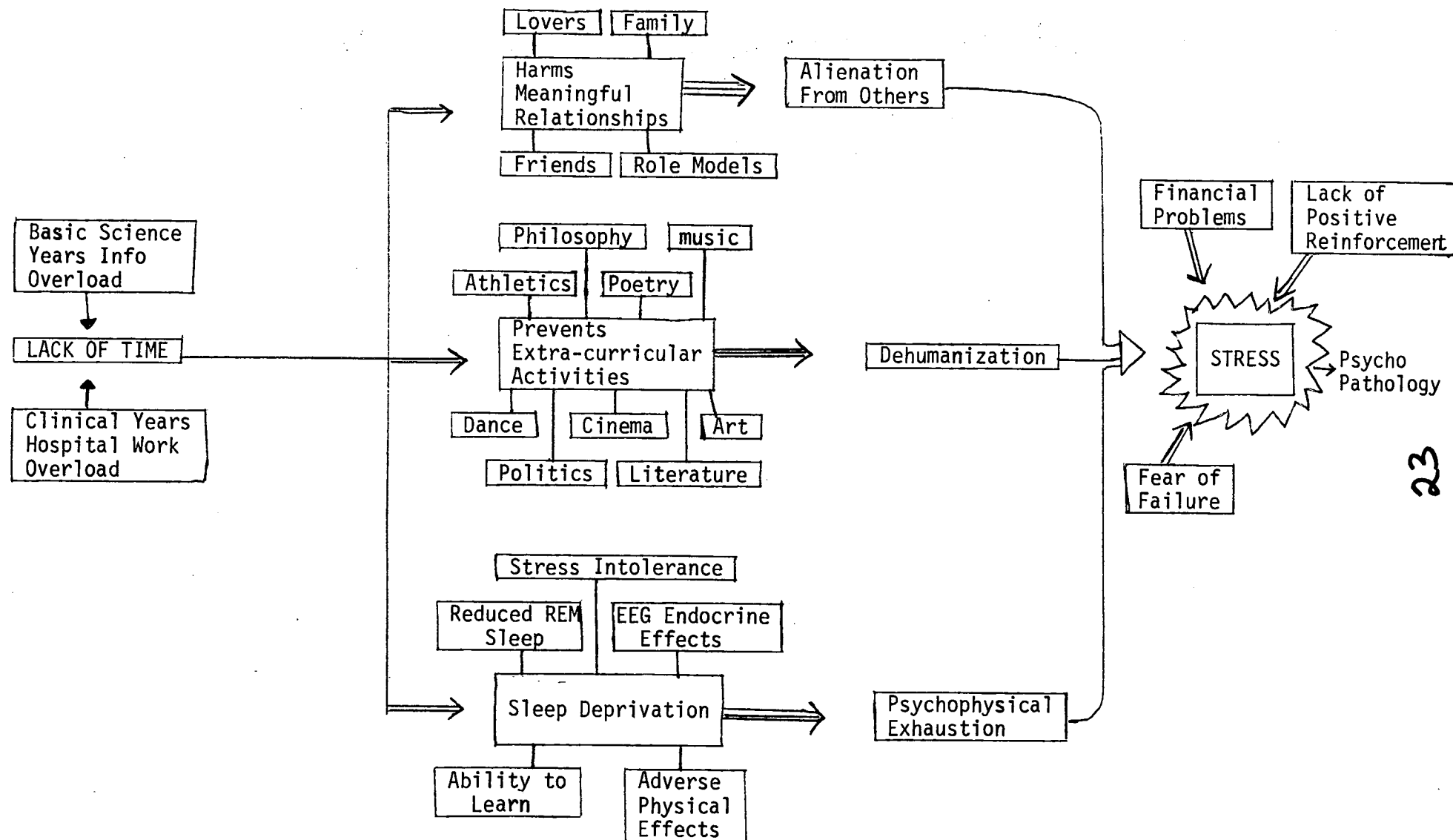
- COD
- OSR
- CAS
- GME
- GSA

2. Purpose

- determine and evaluate causes of stress in medical education
- determine the effects of stress, short and long range, on medical students
- develop a model, low stress, medical school
- develop a group of modifications, which if made in medical schools would eliminate much of the stress in them

Objective

Time and the Medical Student: A Schematic Representation



HUMANISM IN MEDICAL EDUCATION

Subjective:

Too many medical students are depressed and/or dropping out and/or divorcing and/or dying.

MSI: "My classmates are really angry at me because I'm not as upset as they are."

MSI: "If I'd known it was going to be like this, I wouldn't have come. It's as bad as the service."

MSIII: "She said she deserved more than a half-dead zombie who only studied. She said she wasn't that masochistic."

Dean of Student Affairs concerning the third suicide that year in the same class: "Well, you know, these things are to be expected."

Dr. George Engel described it this way:¹

Physicochemical reductionism and technologic primacy--the bywords of medicine for the past 40 years or so--explain all phenomena of life in terms of chemistry and physics, and claim that all human problems are amenable to technologic solutions. The leaders of modern medical education have bought those dogmas, and expect the finest system of medicine and the best medical care in the world to be constructed on those principles--using the finest biochemists, the best molecular biologists, the most sophisticated technology and the best equipped hospitals."

Where in our educational programs, graduate or under undergraduate, is there genuinely serious attention devoted to preparing the student to deal with the human elements of medicine, indeed, to serve the health needs of human beings?"

Including himself.

It is a multifaceted problem that can be attacked on any of three levels and must be attacked on all: (1) Pinpoint and divert students incapable of coping with the stress inherent in the practice of medicine and with the stress of the educational process; (2) Reduce the reducible stresses of the process: time, anxiety, competition, inadequate relationships, ethical-moral dilemmas, and identity as "doctor" rather than self; and (3) Augment the student's

successful coping with non-reducible stresses.

I have chosen to deal with the third problem because admissions selection awaits development of better tools (in progress), reduction of stress involves institutional revamping while deaths demand more immediate actions. Indeed, we cannot ignore the choice of medicine by many for the stresses (challenges) that it offers. How much is non-reducible? Who will help the healers?

The format below consists of the issues (Roman numerals) followed by the related goals (letters) and specific plans (Arabic numerals).

I. Acknowledgment of the problems:

Depression-as a mood; as a pathology.
 Drop-outs-a percentage unable to cope with stresses.
 Divorce rate-approaching 20% of the married class members per year during the basic science years; "divorce" among the non-married students.
 Death-three suicides in one class in one year.
 Drugs and alcohol-when other coping fails.

A. Document the nature and extent of the problem.

1. Informal questionnaire (Appendix I) at given schools; nationally
2. Investigate studies done to date

- ## B. Acknowledge the problems as part of medical school curriculum in the Behavioral Science component, providing opportunities to air and explore feelings
1. Lecture with extensive coverage of documentation of problems, possible sources, etc.
 2. Seminars for discussion of lecture presentations with carefully selected leaders.
 3. Weekend seminars with experts for interested students and faculty.

II. Develop Coping Abilities

- ## A. Develop the concept of coping: recognition of strengths and weaknesses, effective vs. ineffective coping, role of self-help and the help of others
1. Lecture
 2. Seminar

- ## B. Knowledge of the developmental stages of man and of marriages, families; normal "crises" inherent in each stage (e.g. death, divorce)
1. Lecture
 2. Seminar

- C. Develop related concepts: the universality of the need for the support of others; the "medicine is everything" myth; energy use in coping and physical fatigue
 - 1. Lecture
 - 2. Seminar
- D. Define the "normal crises" of medical school: delineate these, discuss related coping mechanisms
 - 1. Lecture
 - 2. Seminar
 - 3. Group interactions (not therapy) utilizing large groups with psychiatric professionals as leaders during times of peak crises
- E. Seeking change as a coping mechanism
 - 1. Lecture
 - 2. Seminar
 - 3. Project of choice

III. Recognition of non-coping

- A. In self
- B. In others--patients, peers, family, faculty
- C. Recognition of depression; symptoms
- D. Recognition of behavior as an indicator of emotions
- E. Exploration of mechanisms of denial used by oneself of non-coping one sees; reasons for such denial; overcoming denial
 - 1. Lecture
 - 2. Seminar
 - for A.-E. 3. Essential inclusion of faculty and housestaff to benefit maximal number of students
 - 4. Seminars for spouses, families, others

IV. Actions for recognized non-coping in self and others

- A. Knowledge of crises intervention for peers, patients
 - 1. Lecture
 - 2. Seminar
 - 3. Seminars for spouses, families, faculty, housestaff
 - 4. Discussion of responsibilities vs. desire "not to get involved"
- B. Legitimize seeking of help in coping--the attitudes toward psychiatry challenged (laymen and physicians)
 - 1. Lecture covering the following:
 - attitudes
 - resources in the community with advantages and disadvantages
 - records--what type and where: school, hospital, clinic, insurance

cost

time

professional personnel willing to see medical
students with phone numbers (not necessarily
psychiatrists)

reasonable expectations one might have of
a professional psychiatric visit

2. Seminar for discussion of attitudes and expectations
3. Seminar for spouses and families??

C. Mechanisms of denial of the need for action; reasons
for denial; overcoming denial

1. Lecture
2. Seminar
3. Seminar for spouses, families, faculty, housestaff

D. Assisting families of non-coping individual students

1. Designation of key person willing and capable of
assuming this role
2. Unhindered communication of the need for this
assistance to the person in 1 by peers, faculty,
families, housestaff, etc.
3. Utilization of this referral mechanism for
non-coping individuals not getting help
-assist the family to encourage the individual
to seek help
-assist the family which hinders help for the
individual

E. Assisting the individual into another environment--
leave of absence; alternative career

1. Present in lecture
2. Specific individual counselling when indicated
3. Referral system--see D.2.

V. Facilities for assistance of non-coping individuals

A. Outpatient services:

Free?? (Problem: Treatment more effective if
individual pays for it himself.)

Insurance

Off-campus--out of stressful environment

out of hospital "family"

therapy by faculty related to later
clinical evaluation situations

school record

observed by peers(?)

B. Hospitalization

1. Lecture
 2. Seminar
- for A.-B.

What I have outlined is the skeleton of a proposal to meet some needs I have identified at my school. My course of action (planned) follows:

1. Questionnaire to the students to define the needs here
2. Search of the literature regarding defined needs
3. Requests of information from Drs. Howell, Engels, others, head of psychiatry department, other schools
4. Discussion with counselling centers in the community
5. Development of a detailed course with bibliography
6. Secure the Dean's assistance for gathering funds (promised)
7. Interim weekend seminars to ascertain interest, test curriculum, and, not least of all, to meet the current need until the proposals can be put into action.

I am submitting this to the CSR Administration Board for information, consideration and criticism. I think my experiences in development and implementation of the final proposal could serve as useful guidelines for other schools making similar efforts. I am not at all convinced that the solving of the problem of dehumanization in medical education should be the responsibility of the school and its administration.

Shirley Grove

Appendix I

Questionnaire to seek the following information:

Emotions experienced during medical education: "blue", depressed, angry, anxious, paranoid, isolated, overwhelmed, insignificant, unable to cope

When were each of these feelings the worst (in relation to the educational process, if related)?

Did you seek help from: no one, friend (same sex), spouse or friend of opposite sex, parent, sibling, physician, teacher, academic counsellor, other?

Do you presently have close, personal relationships? Married?

If no, is medical school implicated?

Have you lost close personal friends since you started medical school? Divorced?

If yes, is medical school implicated?

Do you use drugs of ETOH to alter mood or forget stress?

Has this changed since you have started medical school?

Have you considered suicide since starting medical school: never, briefly but not seriously, seriously under acute stress, frequently?

If yes, is medical school implicated?

Have you sought professional help since starting medical school?

Are you willing to seek professional help?

If not, why not?

Don't trust psychiatry/Don't know who to call/Reluctant to see psychiatrists who are faculty/Takes too long to get appointment/No money/No time/Fear of report on records

Would you be more willing to seek help outside your medical center?

Would you be more willing to seek help if only the professional had access to the record?

Would you be more willing to seek free help?

If you have sought professional help, was it helpful?

Why or why not?

Bibliography (to be submitted later in full)

Engel, George. "The Best and the Brightest: The Missing Dimension in Medical Education," New Physician, May, 1974 (Vol. 23 No. 5), pp. 30-31.

Howell, Mary C. "Stop the Treadmill--We Want to Get Off," New Physician, Nov., 1974 (Vol. 23, No. 11), pp. 27-30.

Rezler, Agnes G. "Attitude Changes During Medical School: A Review of the Literature," Journal of Medical Education, Nov., 1974 (Vol. 49), pp. 1023-1030.

MEDICAL STUDENT STRESS

The factors that create stress for medical students and potential means of alleviating stress-producing factors in medical education will be examined in the three-year curriculum study, which will be conducted by Dr. Robert Beran and his staff in the Division of Educational Measurement and Research. This study includes questions intended to measure the degree of stress experienced by students in an accelerated curriculum. A portion of the survey instrument is included in this agenda, and Dr. Beran will be present at the Administrative Board meeting.

A Study of Three-year Curricula in U.S. Medical Schools

The purpose of the project is to conduct a study of three-year curricula in U.S. medical schools. Specifically, the study will (1) identify and describe the changes that were required within institutions in the process of shortening of the curriculum, (2) examine the methods employed in adapting the curriculum from a four-year to a three-year time period, and (3) identify the institutional considerations that led to the decision to initiate a three-year program. The project will compare the experiences of those institutions that shortened the length of training and also include a comparative analysis of three-year programs with a sample of four-year programs.

Under the authority provided in Sections 770(a) and 772 of the Comprehensive Health Manpower Training Act of 1971, the federal government has been and continues to support curricula designed to shorten the length of training in schools of medicine.

Under the authority provided in Section 772, the Secretary may make grants to assist schools of medicine in meeting the costs of special projects to:

"Effect significant improvements in the curriculums of any such schools (including projects to shorten the length of time required for training in such schools), with particular emphasis, in the case of schools of medicine or osteopathy, under the establishment of new, or expansion of existing, programs for training in family medicine."

An even more significant incentive for shortened programs in schools of medicine is contained under the authority provided by Section 770(a). This Section grants authority for capitation grants. In addition to other formula elements which determine the maximum grant award for which a school is eligible, a special additional allowance of \$2,000 is made to each school for each full-time student who will graduate that year from either a program which leads to the M.D. degree within six years of graduation from secondary school or a post-college medical training program which is not more than three years.

In light of past federal support of shortened curricula in schools of medicine, the evaluation of the effect of such programs (via federal support) is appropriate. The description of the institutional process and the comparative analysis of these processes among participating institutions will provide base data regarding changes in medical education programs and their effects on the institution and its constituency.

Specified studies addressing the evaluation of three-year curricula are lacking. The results of the project will be submitted in final report form to the Bureau of Health Manpower, Health Resources Administration.

* * *

Following is the "Student Survey" portion of the three-year curriculum study:

STUDENT SURVEY

Some of the following questions ask you to try to remember your feelings and opinions earlier in your undergraduate medical education career. Please try to answer those questions as you felt at the time specified in the question. All of your responses will be treated as strictly confidential, so please be candid in your answers to the questions. Please do not identify yourself specifically by name or the name of your institution.

1. Please indicate below the factors or characteristics which were critical and influential in your evaluations of the particular medical schools to which you applied. (You may check more than one.)

- ☐ My perception of the medical school's academic reputation.
- ☐ The length of the undergraduate medical education curriculum.
- ☐ Recommendations of members of my immediate family.
- ☐ Recommendations of my family physician.
- ☐ The schools were state supported schools in my state of residence.
- ☐ Schools conducting a particular type of undergraduate medical education program for which I had a special interest.
- ☐ The tuition and other associated education costs.

2. Are you currently attending the medical school of your first choice?

- ☐ Yes ☐ No

3. Did you select the medical school you are now attending because it was conducting a three-year undergraduate medical education program?

- ☐ Yes ☐ No

3. cont'd.

If "yes", at the time you entered the medical school, which of the following did you perceive as advantages of the three-year program? (Check all that apply.)

- ☐ I felt the three-year program would permit me to gain a year in my educational process and thus graduate a year earlier than I could from a four-year program.
- ☐ I felt that I knew what career path I was going to choose and wanted to begin that training as soon as possible.
- ☐ I felt the three-year program would be a more clinically relevant program than a four-year program.
- ☐ I felt that the three-year program would permit a shorter period of time in the basic sciences and allow me to begin my clinical education at an earlier date than a four-year program.
- ☐ I felt that the learning requirements and educational process of the three-year program were not significantly different from those in four-year programs.
- ☐ I felt that attending an institution that was conducting a three-year program would cost me less in tuition costs than a four-year program.
- ☐ I felt that a three-year program would offer more flexibility in rate and mode of study than a four-year program.

4. Now that you have experienced participation in a three-year program, do you now feel that those factors which you perceived as advantages of a three-year program when you entered medical school are still advantages of a three-year program?

- ☐ Yes ☐ No

4. cont'd.

If "no", please indicate below those factors which you no longer perceive as advantages, but did when you entered.

- ☐ I felt the three-year program would permit me to gain a year in my educational process and thus graduate a year earlier than I could from a four-year program.
- ☐ I felt that I knew what career path I was going to choose and wanted to begin that training as soon as possible.
- ☐ I felt the three-year program would be a more clinically relevant program than a four-year program.
- ☐ I felt that the three-year program would permit a shorter period of time in the basic sciences and allow me to begin my clinical education at an earlier date than a four-year program.
- ☐ I felt that the learning requirements and educational process of the three-year program were not significantly different from those in four-year programs.
- ☐ I felt that attending an institution that was conducting a three-year program would cost me less in tuition costs than a four-year program.
- ☐ I felt that a three-year program would offer more flexibility in rate and mode of study than a four-year program.

5. If you have begun your clinical clerkships (clinical service rotations), how many months ago did you begin?

_____ months

- ☐ I have not yet begun my clinical clerkships.

6. For each activity below, please indicate your personal opinion regarding the amount of time allocated for that activity in the three-year curriculum. For each activity, indicate whether the time allocated is, in your opinion, more than necessary or less than necessary by marking the appropriate response to the right of the activity. For those activities in which you have not yet been involved, simply indicate by marking the "not applicable" response.

<u>Activity</u>	Time allocated for the activity is:					
	Much More Than Necessary	A Little More Than Necessary	About Right	A Little Less Than Necessary	Much Less Than Necessary	Not Applicable
<u>BASIC SCIENCES</u>						
Scheduled lectures in:						
Biochemistry	_____	_____	_____	_____	_____	_____
Anatomy	_____	_____	_____	_____	_____	_____
Physiology	_____	_____	_____	_____	_____	_____
Pathology	_____	_____	_____	_____	_____	_____
Pharmacology	_____	_____	_____	_____	_____	_____
Microbiology	_____	_____	_____	_____	_____	_____
Scheduled laboratories in:						
Biochemistry	_____	_____	_____	_____	_____	_____
Anatomy	_____	_____	_____	_____	_____	_____
Physiology	_____	_____	_____	_____	_____	_____
Pathology	_____	_____	_____	_____	_____	_____
Pharmacology	_____	_____	_____	_____	_____	_____
Microbiology	_____	_____	_____	_____	_____	_____
Small group discussions in all Basic Science disciplines	_____	_____	_____	_____	_____	_____
Overlap of subject matter by Basic Science disciplines	_____	_____	_____	_____	_____	_____

6. cont'd.

Activity	Time allocated for the activity is:					Not Applicable
	Much More Than Necessary	A Little More Than Necessary	About Right	A Little Less Than Necessary	Much Less Than Necessary	
Faculty time available for individual assistance in subject matter	_____	_____	_____	_____	_____	_____
Early exposure to patients in your curriculum	_____	_____	_____	_____	_____	_____
Clinical relevance of basic science information	_____	_____	_____	_____	_____	_____
Available personal study time	_____	_____	_____	_____	_____	_____
Available personal free time	_____	_____	_____	_____	_____	_____
Vacations	_____	_____	_____	_____	_____	_____
<u>CLINICAL SCIENCES</u>						
Required ward rotations	_____	_____	_____	_____	_____	_____
Curricular time for clinical electives	_____	_____	_____	_____	_____	_____
Available didactic sessions during ward rotations	_____	_____	_____	_____	_____	_____

7. Please indicate below your date of entry into medical school (month, year).

_____ (month)

_____ (year)

8. Please indicate below, the Basic Science disciplines which you have already completed.

- ☐ Anatomy
☐ Biochemistry
☐ Microbiology
☐ Pathology
☐ Pharmacology
☐ Physiology
☐ I have completed all Basic Science portions of the curriculum.

9. Please indicate, by checking the appropriate response below, the type of medical school program in which you are now enrolled.

- ☐ Regular three-year program
☐ Three-year program with option for four-years
☐ Four-year program with option for three-years
☐ Regular four-year program

10. Have you already selected your option (if program has an option)?

- ☐ Yes ☐ No ☐ There is no option

11. What option did you (will you) choose?

- ☐ Three-years ☐ Four-years ☐ There is no option

Below are listed a number of statements regarding the three-year undergraduate medical education program. Please indicate your personal views regarding each statement. Even though a number of the statements are very general, please indicate your extent of agreement or disagreement with each statement as it appears by circling the appropriate response.

Strongly Agree - SA
 Agree - A
 Mildly Agree - MA
 Mildly Disagree - MD
 Disagree - D
 Strongly Disagree - SD

STRONGLY AGREE
 AGREE
 MILDLY AGREE
 MILDLY DISAGREE
 DISAGREE
 STRONGLY DISAGREE

1. Students in three-year programs are as well prepared for their clinical education as four-year program students. SA A MA MD D SD
2. Students in three-year programs have as much free time as students in four-year programs. SA A MA MD D SD
3. In the normal operation of a three-year undergraduate medical education program:
 - a. Students have sufficient time for independent, in-depth study of selected content areas. SA A MA MD D SD
 - b. Students have sufficient time for the synthesis and integration of presented concepts. SA A MA MD D SD
 - c. Students do not have sufficient time to participate or attend community cultural activities. SA A MA MD D SD
 - d. Students feel somewhat uncomfortable about their level of knowledge because they feel they cannot thoroughly learn the presented content. SA A MA MD D SD
 - e. Students who experience personal problems have sufficient time to resolve these problems without suffering severe academic setbacks. SA A MA MD D SD
 - f. The "stress" on students is generally greater than in four-year programs. SA A MA MD D SD

STRONGLY DISAGREE
DISAGREE
MILDLY DISAGREE
MILDLY AGREE
AGREE
STRONGLY AGREE

- | | | | | | | |
|---|----|---|----|----|---|----|
| 4. The three-year curriculum is more relevant to the current medical needs of society than the four-year curriculum. | SA | A | MA | MD | D | SD |
| 5. The "compression" of content presentation in a three-year curriculum causes otherwise qualified students to experience more academic problems than would be the case in a four-year program. | SA | A | MA | MD | D | SD |
| 6. Students in a three-year curriculum appear to be <u>more</u> highly motivated as a result of the shorter time to the M.D. degree. | SA | A | MA | MD | D | SD |
| 7. There is a noticeable decline in individual faculty/student tutorial sessions as a result of a three-year curriculum. | SA | A | MA | MD | D | SD |
| 8. The basic medical science faculty have generally transmitted a favorable opinion of the three-year program to the students. | SA | A | MA | MD | D | SD |
| 9. The clinical faculty (including house staff) have generally transmitted a favorable opinion of the three-year program to the students. | SA | A | MA | MD | D | SD |
| 10. There appears to be more interdepartmental cooperation in a three-year program than in a four-year program. | SA | A | MA | MD | D | SD |
| 11. There appears to be more interdepartmental teaching in a three-year program than in a four-year program. | SA | A | MA | MD | D | SD |
| 12. Students in a three-year program have as much opportunity to develop "role identity" as do students in a four-year program. | SA | A | MA | MD | D | SD |

STRONGLY DISAGREE
DISAGREE
MILDLY DISAGREE
MILDLY AGREE
AGREE
STRONGLY AGREE

- | | | | | | | |
|---|----|---|----|----|---|----|
| 13. There is a decrease in student-faculty interaction as a result of a three-year program. | SA | A | MA | MD | D | SD |
| 14. Students in three-year programs have just as much exposure to clinical faculty during their <u>preclinical</u> training as do students in four-year programs. | SA | A | MA | MD | D | SD |
| 15. There is <u>not</u> sufficient time for students to plan their career goals in a three-year program. | SA | A | MA | MD | D | SD |
| 16. There seems to be an informal or unconscious bias <u>against</u> students of three-year curricula on the part of: | | | | | | |
| a. basic medical science faculty | SA | A | MA | MD | D | SD |
| b. house staff | SA | A | MA | MD | D | SD |
| c. internships following graduation | SA | A | MA | MD | D | SD |
| d. clinical faculty | SA | A | MA | MD | D | SD |
| e. careers available to students | SA | A | MA | MD | D | SD |
| 17. In three-year programs, students express the concern that they have virtually no time to do anything else but study. | SA | A | MA | MD | D | SD |
| 18. If I had it to do over again, I would again choose the three-year program. | SA | A | MA | MD | D | SD |

NIRMP and the Transition from Undergraduate to Graduate Medical Education

NIRMP and the process of selecting graduate training programs continue to pose problems to students. The OSR Administrative Board might wish to examine this area with particular attention to some of the problems which threaten the efficient operation of NIRMP and which make it difficult for students to make well-informed graduate program choices. Some of the issues involved are:

- A. NIRMP Monitoring. The OSR/GSA Monitoring Program has been in existence for three years. While there is no current data on the numbers of schools that have monitoring committees, feedback that is available indicates that the program is basically ineffective. The OSR might address this issue by developing a proposal for increasing the effectiveness of this program or by exploring other methods for monitoring NIRMP policies and procedures.
- B. Accessibility of Information about Graduate Programs. Students are having difficulties in receiving information about residency programs since the green book is issued too late in the year to be of much assistance in making plans for graduate training. The OSR might address itself to the availability and accessibility of such information and define solutions for increasing the information flow.
- C. Dean's Letters of Evaluation. Members of the Group on Student Affairs (GSA) have expressed concern about requests from program directors for early dean's letters of evaluation for students who, in some cases, have completed only one or two rotations. At its annual business meeting, GSA suggested the establishment of a uniform date before which requests for letters would not be honored. OSR might also consider ways of addressing this problem.

WOMEN IN MEDICINE

Since this is International Women's Year, ideas for creatively expressing the achievements, past, present and future, of women are everywhere. The tone of the OSR involvement should therefore be implementation in order to firmly establish our ideals within the operational framework of health care delivery. We must also insure cooperation with our sister groups: AMSA, SNMA, AAQWA, IWY, etc.

Our first concern should be the establishment and usage of the AAMC's women in medicine office along the lines of:

1. data collection and collation
2. resource reference center
3. speakers' bureau
4. liaison office within and without AAMC
5. newsletter
6. advisory council, from pre-med to faculty
7. legal action
8. watchdog

Hopefully, these rather broad categories will generate specific projects during the coming year as women students, faculty, and staff coordinate their activities.

The initial efforts this year should be a raising of consciousness among all health care personnel through:

1. presentations at regional meetings
2. availability of pertinent data to women students
3. organization of sample seminars for schoolwide presentations
4. visitation to high schools and undergraduate schools

Possible practicalities:

1. questionnaire on attitudes, realities, opinions about women to students, faculty, pre-meds, public
2. dissemination fo data
3. coordination of sample package for campus use
 - a. speakers and contacts
 - b. achieveable projects (size of gloves in OR, etc.)
 - c. posters
 - d. publications

Jessica Fewkes
University of California-
San Francisco

Why Should AAMC Develop an Office of Women's Affairs?

Although two organizations dealing with issues of Women in the Health Professions, Center for Women in Medicine and Radcliffe Institute Programs in Health Care, now exist (see attached descriptions), there is now no national focus for any medical school, teaching hospital or individual with a problem/question in the area of Women in medicine. There is no coordinated input into national policy. Nor is there an organization, other than the AAMC, which has collected data concerning women in all phases of medical education, undergraduate, graduate, faculty, administration.

The AAMC, an organization which includes all institutions involved in medical education, has the unique ability to do all of the above. The already existing communication among students, faculty and administration would allow such functions to be done much less expensively than outside the AAMC. Further, the AAMC has already collected data, much of which might be used to understand the particular problems facing institutions and individuals as regards women in medicine.

Submitted by,

Cindy Johnson

AAMC Activities to date

The following are excerpts from AAMC reports and the AAMC Issues, Policies, and Programs Manual:

From the AAMC Officers' Retreat, 1972:

Other programs receiving detailed consideration and emphasis included women in medicine, graduate medical education, and expanded activities in the international areas.

From the AAMC Annual Report, 1972-73, Institutional Development:

In response to the numerous requests for information about women in medicine from students, faculty, medical school administrators and professional and scientific organizations, the AAMC's Department of Institutional Development is attempting to organize data available on this subject. Drawing on the existing and extensive AAMC sources including Student Information, Faculty Profile Studies, and the Longitudinal Study, this office will coordinate the pooling of information pertaining to women. A special effort has been made to gather information from a wide variety of resources outside the AAMC and to represent the AAMC to the extent possible on an ad hoc basis at meetings and conferences which deal in a significant and relevant way with the subject of women in medicine. Additionally, the Association will focus on the special problems encountered by women who choose medicine as a career.

From the AAMC Annual Report, 1973-74; Institutional Development:

The Association collects and analyzes data describing the status of women applicants to medical schools, women faculty members at U.S. and Canadian medical schools, and the cohort of women physicians who are participants in a longitudinal study which began in 1956. Additionally, participation in a number of conferences for professional women has provided a forum for formal and informal exchange of information related to the impact of increasing the numbers of women in medicine and other health professions, and in the more general category of non-traditional fields.

AAMC Activities to date (cont.).

From the AAMC Issues, Policies and Programs Manual

ISSUE: SHOULD MORE WOMEN BE ENCOURAGED TO ENTER THE MEDICAL PROFESSION?

PRESENT STATE OF POLICY DEVELOPMENT:

AAMC has clearly enunciated a policy of no discrimination in admission of students to medical school and in employment on the basis of sex. It has not, however, advanced a policy that more women should be encouraged to enter the medical profession.

PROGRESS TOWARD ACCOMPLISHMENT:

In response to the numerous requests for information about women in medicine from students, faculty, medical school administrators and professional and scientific organizations, the AAMC is attempting to organize data available on this subject. Drawing on the existing and extensive AAMC sources, including Student Information, Faculty Profile Studies, the Longitudinal Study, etc., we have attempted to coordinate the pooling of information pertaining to women in medicine. A special effort has been made to gather information from a wide variety of sources outside the AAMC and to represent the AAMC to the extent possible on an ad hoc basis at meetings and conferences which deal in a significant and relevant way with the subject of women in medicine.

Additionally, the Association will focus on the special problems encountered by women who choose medicine as a career and, for example, has established a Staff Task Force on Affirmative Action to develop means by which the AAMC might assist schools in meeting requirements for affirmative action.

An office focused on Women in Medicine has been approved in principle and staffed on a collateral duty basis, but has not been formalized organizationally. A project has been outlined which would bring to bear considerable knowledge and expertise about the question posed by this issue. This was being discussed with the Radcliffe Institute as a joint project and planning funds were sought from foundations, but without success. The press of other work has precluded additional effort directed toward raising the funds for the policy development effort or any full time staff.

The enrollment of women in first-year medical school classes was 9.1 percent in 1969-70, 11.1 percent in 1970-71, 13.7 percent in 1971-72, 16.8 percent in 1972-73, and 19.7 percent in 1973-74.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Department of Institutional Development

AAMC COMMITTEE:

OSR RECOMMENDATIONS
National Meeting, 1974-75

1. An Office of Women's Affairs should be established with the AAMC to deal with the large number of issues concerning women which face the AAMC and its constituent medical schools.

2. Many medical students and house officers decide to have children during their training at their optimal age for child bearing and rearing. More women are entering full-time careers in health and other areas, and desire to share child-rearing responsibilities between both parents. Working parents are therefore required to neglect their children during the most important early years. More house officers, male and female, are desiring more time for their physical and mental health and other interests. Many physicians desire to participate in research, public health and other training during their residencies. Therefore, the AAMC should study and urge the development of flexible residency programs. (See proposed study - attached.)

3. We believe that having women faculty and administrators is an essential learning experience for all students. Therefore, the AAMC should urge the increasing recruitment, hiring and promotion of women in all aspects of medical education and administration.

4. In keeping with the Association's theme in the coming year of "Educating the Public About Health," the OSR urges the AAMC to address itself to the special and changing roles of women in the health profession as they have been reflected in both educational and mass media.

A situation exists today in which women are rarely portrayed as, or referred to, as physicians in the media, including television, radio, magazines, newspapers, government publications, textbooks and early-education materials.

Such a situation does little to alleviate the prejudice against women physicians on the part of the general public, and furthermore discourages women from seeking out careers as physicians.

We urge the AAMC to investigate the possibility of using its influence to change this situation by increasing the visibility of women physicians in the media, educational materials, and especially its own publications.

5. Because many excellent candidates for medical school are misdirected into nursing through cultural bias and inadequate counseling services, we recommend that the general pre-medical requirements for registered nurse medical school applicants be decreased in consideration for the specific science courses they have taken and for their on-the-job training. Implementation of this recommendation would encourage such nurses to enter medical school and would provide the schools with a fund of students who have had a wider (than average) exposure to medicine and consequently a more realistic commitment to it.

6. We recommend that the OSR appoint an Ad Hoc Committee on issues of concern to women in the health professions in order to extend the work begun in this discussion group throughout the year.

REDUCED SCHEDULE (PART-TIME) RESIDENCY QUESTIONNAIRE

Attached are drafts of two instruments designed to measure varying aspects of part-time residencies. The first questionnaire is constructed to measure the existence of part-time residency programs among COTH member hospitals. The second questionnaire measures attitudes toward reduced schedule residencies.

The construction of these instruments was based upon existing literature and ongoing studies of part-time residency training.

REDUCED SCHEDULE¹ (PART-TIME) RESIDENCY QUESTIONNAIRE

1. Do any of the residency programs at your hospital provide house officers with reduced schedule training options ?

Yes _____ No _____

If No, skip to question 5.

2. In any residency program which offers reduced schedule options, estimate the average number of working hours per week required by department. For these same departments, list the corresponding full-time weekly work requirements.

<u>Department Name</u>	<u>Estimated Average Working Hours Per Week</u>	
	<u>Reduced Schedule</u>	<u>Full-time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

¹ A residency program having reduced schedule training options is one in which the house officer may elect to complete residency training by working a number of hours per week that is lower than the usual program requirement

3. For all residency programs with reduced schedule training options, list the number of house officers who are currently on-duty and the number who applied for first-year positions in such programs since July, 1974.

Department Name

Number of House Officers

	<u>On-Duty</u>		<u>Applied</u>	
	<u>Men</u>	<u>Women</u>	<u>Men</u>	<u>Women</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Which of the following options characterize the reduced schedule residency program(s) at your institution? Check all that apply.

- a. _____ shared residencies (please specify) _____
- b. _____ leave of absence in elective time slots
- c. _____ reduced schedule during out-patient and other episodic care slots; full-schedule during ward and other continuing care slots.
- d. _____ night float or team-shift system
- e. _____ special time off
- f. _____ special work scheduling due to childbirth/child care activities
- g. _____ provisions for alternating between clinical training and research.
- h. _____ other (please specify) _____

Please attach any descriptive material which further outlines existing reduced schedule residencies by department to this questionnaire.

5. Person to whom questions may be directed.

Name	Title	Phone Number
------	-------	--------------

Answer question 6 only if you responded "no" to question 1.

6. a. Has your hospital considered implementing reduced schedule options in any existing residency programs ?

Yes _____ No _____

b. Are any reduced schedule residency programs definitely being planned for operation in the near future ?

Yes _____ No _____

If yes, indicate department name(s) _____

Reduced Schedule¹ (Part-time) Residency

Questionnaire

1. Do any of the residency programs at the institution(s) with which you are affiliated provide house officers with reduced schedule training options ?

Yes _____ No _____

If no, would you predict that your institution(s) would consider implementing reduced schedule residencies should sufficient demand be demonstrated ?

Yes _____ No _____

2. The following series of statements concern the relationship between reduced schedule residency training, overall program services and the individual house officers involved. Please respond to these items according to your perception of your institution's sentiments concerning these issues.

Response Definitions

1 = Strongly agree
2 = Agree
3 = No opinion
4 = Disagree
5 = Strongly disagree

	SA	A	N	D	SD
a. More individualized training for house officers is a likely result of reduced schedule residency programs.	1	2	3	4	5
b. Continuity in patient care would be diminished by the institution of part-time residencies.	1	2	3	4	5
c. Participation in reduced schedule residency training would primarily be used by the house officer to devote time to other medical activities.	1	2	3	4	5
d. Part-time residencies would primarily benefit women house officers.	1	2	3	4	5

¹ A residency program having reduced schedule training options is one in which the house officer may elect to complete residency training by working a number of hours per week that is lower than the usual program requirement.

	SA	A	N	D	SD
e. Program costs would not be significantly increased by the existence of reduced schedule training options.	1	2	3	4	5
f. On the average, the quality of applicants to reduced schedule residencies would be comparable to that of applicants to full-time programs.	1	2	3	4	5
g. The inclusion of reduced schedule training options would permit the education of more house officers, most notably in traditionally demanding residency programs.	1	2	3	4	5
h. Reduced schedule residencies would attract roughly equivalent numbers of men and women house officers.	1	2	3	4	5
i. The flexibility in scheduling afforded by part-time residencies will enhance coverage.	1	2	3	4	5
j. A decrease in house officer morale would be observed as a result of the existence of reduced schedule options.	1	2	3	4	5
k. Difficulties in scheduling teaching sessions may arise where reduced schedule residencies exist.	1	2	3	4	5
l. The main benefit of reduced schedule residency training options is that the house officer is provided with the opportunity for fuller participation in family life.	1	2	3	4	5
m. It would be more difficult to evaluate part-time rather than full-time resident performance.	1	2	3	4	5
n. Reduced schedule residency programs would not diminish the quality of house officer education.	1	2	3	4	5

	SA	A	N	D	SD
o. Inferior performance in patient-related duties would exist as a by-product of reduced schedule residencies.	1	2	3	4	5
p. Participation in reduced schedule residencies enable house officers to develop an adequate sense of responsibility concerning medical duties.	1	2	3	4	5
q. The lack of continuous, intensive experience during graduate medical education is a definite disadvantage of part-time residency training.	1	2	3	4	5
r. Reduced schedule residencies provide too many distractions for house officers.	1	2	3	4	5
s. Residents in reduced schedule programs can be expected to retain their technical skills as well as those in full-time programs.	1	2	3	4	5
t. House officers in reduced schedule residencies cannot readily transfer to other programs.	1	2	3	4	5
u. Within specific residency programs, the participation of some house officers in reduced schedule training would not negatively influence team effort among residents.	1	2	3	4	5
v. The existence of part-time residencies would encourage moonlighting by house officers.	1	2	3	4	5
w. Reduced schedule residency training options would not interfere with the successful operation of the National Intern-Residency Matching Program (NIRMP).	1	2	3	4	5

OSR ACCREDITATION PAMPHLET

A final draft of the OSR Accreditation Pamphlet will be distributed to the OSR Administrative Board at its meeting. In addition to reviewing the pamphlet, consideration should be given to defining a process for distributing the pamphlet, for informing students of pending site visits, and for receiving feedback on how the system for increasing student participation in accreditation site visits is working.