

OSR ADMINISTRATIVE BOARD AGENDA

Conference Room
One Dupont Circle
Washington, D.C.

March 23, 1976
7:00-10:00 pm
March 24, 1976
9:00 am - 4:00 pm

- I. Call to Order
- II. Consideration of Minutes
- III. Report of the Chairperson
- IV. ACTION ITEMS
 - A. Executive Council Agenda
 - B. Health Research Services and Analysis Study 41
 - C. Resolutions Approved by OSR at 1975 Annual Meeting 43
- V. DISCUSSION ITEMS
 - A. Curriculum and Evaluation 45
 - B. OSR Regional Meetings 49
 - C. Medical Student Stress
 - D. Discrimination Against Students with Service Commitments 50
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- VI. INFORMATION ITEM
 - A. Non-Cognitive Assessment Program
- VII. OLD BUSINESS
- VIII. NEW BUSINESS
- IX. ADJOURNMENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

January 12 and 13, 1976

AAMC Headquarters

Washington, D.C.

Chairperson

--Richard Seigle

Vice-Chairperson

--Thomas Rado, Ph.D.

Regional Representatives

--Robert Cassell (Southern)

--Jessica Fewkes (Western)

--Robert Rosenbaum (Central)

--Karen Skarda (Northeast)

Representatives-at-Large

--Robert Bernstein, Ph.D.

--Sheryl Grove

--Peter Kotcher

--Stephen Scholle

Immediate-Past-Chairperson

--Mark Cannon, M.D.

AAMC Staff

--Robert Beran, Ph.D.

--Robert Boerner

--Hilliard Jason, M.D.

--Amber Jones

--Joseph Keyes

--Richard Knapp, Ph.D.

--Marcia Lane

--Diane Mathews

--Charles Sherman, Ph.D.

--August G. Swanson, M.D.

--Marjorie Wilson, M.D.

Guests

--Laurel Cappa

--Louis Giancola

--Diane Rafalik

--John Barrasso

I. Call to Order

The meeting was called to order by Richard Seigle at 9:30 a.m.

II. Consideration of Minutes

The minutes of the September meeting were approved with the addition of a statement regarding the amicus curiae brief attached as Addendum 5. (Copy attached to this set of minutes as Addendum 1.)

III. Orientation to AAMC

August G. Swanson, Director of the AAMC Department of Academic Affairs, provided an outline of the AAMC's on-going programs and priorities for the coming year. He indicated that all AAMC programs and policies are included in Issues, Policies, and Programs which has been sent to the dean's office and the library of each U.S. medical school.

IV. Chairperson's Report

Richard Seigle reviewed with the Administrative Board the actions taken on the resolutions approved by the OSR at the Annual Meeting. He reported that after much deliberation and consultation with other members of the board, he decided not to act on the health manpower resolution until after the AAMC officers' retreat in December. Rich indicated that further discussion of the recent actions on the resolutions and consideration of possible future actions would be undertaken at a later point in the meeting when health manpower legislation and housestaff issues were addressed.

Tom Rado provided a brief report about the AAMC Retreat. He prefaced his report by mentioning that the Retreat was not a forum for decision-making but rather an informal discussion of general goals and priorities for the Association for the coming academic year. In the area of minority affairs, Tom reported that the officers of the Association expressed great concern that minority enrollment was not increasing at a sufficient rate to reach the goals established by the 1969 task force on minority affairs. The officers recommended the formation of a task force to review the status of minority enrollment and education in the medical schools.

OSR's role as a constituent of the AAMC was also discussed at the Retreat. Tom reported that one outcome of that discussion was the agreement that OSR would relate more closely with COD both at the staff level and by increased interaction of the OSR and COD Administrative Boards. It was also agreed that OSR would be afforded more opportunity for participation in policy decisions reached by AAMC. Tom indicated that a consensus was reached that when OSR had ample opportunity for input on positions reached by AAMC, it would be unnecessary and inappropriate for OSR to publicize dissenting views if the final positions were in conflict with OSR position. He stressed, however, that no absolute commitment was made on behalf of the OSR that they would not under any circumstances publicize a dissenting view. He emphasized the importance of clarifying positions to OSR representatives and pointed out that OSR members could dissent as individuals but not as representatives of OSR. Rich expressed his feeling that comments he had made in his newsletter had been misperceived and that this was a more accurate summary.

Tom also reviewed with the board the major points of a Retreat discussion about financing education in the ambulatory care setting. He reported that the Retreat participants concurred that educational programs in the ambulatory care setting are a major source of deficits for the medical schools and teaching hospitals. Tom pointed out that most medical schools and teaching hospitals do not have an adequate assessment of the cost of such programs and that medical schools use the out-patient departments for a teaching function to widely varying degrees. The Administrative Board expressed concern about this issue and discussed the possibility of polling the OSR regarding the extent to which out-patient departments are utilized in their educational programs.

A question was raised by Karen Skarda regarding the report of the Retreat which stated that "there was no disagreement expressed at the Retreat about the present position of the Association." The board felt that this statement inaccurately portrayed the degree to which the constituents agreed with the AAMC position since the OSR had expressed disagreement at the Annual Meeting and at other meetings with various portions of AAMC's health manpower position. The Administrative Board requested that Rich clarify the statement at the Executive Council meeting.

V. Student Nominees to AAMC Committees

ACTION: On motion, seconded, and carried the OSR Administrative Board agreed to forward the following nominations to Dr. Cronkhite, Chairman of the Association, for appointment to AAMC Committees:

Committee on International Relations in
Medical Education -- David Bell
Health Services Advisory Committee --
Standiford Helm
Data Development Liaison Committee --
Jessica Fewkes; Adrian Long (alternate)
Journal of Medical Education Editorial
Board -- Charles Ludmer (alternate);
Sheryl Grove (alternate); Mark Cannon
(alternate); and Ian Smith (alternate)
Resolutions Committee -- Stephen Scholle
Flexner Award Committee -- Charles Ludmer;
Ian Smith (alternate); Fred Frumin (alternate)
GSA Committee on Financial Problems of Medical
Students -- Joyce Pittenger
GSA Committee on Medical Education of Minority
Group Students -- William Wilkenson; Derrick
Taylor (alternate)
GSA Committee on Medical Student Information
System -- Nancy Hardt; David Diamond (alternate)
GSA Committee on Professional Development and
Advising -- William Meade; David Diamond (alternate)

VI. Women in Medicine

Dr. Marjorie Wilson, Director of the AAMC Department of Institutional Development, provided an historical review of the Association's activities in the area of women in medicine. Dr. Wilson indicated that AAMC activities in this area have been carried out largely on an ad hoc basis to date and have been decentralized in the various departments and divisions. She added that while a newly-created position in the President's office will provide a formalized focus for such efforts, the Association activities in this area will remain decentralized in the various segments of the staff.

After this introduction, Jessica Fewkes discussed her approach to the issue of women in medicine. She explained that her proposals were based on working first on the local level to initiate workshops for women medical students, to develop systems for counseling women contemplating a medical career, and to explore means of organizing rape counseling centers, child care facilities, and support groups for women at individual schools. Jessica reported that her efforts on the local level to accomplish these goals have been promising and recommended that the regional meetings would provide an excellent forum for expanding local activities to the national level. The regional chairpersons agreed to devote a portion of their spring meetings to the issue of women in medicine and to work with GSA members and premedical advisors in planning a program.

Jessica also reported that she was in the process of developing a questionnaire to be sent to OSR representatives in order to identify the key issues that should be addressed on the National level. It was pointed out that problems that women in medicine encounter in the medical school environment vary greatly among the schools. A national survey such as the one conducted in the late 1960's by Dr. Mary Howell would provide a means of focusing on the issues that continue to be encumbrances for women medical students nationally.

VII. NIRMP and the Transition from Undergraduate to Graduate Medical Education

Dr. Swanson reviewed for the Administrative Board the background of the National Intern and Resident Matching Program with particular emphasis on the growing number of NIRMP violations and the increasing requests from program directors for letters of evaluation on second-year students. He explained that the transition phase from undergraduate to graduate medical education poses many problems for students and student affairs deans.

Members of the Group on Student Affairs (GSA) suggested at their Annual business meeting the establishment of a uniform date before which requests for letters of evaluation would not be honored. The Administrative Board agreed that undue pressure is put on students when they must make career choices after having completed only one or two rotations. The board did not reach agreement about how this problem could be confronted without risking the chances for some students to obtain the programs they desire.

The OSR/GSA NIRMP monitoring system has proven to be basically ineffective in serving as a deterrent to program directors' pressuring students into making early commitments about program choices before matching day. Most of the board members agreed that the system is not a viable one but were not able to envision a more effective means for monitoring violations. It was pointed out that with the decreasing numbers of programs available and with the increasing preferences for primary care programs, it is likely that the competition among students for quality programs will result in more student-initiated rather than program director-initiated violations. There was consensus that Tom Rado should express the OSR's concerns to the GSA at the GSA Steering Committee meeting on February 1 and should work with staff to develop possible solutions to this problem.

VIII. Health Manpower Legislation

John Barrasso, OSR representative from Georgetown University School of Medicine, brought the Administrative Board up-to-date on recent developments related to health manpower legislation and the Labor-HEW appropriations bill. The Administrative Board discussed at length the AAMC position on health manpower and the variations from that position of the OSR Annual Meeting resolution on health manpower legislation. It was pointed out that the major disagreement between the OSR's position and the AAMC's position was the question of whether schools should receive baseline funding in the form of capitation grants.

Dr. Swanson and Mr. Keyes provided an historical perspective on this issue by pointing out that in the Comprehensive Health Manpower Training Act of 1971, the decision was made by the medical schools in collaboration with the federal

government to make basic changes in the structure of medical education by increasing enrollment and by supporting the development of new medical schools. The implied commitment made by the federal government was that medical schools as national resources should receive some baseline support to ensure their stability and viability. It is the Association's view that Congress has lost sight of that long-range goal and now intends to use support funds as a lever to accomplish goals that will continually change with political trends of the time.

Steve Scholle expressed his opinion that direct support to students is more desirable than capitation. He stated that because of the government's record with low-interest loans and the National Health Service Corps (NHSC), he feared the elimination of capitation might be coupled with an only slight increase in direct student support. The board members generally agreed that this situation would lead to a very undesirable "two-class system" in medical education.

IX. Recess

The OSR Administrative Board recessed at 5:00 p.m. until 9:00 a.m. on the following morning.

X. Executive Session

The OSR Administrative Board reconvened in Executive Session at 9:00 a.m. on January 13.

XI. Health Manpower Legislation

Richard Seigle called an Executive Session of the Administrative Board to discuss its current stand on the health manpower issue. He stated that he had chosen not to disseminate the OSR's Annual Meeting resolution on health manpower to members of the Senate health subcommittee primarily because the OSR had significant input to AAMC's position and because dissemination of the resolution would cause the OSR to lose much of its effectiveness within AAMC.

The board addressed the question of their responsibility to carry out a mandate from their constituency. There was general agreement that the OSR resolution, if not legislated by Congress in its entirety -- i.e., if the elimination of capitation were not coupled with a dramatic increase in student support -- would be detrimental to OSR's goals. Mark Cannon stated that this factor as well as consideration of the atmosphere in which the resolution was passed, made it necessary for the Administrative Board not to carry out the mandate.

Bob Cassell reasserted his opinion that the Administrative Board had a responsibility to respond to its constituents' mandate. Karen Skarda suggested that as a compromise measure the Administrative Board send a letter stating the essence of the resolution to the subcommittee members. The board also discussed whether it supported the actions taken by Tom Rado and Richard Seigle between the Annual Meeting and the Retreat in regard to the health manpower resolution.

ACTION: On motion, seconded, and carried, the OSR Administrative Board voted to support the actions taken to date by its Chairperson and Vice-Chairperson on the OSR's health manpower resolution.

ACTION: On motion, duly seconded, a resolution to send a letter expressing the OSR's dissenting position on health manpower legislation to members of the health subcommittees was defeated.

Steve Scholle moved that consideration of the issue of health manpower legislation be postponed indefinitely. He pointed out that the OSR had had substantial input into AAMC's position and that further input would have virtually no impact on Congress' deliberations.

ACTION: On motion, seconded, and carried the OSR Administrative Board voted to postpone consideration of health manpower legislation indefinitely.

XII. General Session

The OSR Administrative Board convened its General Session at 11:00 a.m.

XIII. Curriculum and Evaluation

Dr. Hilliard Jason, Director of the AAMC Division of Faculty Development, discussed his division's project to develop a methodology which will enable faculty members to assess their own effectiveness as teachers. Following Dr. Jason's brief review of AAMC's efforts related to curriculum and evaluation, Mark Cannon asked what strategies would be most useful for students to undertake to effect change in a medical school's curriculum. Dr. Jason responded and the board agreed that rather than encouraging the mandating of the content of curriculum, students should be encouraging a process of continuous evaluative review of curriculum.

The Administrative Board decided to work with Dr. Jason and other staff members in compiling a minimum recommended set of procedures for ongoing curriculum and teaching evaluation which could be used by students at the local institutions.

XIV. Reduced-Time Residency Survey

Marcia Lane, Research Associate in the Division of Educational Measurement and Research, discussed with the Administrative Board a survey she will be conducting to measure the existence of reduced-time residency programs and attitudes toward reduced-time residencies. The board expressed interest in and support of this project and requested that they be informed of the progress of the survey.

XV. Three-Year Curriculum Study

Dr. Robert Beran, Project Coordinator of the Three-Year Curriculum Study in the AAMC Division of Educational Measurement and Research, described in detail the project currently underway at AAMC to evaluate the three-year medical school program. Factors that create stress for medical students in a three-year curriculum will be examined, and the Administrative Board expressed particular interest in this aspect of the study. Dr. Beran agreed to keep the board informed about the progress of the study and to discuss in further detail at future meetings, plans for OSR to assist in the dissemination of the "Student Survey" portion of the survey.

XVI. Stress in Medical Education

Bob Rosenbaum presented to the Administrative Board a position paper (See Addendum 2)) which assessed the cause and effect relationship of stressful factors in the medical school environment and which made suggestions about ways to alleviate stress. Sheryl Grove also presented a position paper (See Addendum 3)) which concentrated on ways to assist students' ability to cope. Sheryl emphasized that her proposal was based on an outline for a course she has designed for use at her own medical school. It was generally agreed that there are two aspects to this issue: (1) how to reduce unnecessary stress-producing factors, and (2) how to cope with non-reducible stress.

The Administrative Board discussed these position papers at length and appointed Mark Cannon, Bob Rosenbaum, and Sheryl Grove to an OSR study group to further define the issue and to develop concrete proposals for dealing with it.

ACTION: On motion, seconded, and carried, the OSR Administrative Board appointed a study group on stress and charged the group to work with Dr. Hilliard Jason on the gathering of data and the development of proposals for addressing the issue of stress. The Administrative Board also recommended that sessions be held at the regional meetings to identify and categorize factors that contribute to medical student stress.

The Administrative Board requested that staff draft a student questionnaire on stress to be reviewed by the OSR at regional meetings.

XVII. Housestaff Issues

Tom Rado presented a position paper (See Addendum 4) which outlined the background of the AAMC amicus curiae brief filed with the NLRB and which analyzed the development of the Housestaff position within AAMC and OSR. Tom indicated

that as a result of the resolution passed at the OSR Annual Meeting, he sent a letter (See Addendum 5) to the National Labor Relations Board expressing OSR's dissent on this issue. He reported that at the Retreat, the AAMC officers agreed that OSR had not had sufficient input in the development of AAMC's position. Dr. Richard Knapp, Director of the AAMC Department of Teaching Hospitals, reiterated AAMC's recognition that OSR should have been provided an opportunity to participate to a greater extent in the formulation of AAMC policy on this issue.

The Administrative Board discussed the feasibility and desirability of obtaining a formal mechanism for housestaff input to AAMC. There was a consensus that a proposal for such a mechanism would be inappropriate at this point since a decision from NLRB is still pending. Karen Skarda pointed out the importance of continuing liaison with PNHA. Mark Cannon expressed the opinion that discussions and interactions with PNHA should revolve around mutual areas of interest in medical education rather than labor-related issues.

XVIII. OSR Communication

Peter Kotcher led a discussion about mechanisms for improving the communication between the Administrative Board and OSR representatives and between the OSR and AAMC staff. It was pointed out that many representatives do not receive background material for the Annual Meeting since AAMC often is not informed of the new representatives' names and addresses until late October or early November. Jessica Fewkes suggested that out-going OSR representatives should take responsibility for notifying AAMC when new representatives are elected to make the communication flow more efficient.

Laura Cappa mentioned that AMSA would be willing to add OSR representatives to its mailing list to receive general communications of interest to students. The Administrative Board agreed that this additional information would be helpful to OSR representatives and decided to poll the membership in a future mailing to determine which representatives would be interested in receiving AMSA publications.

XIX. Executive Council Agenda

A. Appointment of the Executive Committee

The Administrative Board explored the possibility of increasing the level of student input to AAMC by requesting that the OSR Chairperson be appointed to the Executive Committee. It was explained that the Executive Committee acts on behalf of the Executive Council in the interim between Executive Council meetings.

ACTION: On motion, seconded, and carried the OSR Administrative Board recommended the inclusion of the OSR Chairperson as a member of the AAMC Executive Committee.

In lieu of the permanent appointment of the OSR Chairperson to the Executive Committee, the board urged the Executive Council to appoint the OSR Chairperson to the Executive Committee on a temporary, trial basis for one year. The board also discussed the possibility of recommending that the OSR Vice-Chairperson be named as a second voting member of the Executive Council. It was the opinion of the Administrative Board that student views would receive more significant consideration if OSR had two voting seats on the Executive Council.

ACTION: On motion, seconded, and carried the OSR Administrative Board recommended that OSR be granted two voting seats on the Executive Council.

B. CCME Report: Physician Manpower and Distribution: The Role of the Foreign Medical Graduate

Sheryl Grove presented a position paper (See Addendum 6) which outlined the problems of the U.S. citizens studying medicine abroad and described the pathways for such students to enter the U.S. medical care system. Following this introduction, the Administrative Board discussed the issue with particular attention to the fifth pathway program. It was pointed out that AAMC had exercised its line-item veto within the CCME by not approving three recommendations in the original CCME report--one of which was that medical schools continue to offer the fifth pathway program on a voluntary and temporary basis. The CCME had requested the Executive Council to reconsider the three items it had deleted from the original report since the other parent bodies had approved the entire report. The Administrative Board reached a consensus that the fifth-pathway program should be phased out and supported the recommended alternate wording in the CCME Report (See Addendum 7).

ACTION: On motion, seconded, and carried the OSR Administrative Board recommended that the Executive Council approve the alternate wording proposed for Items A-4, B-11, and C-6 of the CCME Report on the Role of the Foreign Medical Graduate.

C. Position Paper on the Status of the Committee on Medical Education of Minority Group Students and Minority Affairs within the AAMC

The OSR board discussed the position paper which requested the establishment of an Organization of Minority Affairs similar in structure to the OSR. Rich Seigle explained that this proposal was discussed at the Retreat, and it was recommended that the request be referred to an Association standing committee which would be charged with reviewing this request as well as future requests for change in the Association's governance and structure. The OSR board concurred that this proposed committee would be the appropriate body to make a decision regarding the formation of such an organization.

A motion was made that the OSR support the request for an Organization of Minority Affairs. During the discussion, several board members expressed the opinion that changing the structure of AAMC would not necessarily alleviate the problems that exist in relation to minority enrollment. It was also pointed out that minority affairs concerns, rather than being structurally separate within the Association, are within the purview of the already existing constituent bodies. While most board members agreed that the creation of a separate organization of minority affairs officers was not a viable solution to the current problems in this area, they expressed the hope that a sincere effort be made by AAMC to examine the reasons why the goals for minority enrollment have not been reached.

ACTION: On motion, duly seconded, the OSR Administrative Board disapproved a motion to support the formation of an Organization of Minority Affairs within the AAMC.

XX. New Business

Karen Skarda pointed out that the AAMC Issues, Policies and Programs states that AAMC has not advanced a policy that more women be encouraged to enter the medical profession (See Addendum 8). The Administrative Board urged its representatives to the Executive Council to request that a policy clearly encouraging women to enter medicine be adopted.

ACTION: On motion, seconded, and carried, the OSR Administrative Board recommended that the AAMC adopt a policy to encourage women to enter the medical profession.

The board discussed the desirability of continuing to meet in joint sessions with officers of the other medical student organizations--AMSA, SNMA, and the Student Business Session of AMA. Laurie Cappa, President of AMSA, related to the board some of her organization's concerns regarding the viability of such joint meetings. Mark Cannon provided a review of the past activities of the joint group, and after brief discussion the board agreed that OSR should recommend the continuation of the joint meetings of the medical student groups.

XXI. Adjournment

The meeting was adjourned at 6:00 pm.

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.

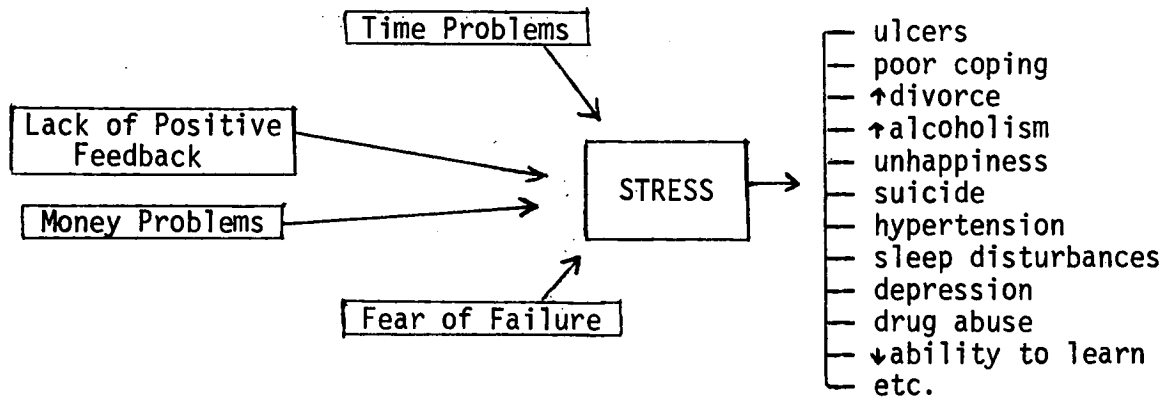
One point in question is the brief's assertion that the NLRB is at liberty to "decline jurisdiction over any labor dispute involving any class or category." The brief goes on to suggest that even if interns and residents are classified as "employees," the NLRB should decline jurisdiction over this category 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.

STRESS IN MEDICAL EDUCATION (CONT.)Assessment

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

Plan

AAMC Task Force

1. Composition

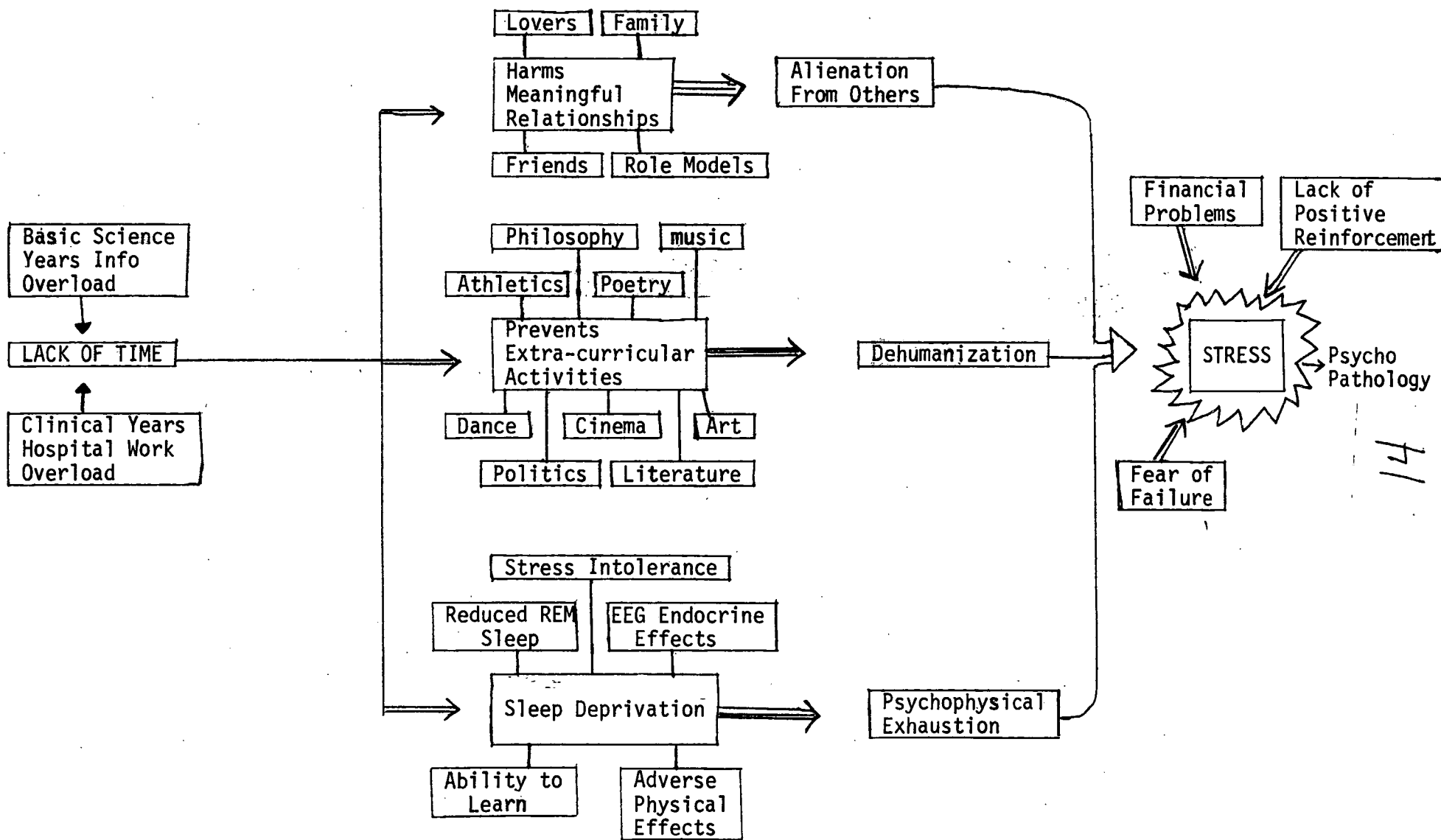
- COD
- OSR
- CAS
- GME
- GSA

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-graduate, 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.

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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.

Stuart Grove

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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?

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

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. 27

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.

Dear Ms. Murphy:

I'm writing to you at this time to carry out a resolution passed by the Organization of Student Representatives, an affiliate of the Association of American Medical Colleges, at their Annual Meeting in November, 1975 (Appendix I). The sense of the resolution requires that the National Labor Relations Board be informed of OSR's disagreement with the AAMC position on the role of housestaff in the teaching hospital.

The AAMC position was presented in the form of an amicus curiae brief and we recognize that this letter does not have the status of such a brief. We feel it is essential, however, that the Board be aware that while the AAMC brief presents an illusion of unanimity, dissenting views do certainly exist in the medical education community.

As medical students we are in an ideal position from which to assess the importance of service functions rendered by housestaff as teachers and as deliverers of patient care. Without detracting from the critical role performed by attending physicians during conferences and formal rounds, it is necessary to observe that under the present system the moment-to-moment and day-to-day care of patients is in the hands of interns and residents. With house officers, both among themselves and when working with medical students teaching never stops: It is a continuous process of quizzing, sharing knowledge, repeating the catechisms of pharmacotherapy, and reviewing patient progress in the light of recent actions.

In short, the training aspect of the housestaff experience is inextricably bound to the service and teaching function of the position; it would be as erroneous to deny that housestaff learn as it is to deny that they

are indispensable as providers of essential university/hospital functions.

The Organization of Student Representatives takes this opportunity to express its support for the position taken by housestaff in their reply to the AAMC amicus curiae brief. After reviewing the literature in this field, and considering the roles played by housestaff at our institutions we conclude that interns, residents and fellows -- as workers -- require the rights and protections of the Labor Relations Act and are appropriately to be considered under the jurisdiction of the National Labor Relations Board in matters of collective bargaining.

Respectfully submitted,

Thomas A. Rado
Vice Chairperson
Organization of Student Representatives
Association of American Medical Colleges
One Dupont Circle
Washington, D.C.

U.S. CITIZENS IN FOREIGN MEDICAL SCHOOLS

Numbers

There are 3715 Americans studying medicine in foreign countries. Guadalajara alone accepts 800 per year. French medical schools offer packaged plans of language training, transportation and contacts in France, but 80% of the students never make it to the second year due to stiff elimination examinations.

These students are from the 43,000 applicants to U.S. medical schools which have only 14,300 places (1974). Many of those rejected have identical pre-medical and MCAT credentials to those accepted, but were rejected due to sheer numbers of applications for each slot, particularly in the more populous states. (75% are qualified.)

According to AAMC figures, 80% of those who enroll in foreign med schools never survive the first year. Less than one-third ever make it back into U.S. medicine. The students themselves are bitter. They feel as qualified. They see many vacancies at the graduate medical education level filled with "true" FMG's. They read about doctor shortage areas. Some charge the AMA with holding down enrollment to perpetuate the tradition of high-priced medicine delivered by an elite. Parents and students have formed lobbying groups.

Problems

Many foreign schools are sharply limiting their acceptance of U.S. citizens. Those that do set high grade-points and MCAT scores. Once accepted, the American medical student must learn another language and adapt to a different culture, political system and health care delivery system.

Financial problems are severe. Tuition is very high and is estimated by some to far exceed the actual cost of educating the student. There is little loan or scholarship money available. School may take six or seven years to complete.

American students find themselves repeating courses they took in pre-med. Faculties are small. Basic sciences resources are limited; there is no carefully supervised bedside teaching until after the fourth didactic year.

The clinical internship may be poorly supervised. Many countries require a year of social service before granting the M.D., often in rural areas without supervision. Students attempt to avoid these two years by arranging for clinical clerkships in the U.S.--if they can get the foreign school to accept this.

The biggest hurdle of all is returning to the U.S.

Pathways

The first pathway is COTRANS--Coordinated Transfer Application System Program. In 1970 AAMC with the approval of AMA and with the cooperation of NBME instituted this program to assist U.S. citizen students who wish to transfer from foreign medical schools to advanced standing in U.S. medical schools. The steps are:

- review of applicants' credentials to determine eligibility for Part I of National Boards
- take Part I
- credentials available to interested U.S. schools to which the student must apply personally.

The advantages are earlier return to U.S. schools and graduation from an approved school with M.D. However, in no way does a passing score guarantee admission to any medical school. From 1970-74, 3150 students have taken the exam, 1044 (33.1%) have passed and 826 have transferred. Most of the 46 schools that currently participate in the program do not make special places for these students but simply use them to fill up a class when students drop out. In addition, the Mexican government has set up a roadblock by forbidding the students to take Part I until the third year.

National Boards performances have been poor. This may reflect deficiencies in the educational program or the limited abilities of the students. However, it may be the result of frantic attempts by these students to transfer in that they take the exams as early as the first semester before completing the courses covered in the exams.

The second pathway involves the ECFMG Qualifying Examination (Educational Commission for Foreign Medical Graduates). This is given to all foreign medical graduates with proof of medical education. It makes one eligible for graduate medical education programs and is required by state boards before one can take the licensing exam. The U.S. citizen must complete his education in the foreign school, for example, 6 years in Mexico. Only 36% of the 663 U.S. citizens passed this exam January, 1974. Some argue that the U.S. citizen should not have to meet criteria different from the USMG; that the ECFMG Exam is less (or more) difficult than National Boards. While the U.S. citizen has a language advantage and cultural conformity, he/she, nonetheless, has the same medical education in a health care delivery system which may bear little resemblance to that in the U.S.

The third and fourth pathways involve competence implied by receipt of a license granted by one of the states. I found no additional information on these.

The fifth pathway was proposed by the AMA Council on Medical Education, June, 1971, in response to pressures of parents and students involved. This consists of substitution of one academic year of supervised clinical training, under the direction of a medical school approved by the LCME for an internship required by a foreign medical school. Those who successfully complete this may enter the first year of AMA-approved graduate training programs without completing foreign social service obligations and without obtaining certification by the ECFMG. To be accepted for this, the student must complete:

- a review of premedical accomplishments to ascertain that he/she was qualified for U.S. schools
- the didactic portion of the foreign medical school
- successfully complete a screening exam which would also indicate needed remedial education (ECFMG or other).

The medical school has the responsibility of determining admission and completion criteria as well as the content of the clinical internship and needed remedial work. The most serious problem is that the student does not receive an M.D. degree when proceeding to licensure via this mechanism. In addition, U.S. schools' resources are committed to expansion of regular student body and not to remedial work and supervision that may be required by these students. Some states must pass special legislation for licensure (22 states now recognize the fifth pathway).

CCME Recommendations, June, 1975

1. Continuing efforts for U.S. to be self-sufficient in meeting health manpower needs
2. Every American interested in and qualified for entry into U.S. med schools have an equal opportunity to compete for admission -that the unsuccessful candidates be given counselling to enter an alternative career rather than enroll abroad
3. U.S. med schools continue and expand use of COTRANS
4. Pending achievement of #1, funds sought to assist U.S. medical students "in underwriting the special costs of educational programs for U.S. nationals who are studying in or have graduated from foreign medical schools." (?)
5. Eligibility requirements for U.S. nationals from non-accredited schools to qualify for medical licensure in U.S. be identical with those required of other graduates of unaccredited schools.
6. U.S. med schools continue to offer the fifth pathway on a voluntary and temporary basis.

AAMC Executive Council Recommendations

Where resources are available, qualified U.S. citizens should be selected by the faculty and admitted to advanced standing at a level deemed appropriate to place them in the normal pathway leading to the M.D. degree, this to supersede the fifth pathway program.

Other Recommendations in the Literature

1. American students abroad should be given utmost assistance....
2. Should not be classified as FMG but as ASA (American Studying Abroad)
3. ECFMG certification for 5th path should be eliminated
4. Method of increasing the number of medical students for little money compared to building a new school
5. Flow of FMG's can be diminished; return to own countries after completion of training

6. Student who completes the 5th path be awarded an equivalent American medical degree by the sponsoring medical school
7. 5th path should be officially inspected by the AMA and the AAMC

Dr. Richard Egan comments:

"We must try to effectively discourage the exodus to foreign schools of poorly qualified and disappointed applicants to U.S. schools. It will be unfortunate if our concern for return of qualified students is misinterpreted as encouragement to attend foreign schools."

Recommendations by author:

WHEREAS, there is no way to monitor the quality of education at foreign medical schools, and success rates of U.S. citizens in foreign schools is low (National Boards, ECFMG), and rejection may have been based on a valid reason apart from pre-med and MCAT credentials, and few medical schools seek active responsibility for the education of these students via COTRANS and 5th path, and expanded U.S. classes are already overloading clinical facilities at many schools, and many questions are raised about the ethics of using FMG's to meet manpower needs, the ethics of allowing other countries to shoulder the responsibility of medical education for U.S. citizens, the ethics of allowing U.S. citizens to take slots of foreign nationals, the ethics of evading the responsibility to the country educating them in the form of social service, and HEW has predicted oversupply of physicians by 1980,

OSR RECOMMENDS, that only carefully selected U.S. citizens in foreign medical schools of exceptional ability be allowed to re-enter U.S. medical education via COTRANS program,

AND that all medical students unsuccessful in their application to U.S. med schools be firmly counselled against studying abroad and into other (hopefully health-related) careers.

Respectfull submitted,

Sheryl Grove

Sheryl Grove
Representative at large

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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:

September 30, 1974

CCME REPORT
 PHYSICIAN MANPOWER & DISTRIBUTION:
THE ROLE OF THE FOREIGN MEDICAL GRADUATE

At its September meeting the Executive Council reviewed and approved the CCME Report on the Role of the Foreign Medical Graduate, specifically deleting three sections in accordance with its line-item veto power. At the most recent meeting of the CCME it was noted that all other parent organizations had approved the FMG Report in its entirety and the CCME requested that the AAMC reconsider its actions in deleting the three contested sections.

The provisions which were deleted by the Executive Council in September are listed below along with proposed alternate wording. In the first two instances this alternate wording was proposed by the CCME and would be acceptable as an editorial change. The third section dealing with Fifth Pathway programs is supported in its original form by the other members of the CCME; although this section did not appear in the original committee report to the CCME, it was added over the objections of several committee members after the CCME sponsored invitational conference.

ITEM A-4

PROVISION DELETED BY AAMC

That commencing one year following the adoption of this report the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools or other accredited schools of the health professions;

ALTERNATE WORDING (PROPOSED BY CCME)

That commencing one year following the adoption of this report the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools together with affiliated hospitals or other accredited schools of the health professions;

ITEM B-11

PROVISION DELETED BY AAMC

That on an interim basis special programs of graduate medical education be organized for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976. [This time restriction does not apply to physicians entering the U.S. with Seventh Preference visas (refugees).] Immigrant

physicians applying to such programs must present credentials acceptable to the sponsoring schools; the purposes of these special programs are:

- a. to provide a proper orientation to our health care system, our culture and the English language, and
- b. to identify and overcome those education deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and

ALTERNATE WORDING (PROPOSED BY CCME)

That on an interim basis special programs of graduate medical education be organized for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976. [This time restriction does not apply to physicians entering the U.S. with Seventh Preference visas (refugees).] Immigrant physicians applying to such programs must present credentials acceptable to the sponsoring agencies; the purposes of these special programs are:

- a. to provide a proper orientation to our health care system, our culture and the English language, and
- b. to identify and overcome those education deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and

ITEM C-6

PROVISION DELETED BY AAMC

That U.S. medical schools continue to offer on a voluntary and temporary basis to qualified U.S. nationals who have studied medicine abroad and have completed all of the formal requirements of the foreign medical school except internship and/or social service, an academic year of supervised clinical training (The Fifth Pathway program) prior to entrance into the first year of approved graduate medical education.

ALTERNATE WORDING (FROM AAMC POLICY)

That the special programs currently offered by some medical schools commonly called The Fifth Pathway Program should be phased out. Qualified U.S. citizens who have studied medicine abroad should be provided the same educational opportunities and recognition as their colleagues who enter U.S. medical schools directly. If resources can be made available, qualified students should be selected by the faculty and admitted to advanced standing. Their levels of admission should be determined by the

policies of the faculty, and they should be provided the regular educational opportunity and challenge deemed necessary for the awarding of the M.D. degree.

RECOMMENDATION

It is recommended that the Executive Council reconsider its actions in disapproving these three items and consider the adoption of the alternate wording suggested.

Health Research Services and Analysis Study

Health Research Services and Analysis, Inc., under contract with DHEW, Health Resources Administration, Office of Health Resources Opportunity, is conducting a national research study on Hispanic Physicians and Medical Students in the U.S.A. The study is designed to solicit and collect data which can be utilized for planning and improving the nation's health care programs serving the Hispanic population.

In order for the study to be effective, a random and scientific sample from the Hispanic medical student population must be selected. Since the names and addresses of students cannot be released in accordance with the Privacy Act of 1974 protecting the rights of students, it is suggested that the AAMC mail out the information regarding the study to the Deans of Student Affairs for distribution to Hispanic students. If the students decide to participate in the study, they can contact the Health Research Services and Analysis, Inc. by the mechanism provided in the survey material.

The information regarding the study has been reviewed by appropriate AAMC staff. It is recommended that OSR review the attached letter and endorse its dissemination by AAMC to Student Affairs Deans.



HEALTH RESEARCH SERVICES AND ANALYSIS, INC.

1100 GLENDON AVE. SUITE 1151 LOS ANGELES, CALIFORNIA 90024 AREA CODE (213) 477-2042

Dear Medical Student:

Health Research Services and Analysis, Inc., under contract with the Office of Health Resources Opportunity, Health Resources Administration, Department of Health, Education, and Welfare, is conducting a national research study. This study, the "Hispanic Physicians and Medical Students Study in the U.S.A.," is designed to enumerate Hispanic physicians and medical students with the objective of providing meaningful data which can be used for rational planning of U.S. health care programs serving the Hispanic population.

The importance of this study is emphasized by the relative paucity of data concerning Hispanic health providers. Even less data are available regarding Hispanic medical students who have recognizably lacked parity in the health field. Information gathered by HRSA could impact directly on recruitment and admission policies for Hispanics, resulting in a more equitable representation.

In this inceptive study, a randomly and scientifically selected sample of the Hispanic physician and medical student population will be personally interviewed using a structured questionnaire. However, before this representative sample can be drawn, comprehensive name and address lists of both Hispanic physicians and medical students must be compiled. HRSA's study list of physicians is complete; we are now soliciting your cooperation in assembling the list of medical students.

Hispanic medical students throughout the country are being asked to fill out and return the detachable portion at the bottom of this letter. This would insure the inclusion of your name on the preliminary listing. The Hispanic medical student portion of this survey will not be possible unless a complete list is compiled to insure the representativeness of the sample.

Any information you provide is on a voluntary basis only, with personal rights protected by the Privacy Act of 1974. All data collected from this study will be held in strict confidence and reported in statistical summary form only. Furthermore, all linkages between your name and the data will be destroyed after the data collection phase is completed.

The enclosed self-addressed stamped envelope is for your convenience. We urge you to return the requested information immediately as it has great importance and implication for the improvement of health services delivery systems to the U.S. Hispanic populations. Thank you for your time and cooperation.

Sincerely,

Jaime G. Salazar
Project Director

JGS:as

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RESOLUTION APPROVED BY OSR AT THE 1975 ANNUAL MEETING

Dissemination of Additional Information Regarding Health Manpower Legislation to Medical School Applicants

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

WHEREAS, applicants to medical school are generally unaware of the financial crisis in medical education and of health manpower legislation,

BE IT RESOLVED, that the OSR requests the addition of a new section in Medical School Admission Requirements designed to acquaint the applicant with these issues. The purpose of this section would be not to provide an up-to-date bulletin but rather to inform applicants about the existence of these problems.

Student International Exchange Programs

ACTION: *On motion, seconded, and carried, the OSR adopted the following resolution:*

WHEREAS, student international exchange programs provide an invaluable opportunity to broaden student perspectives on alternative health care delivery systems and cultural values,

WHEREAS, the AAMC Division of International Medical Education has in the past sponsored such exchange programs but at present is not doing so for lack of outside funding,

BE IT RESOLVED, that the OSR requests that the AAMC Division of International Medical Education make every effort to find sources of funding to establish such programs.

Guidelines for the Clinical Curriculum

The OSR adopted the following statement regarding guidelines for clinical curriculum:

Medical students in their third and fourth years function as service providers as well as learners.

Most of the time these roles serve each other but occasionally they conflict. We the members of the OSR feel that priority should be given to the students role as learners and that to implement this priority we recommend that the following guidelines for the clinical years of the medical school curriculum be adopted:

1. That hours per week in the hospital be limited to a maximum of 60-70.
2. That night call be no more frequent than every fourth night.
3. That teaching directed to the students' level take place for a minimum of 5-7 hours per week.
4. That scut work be held to the minimum necessary. for the students to learn the procedures involved.

Continuing Medical Education

The OSR approved the following statement regarding periodic relicensure of physicians:

We believe physicians to have an ongoing responsibility for maintaining competence in medicine and we believe that periodic relicensure of physicians is a necessity. To this goal we propose that the AAMC support the concept of physician relicensure on a periodic basis and support NBME's study of meaningful methods of relicensing M.D.s.

CURRICULUM AND EVALUATION

At the January Administrative Board meeting, medical school curriculum and evaluation was discussed with particular emphasis on ways by which students can impact on the curricular development and evaluation procedures at their local schools. The attached outline, prepared by Mark Cannon, is an assessment of this issue based upon the discussions which took place at the Annual Meeting. The Administrative Board may wish to discuss this issue further and consider the proposals presented in the attached outline.

CURRICULUM AND EVALUATION

SUBJECTIVE

1. Basic science material

- a. should be correlated more with clinical material
- b. much of what is presented is "irrelevant"
- c. too much emphasis on rote memorization, rather than thinking, understanding of concepts, and problem solving
- d. should be inter-departmentally integrated
- e. lecture format is overemphasized

2. Clinical training

- a. decrease hours and routine night-call obligations
- b. eliminate "scut work," i.e., required performance of procedures beyond the point where they are educational
- c. must have regular specified periods of formal teaching in clerkships

3. General

- a. desire for fewer requirements, more electives
- b. desire for greater emphasis on primary care, ambulatory care, and remote-site training
- c. desire for pass-fail grading system
- d. areas such as nutrition, human sexuality, medical ethics, and preventive medicine are underemphasized in most school's curricula
- e. many schools gear their curricula and teaching toward National Board exams
- f. need for each school to set overall objectives of its curriculum
- g. quality of teaching and teachers occasionally seems to be deficient

OBJECTIVE - Precise, objective national data are difficult to report:

1. Basic science material

- a. Virtually all schools make at least a minimal attempt to infuse some "clinical correlation" into the basic science portion, but few have an overall interlocking of the basic and clinical material
- b.
- c.
- d. About one-tenth of the U.S. schools have inter-departmentally integrated basic science curricula
- e. almost all schools rely heavily on lecture format for basic sciences, although some distribute lecture notes that render attendance optional

2. Clinical training

- a. almost all schools have one or more clerkships with routinely scheduled night call
- b. almost all schools rely on medical students for service functions (i.e., "scut work")
- c.

3. General

- a.
- b.
- c. data on prevalence of pass-fail systems are clouded by existence of such variations as "honors-pass-marginal-fail"
- d. most schools have some instruction in nutrition, human sexuality, medical ethics, and preventive medicine; but the extent and effectiveness at each school is presently unknown
- e. about 80% of schools require students to take National Board exams, and about 25% require passage
- f.
- g.

ASSESSMENT

There is a lack of data upon which to make a certain assessment of the problem. Clearly, there is much dissatisfaction with curriculum on the part of students. At the annual meeting's discussion group, 63% of the representatives said they were basically dissatisfied with their curricula in general, and 79% and 8% expressed dissatisfaction with the basic and clinical portions, respectively. Problems are best assessed and dealt with at the local level. However, it is difficult to mobilize student activism at the local level because of medical students' heavy time commitments and general disinclination to "buck the system." It is difficult to try at the national level to have an impact in the area of curriculum, since the AAMC does not prescribe curricular guidelines to its member schools.

PLAN

1. Increase communication among students at different schools regarding curricular problems and developments, to help stimulate changes at the local level.
2. Have OSR-AAMC serve as "clearinghouse" to put students or faculty desiring to make some kind of curricular change in touch with other schools that have made similar changes.
3. Encourage formation of local workshops (students and/or faculty) to evaluate and possibly reform curricula.
4. Encourage each school to develop a set of objectives for its curriculum.
5. Investigate possibility of mandating certain minimal curricular requirements via the accreditation mechanism.

6. Discourage schools' reliance on present National Board exams.
- 7. Support the development of new, more relevant national exams.

Mark Cannon

CALENDAR OF 1976 OSR REGIONAL MEETINGS*

<u>REGION</u>	<u>DATES</u>	<u>LOCATION</u>
South	March 27-30	Shreveport, LA
Northeast	April 19-22	Rochester, NY
Central	April 22-24	Ann Arbor, MI
West	May 8-11	Pacific Grove, CA

*All meetings will be held jointly with GSA; all meetings with the exception of the Central Region will be held jointly with AAHP.

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