OSR ADMINISTRATIVE BOARD AGENDA

Conference Room
One Dupont Circle
Washington, D.C.

June 22, 1976
7:00-10:00 pm
June 23, 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. Resolutions from OSR Regional Meetings
C. OSR Representation on AAMC Executive Council 17
D. Committee Nominations 20
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V. DISCUSSION ITEMS

A. OSR Annual Meeting 29
B. Medical Student Stress
C. Women in Medicine
D. Liaison with Other Student Groups
E. Housestaff Issues

VI. INFORMATION ITEMS

A. Health Manpower Legislation
B. Regional Meeting Reports

VII. OLD BUSINESS

VIII. NEW BUSINESS

IX. ADJOURNMENT

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

March 23 and 24, 1976
AAMC Headquarters
Washington, D.C.

Chairperson	-- Mr. Richard Seigle
Vice-Chairperson	-- Dr. Thomas Rado
Regional Representatives	-- Mr. Robert Cassell (Southern)
	-- Mr. Robert Rosenbaum (Central)
	-- Ms. Karen Skarda (Northeast)
Representatives-at-Large	-- Dr. Robert Bernstein
	-- Ms. Sheryl Grove
	-- Mr. Peter Kotcher
	-- Mr. Stephen Scholle
Immediate-Past Chairperson	-- Dr. Mark Cannon
AAMC Staff	-- Mr. Robert Boerner
	-- Ms. Judy Braslow
	-- Dr. John A.D. Cooper
	-- Ms. Gail Gross
	-- Ms. Juel Hodge
	-- Mr. Joseph Keyes
	-- Dr. Richard Knapp
	-- Ms. Diane Newman
	-- Dr. August G. Swanson
	-- Ms. Xenia Tonesk
Guests	-- Mr. John Barrasso

I. Call to Order

The meeting was called to order by Richard Seigle at 7:00 p.m.

II. Consideration of Minutes

The minutes of the January meeting were approved with the addition of the following paragraph on page 4 under Item VIII:

> "Robert Bernstein presented a paper to the Administrative Board which discussed national health care legislation. As background for the discussion to follow on health manpower legislation, he outlined various aspects of current leigslation with special emphasis on the National Health Planning and Resources Development Act of 1974. He expressed the opinion that AAMC should take the initiative to develop a comprehensive, rational approach to health care delivery in the U.S."

III. Chairperson's Report

Richard Seigle reported that the Executive Council, at its January meeting, commissioned a Task Force on Medical Student Financing and a Task Force on Minority Student Opportunities in Medicine. Dr. Cronkhite, Chairman of the Association, appointed Joyce Pittenger, OSR representative from University of Kansas, to the task force on student financing and Tom Rado to the minority affairs task force. The Administrative Board discussed the appropriateness of the appointment of a non-minority student to the minority affairs task force, and questioned whether Dr. Cronkhite had consulted the OSR Chairperson prior to making the appointment. The staff indicated that Richard Seigle and Tom Rado had been consulted regarding student appointments to both task forces. Tom Rado stated that he had not reached a decision about serving on the minority affairs task force, and the Administrative Board agreed to support whatever decision he reached. Mr. Seigle also reported that Bob Bernstein had been appointed to an ad hoc committee which would be meeting the following day to review the Institute of Medicine's Report on Medicare-Medicaid Reimbursement Policies.

Mr. Seigle reported that he and Peter Kotcher had attended the AMSA National Convention in early March. One program that both found particularly valuable focused on the medical education program at McMaster University. Mr. Kotcher suggested that the board consider inviting individuals from McMaster to speak on the subject of innovative approaches to medical education at the OSR Annual Meeting. Mr. Seigle reported that he was not granted the opportunity to address the AMSA House of Delegates since only delegates have the privilege of the floor and no special arrangements had been made for leaders of other student groups. The Administrative Board agreed that in order for liaison among the various student groups to be effective, OSR officers should have the opportunity to attend other groups' meetings and to be extended the right to speak in their meetings. A motion was introduced and approved that Mr. Seigle send a letter to AMSA, SNMA, and the Student Business Session of AMA conveying OSR's views on this matter.

IV. Vice-Chairperson's Report

Tom Rado reported that the Council of Deans Administrative Board spent a considerable amount of time at its January meeting discussing various aspects of the medical student financial aid crisis. Information reviewed by the COD showed that recently admitted medical school classes are composed of increasing numbers of students from upper income families. Because of a decrease in direct financial support to medical schools, tuitions are rising at a rapid rate, and cutbacks in federal loan and scholarship programs limit the ability of students from lower-income families to afford medical education. Mr. Rado indicated that the newly-formed Task Force on Medical Student Financing would be attempting to develop innovative approaches to deal with this multi-faceted problem. The OSR board expressed concern that the trends evident in the data presented by Mr. Rado will, if allowed to continue, restrict access to medical education to the wealthy. The board concluded that this issue was of critical concern to students and agreed to follow it closely through the student representative to the AAMC task force.

Mr. Rado also reported that the National Labor Relations Board reached a 4-1 decision that unions representing interns, residents, and clinical fellows will not be granted the protection of the National Labor Relations Act. Several members of the board questioned the nature and extent of the impact of this decision. It was agreed that discussion of all of the issues surrounding the NLRB decision should be postponed to the following day when staff from the AAMC Department of Teaching Hospitals would be present.

V. Recess

The OSR Administrative Board recessed at 10:30 p.m. until 9:00 a.m. on the following morning.

VI. Reconvene

The OSR Administrative Board reconvened at 9:00 a.m. on March 24.

VII. Non-Cognitive Assessment Program

Xenia Tonesk, Research Assistant in the AAMC Division of Educational Measurement and Research, discussed with the Administrative Board the history and current status of the AAMC's non-cognitive assessment program. She reported that the Medical College Admission Assessment Program (MCAAP) National Task Force recommended in 1973 that the Association examine the feasibility of providing medical school admission committees with a means to assess applicants' non-cognitive characteristics. Ms. Tonesk explained that the purpose of the program is to augment admissions committees' ability to assess the total applicant by integrating new and improved non-cognitive assessment techniques with existing cognitive data. The ultimate objective of the project is to make available to medical schools a non-cognitive admission assessment package for their use on a voluntary basis.

The AAMC is currently developing a proposal for funding of the project which presents strategies for collecting information about seven personal characteristics: compassion, interprofessional relations, decision-making, physical and motivational staying power, coping capabilities, sensitivity in interpersonal relations, and realistic self-appraisal. Four collaborators (American Institute of Research, McBer and Company, Dr. Woodrow Morris of the University of Iowa School of Medicine, and Drs. Lorr and Suziedelis of Catholic University) are providing different approaches for measuring these characteristics. Ms. Tonesk indicate the project will require at least four years from the date of funding until the instruments are made available for research purposes. If the instruments prove to be valid and reliable, they will be made available to the schools at a later date.

In the discussion which followed, several members of the board expressed concern about the potential for misuse of non-cognitive instruments by the medical schools. Particular concern was voiced about the possibility that schools may seek to admit, for example, individuals with a high level of coping capabilities and thus not feel responsible for reducing unnecessary stress factors in medical education. Mark Cannon, who served on the original MCAAP Task Force, stated that his experience with the task force and with the project staff led him to believe that the potential for abuse of the non-cognitive assessment program was far outweighed by the potential benefits. The Administrative Board expressed a desire to continue to be informed of the progress of this program.

VIII. Executive Council Agenda

A. Report of the Task Force on Continuing Medical Education

The Administrative Board discussed with AAMC staff member, Dr. Emanuel Suter, the report of the task force and the various issues and implications of the rapidly expanding field of continuing medical education. The board agreed in general with the recommendations included in the report. (See Addendum 1). Several members pointed out that the emphasis in this area must be placed on detecting and evaluating patient care deficiencies and offering programs targeted at correcting those specific deficiencies. Karen Skarda mentioned that the OSR had approved a resolution at its Annual Meeting supporting the concept of periodic relicensure, and suggested that studying the relicensure issue be undertaken by the proposed ad hoc Committee on Continuing Medical Education.

ACTION: On motion, seconded, and carried, the OSR Administrative Board supported the task force report and recommended that the proposed ad hoc committee on Continuing Medical Education study mechanisms for the periodic relicensure of physicians.

B. Admission of Women to Medical School

At the January meeting, the OSR requested the Executive Council to re-examine the AAMC's policy on the admission of women to medical school. The OSR supported the basic thrust of the new proposed policy statement (See Addendum 2), but suggested rewording the introductory paragraph in order to state the policy in a more positive manner.

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the proposed policy statement on the admission of women to medical school with the change of the first paragraph to read: "The Association strongly supports the use of admission policies which do not discriminate against women and is committed to removing any barriers which make it more difficult for women to have a successful career in medicine.

C. LCME Guidelines for Functions and Structure of a Medical School

Dr. James Schofield, Director of the AAMC Division of Accreditation was present to discuss with the board the guidelines which were submitted to the Executive Council for consideration.(See Addendum 3) Dr. Schofield explained that a subcommittee of the Liaison Committee on Medical Education (LCME) had prepared the guidelines as an amplification of current LCME policy set forth in the pamphlet, "Functions and Structure of a Medical School." He pointed out that the LCME had found need for a document that more specifically delineates LCME policy but that is not specific to an extent which would restrict the high degree of diversity which exists among the medical schools. The

OSR Administrative Board was generally supportive of the proposed guidelines and recommended four amendments with regard to clinical instruction, student representation on school committees, student facilities, and curriculum.

ACTION: On motion, seconded, and carried, the OSR Administrative Board endorsed the LCME Guidelines with the following amendments:

Page 29 - Addition of two sentences to second paragraph following third sentence to read: "Clinical instruction of undergraduate students at a level commensurate with their training should co-exist with and not be replaced by, programs directed primarily at housestaff. While it is essential that students perform tasks related to patient-care, the provision of service should not be permitted to take precedence over the learning process.

Page 30 - Addition of clause to end of second paragraph to read: "for delivering medical services, and might include the topics of nutrition, human sexuality and behavior, ethics, doctor-patient interactions, and jurisprudence."

Page 35 - Delete words "mature and responsible" from the last sentence and change "membership" to "participation."

Page 47 - Addition of sentence to first paragraph to read: "Child care facilities and minimal recreational facilities should be included in order to sustain students' mental and physical health."

IX. Graduate Medical Education

The Administrative Board discussed at length the entire area of graduate medical education in light of NLRB's refusal to extend jurisdiction of the National Labor Relations Act to cover house officers. Dr. Knapp, Director of the AAMC Department of Teaching Hospitals, explained that the decision affects housestaff in private hospitals only since public institutions are not subject to the Taft Hartley Act. He also indicated that while the Board's decision denies housestaff the status and protections offered to employee unions by the National Labor Relations Act, the decision will not necessarily affect voluntary negotiations. Dr. Swanson discussed with the Administrative Board the efforts of the Association and of the LCGME and the CCME to improve the quality of graduate training programs through the accreditation process. He reported that although changes in the structure of graduate medical education have been slow, progress has been made to move graduate education away from the apprenticeship/employee realm with wide program to program quality variance to a system based upon broad, institutionalized concern for the quality of programs.

The board voiced disagreement with the lack of housestaff participation in AAMC's efforts to improve the educational content of graduate medical education. The board reached the conclusion that since the NLRB had decided that housestaff are indeed students rather than employees, it would be appropriate for the Association to take a positive step to seek input from this segment of the constituency.

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

In the light of the recent decision by NLRB in the matter of Cedars-Sinai Housestaff Association vs. Cedars Sinai Hospital, it becomes increasingly important that the educational quality of the postgraduate medical experience be protected from erosion by excessive demands for the provision of service.

Therefore, BE IT RESOLVED THAT:

1. The AAMC develop a formal position statement commiting the Association to the primacy of learning over service in graduate programs;

2. Accrediting commissions be urged to obtain input from housestaff regarding the educational quality of their programs;

3. Residents should be informed, perhaps through an accreditation pamphlet, of the importance of their input to the accreditation process;

4. The AAMC should make every effort to ensure adequate respresentation of housestaff views before the Association.

X. OSR Representation on the Executive Council

Tom Rado reported that the Council of Deans (COD) Administrative Board discussed at its January meeting, OSR's request for two voting seats on the AAMC Executive Council. He indicated that while there was mixed reaction among members of the COD Administrative Board, he believed that they would be receptive to such a request if it included a mechanism for ensuring greater continuity in OSR participation on the Executive Council. The COD Board discussed the possibility of OSR's returning to a system of electing both a Chairperson and Chairperson-elect, who would assume the Chairpersonship in the second year of office. The OSR Administrative Board reached a consensus that a more advantageous system for ensuring continuity would be to seat both the Chairperson and the Immediate-Past-Chairperson on the Executive Council. Mr. Keyes responded that such a proposal was potentially unworkable since the Association's tax-exempt status would be jeopardized if the Immediate-Past-Chairperson had graduated from medical school and was not, therefore , an institutional representative.

ACTION: On motion, seconded, and carried, the OSR Administrative Board agreed to request that the OSR Immediate-Past-Chairperson become a voting member of the AAMC Executive Council.

XI. OSR Communication

Peter Kotcher recommended that OSR members begin to receive the AAMC Education News, a newsletter published five times per year by AAMC and supported by the National Fund for Medical Education. AAMC Education News reports on instructional innovation, assessment, and curriculum and is currently distributed to all fulltime medical school faculty. Dr. Swanson indicated that since this is a realtively new publication which receives outside funding, there were financial considerations to expanding its circulation. Staff agreed to explore the feasibility of making AAMC Education News available to OSR members.

Mr. Kotcher also recommended that OSR attempt to follow-up on the medical student liability insurance survey. The survey results indicated that 23% of the responding schools do not carry liability insurance for their students. The board agreed to discuss this matter with the COD Administrative Board and to develop a mechanism for informing students at the individual schools of their insurance status.

XII. Women in Medicine

Judith Braslow, recently-appointed Special Assistant to the AAMC President for Women in Medicine, attended the meeting to discuss with the board her current activities and future plans in the area of women in medicine. Ms. Braslow reported that she hopes to establish a national communications network for women in the health field by compiling a list of active groups concerned with women in medicine across the country. Thus if a medical school wishes to establish a special counseling system for women students, for example, it will be able to contact, by virtue of this list, individuals at other schools who are already conducting a similar program. Ms. Braslow related many other short-range and long-range goals of her office, and expressed an interest in hearing from women students about how she can best serve their needs. The OSR Administrative Board questioned the fact that the position of Special Assistant to the President for Women in Medicine is not a fulltime position since Ms. Braslow spends a portion of her time as a legislative analyst in the AAMC Division of Federal Liaison. The board agreed to recommend that the position be expanded.

XIII. Health Research Services and Analysis Study

Health Research Services and Analysis, Inc., (HRSA) under contract with DHEW, is conducting a national research study on Hispanic physicians and medical students in the U.S. HRSA requested AAMC to assist in their study by disseminating information about the study to Student Affairs Deans for distribution to Hispanic students. Medical student names and addresses cannot be released in accordance with the Privacy Act of 1974, and OSR is routinely consulted about AAMC's cooperating with studies which will involve surveying medical students. The OSR Administrative Board agreed that AAMC should cooperate with HRSA in disseminating information about the study to Student Affairs Deans.

XIV. OSR Annual Meeting Resolutions

The following resolutions, approved by the OSR at the 1975 Annual Meeting, were considered by the Administrative Board for disposition:

A. "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."

ACTION: On motion, seconded, and carried, the OSR Administrative Board referred this resolution to the GSA Committee on Medical Student Information System.

In addition, the board agreed to explore with staff the feasibility of including additional sections which would be of interest to applicants in Medical School Admission Requirements.

B. "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 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."

ACTION: On motion, seconded, and carried, the OSR Administrative Board referred the above resolution to the Committee on International Relations in Medical Education.

C. "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."

ACTION: On motion, seconded, and carried, the OSR Administrative Administrative Board referred the above statement on guidelines for the clinical curriculum to the Council of Deans for information.

XV. Stress in Medical Education

Robert Rosenbaum outlined plans for the OSR regional meeting sessions on stress. Each regional group will be apprised of OSR's activities in this area, and group dynamics techniques will be used to identify and rank order non-productive stress factors. Mr. Rosenbaum explained that following the regional meetings the working group on stress will develop, with the assistance of Dr. Hilliard Jason, a survey form which will assess non-productive stress in medical education.

XVI. Discrimination Against Students with Service Commitments

Robert Cassell presented two questionnaires he designed to assess whether program directors discriminate against students with service commitments in the residency selection process. Mr. Cassell stated that it is difficult to discern how widespread this problem might be since only anecdotal data has been reported. The Administrative Board agreed that rather than proceed with any data collection at this point, it would be a more appropriate first step to discuss the matter with the Council of Academic Societies. It was pointed out that the AAMC is currently under contract with the Bureau of Health Manpower (BHM) to conduct a study of NHSC applicants and participants. The Administrative Board requested that staff explore the possibility of collecting data on this issue through the BHM study.

XVII. OSR Annual Meeting

Tentative plans for OSR activities at the AAMC Annual Meeting were discussed by the Administrative Board. Since the Annual Meeting is scheduled for Thursday, November 11 through Sunday, November 14, the OSR activities will begin on Wednesday, November 10 and will conclude on Friday just prior to the Council of Deans Business Meeting.

XVIII. Adjournment

The meeting was adjourned at 5:00 p.m.

TASK FORCE ON CONTINUING MEDICAL EDUCATION

Report to the Executive Council

INTRODUCTION

The Task Force on Continuing Medcial Education[1] was appointed in the fall of 1975 by the Executive Council and was charged with an assessment of the Association's role in this rapidly expanding field. In developing its report, the Task Force reviewed both the history of the Association's involvement in the area and the current pressures for a more active and visible role.

In 1972, a special ad hoc committee on continuing medical education was appointed by the Executive Council. Its report, only partially adopted, resulted in the acceptance of general policy statements regarding principles of continuing education.

The present Task Force perceived its charge to be that of describing more specifically the role of the AAMC in continuing medical education and of recommending appropriate mechanisms for carrying out this role. The Task Force did not attempt to deal in depth with the many substantive questions, either political or scientific, that relate to continuing medical education. Rather it suggested structures and mechanisms for dealing with these questions over the coming months and years.

The Task Force report is divided into the following four sections: 1) definition of continuing medical education; 2) problems and pressures affecting continuing medical education; 3) role of the Association in continuing medical education; and 4) recommendations for mechanisms to carry out this role.

DEFINITION

Continuing medical education is defined as all activities that result in the maintenance and/or enhancement of the physician's professional knowledge, attitudes and skills. Its purpose is the improvement of professional performance and of the quality of medical services to the public. Continuing medical education encompasses the period of time after completion of undergraduate and graduate medical education. It is a lifelong process requiring persistent motivation and intellectual discipline, qualities that should be developed and maintained during undergraduate and graduate medical education. The definition includes a wide range of learning activities both formal and informal.

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[1] William H. Luginbuhl, M.D., University of Vermont, Chairman
Clem Brown, M.D., South Chicago Community Hospital
Mike Caruso, University of Alabama
Carmine D. Clemente, Ph.D., University of California, Los Angeles
Phil R. Manning, M.D., University of Southern California
William D. Mayer, M.D., University of Missouri, Columbia
Mitchell T. Rabkin, M.D., Beth Israel Hospital, Boston
Edward C. Rosenow, Jr., M.D., American College of Physicians
Neal A. Vanselow, M.D., University of Arizona
John Williamson, M.D., Johns Hopkins University

PROBLEMS AND PRESSURES AFFECTING CONTINUING MEDICAL EDUCATION

1. External Pressures

In recent years, the system of continuing medical education in the United States has been exposed to a number of external pressures, each of which has resulted in demands for change in the traditional methods used to conduct this phase of the continuum of medical education. These pressures arise at a variety of levels: sociopolitical and legal; technical-scientific; professional-organizational; medical practice; and personal. The major external pressures are:

A. Increased public interest in the quality, availability, accessibility, cost, and effectiveness of health care. The rise of medical consumerism as well as the interest of third party payers have increased the demand for more effective and accessible programs of continuing medical education. This trend is likely to continue.

B. Increased governmental interest in health care. This is due largely to increased public interest in health care and has resulted in a number of direct pressures on the system of continuing medical education in this country. Two manifestations are:

1) Changing requirements for re-registration of the license to practice medicine. Several states now require evidence of participation in continuing medical education as a condition for re-registration of the license to practice medicine. Some members of Congress have advocated federal licensure and relicensure of physicians. While no jurisdiction, state or federal, now has re-examination requirements for re-registration, it is not inconceivable that such programs could be developed in the future. All of these factors, directly or indirectly, are acting to increase the demand for continuing medical education.

2) Professional Standards Review Organizations (PSROs). The identification of deficiencies in patient care by federally mandated PSROs can be expected to increase the demand for target-oriented continuing medical education programs.

C. Rapid increase in biomedical knowledge. During the past several decades there has been a rapid increase in the amount of biomedical knowledge directly applicable to the practice of medicine. As a result, it is essential that practicing physicians participate in continuing medical education to keep abreast of advances pertinent to their practice.

D. The malpractice crisis. The crisis over malpractice insurance has increased the demand for continuing medical education in at least two ways: some state legislatures have incorporated continuing medical education requirements in newly passed malpractice legislation, and concerns over malpractice suits have increased the interest of the practicing physician in continuing medical education.

E. Continuing medical education requirements of scientific and professional societies. In recent years some scientific and professional societies have established voluntary programs which promote participation in continuing medical education (e.g. the AMA Physician's Recognition Award, self-assessment program of the American College of Physicians). Others, including at least twelve (12) state medical societies and six (6) medical specialty societies, have mandatory requirements for participation in continuing medical education as a condition of membership.

F. Recertification requirements of medical specialty boards. In response to a rapidly increasing momentum for recertification procedures, the American Board of Medical Specialties has endorsed a policy for voluntary, periodic recertification of medical specialists as an integral part of national medical specialty certification programs. Implementation of this policy is expected to increase the demand for continuing medical education from those board diplomates who are preparing for their recertification examination.

G. Standards of the Joint Commission on Accreditation of Hospitals (JCAH). Standards of the JCAH requiring in-hospital peer review and continuing medical education have increased the demand for hospital-based continuing medical education.

H. Formation of the Liaison Committee on Continuing Medical Education (LCCME). As it becomes fully operational, the LCCME can be expected to exert pressures for change in our traditional system of continuing medical education.

I. Increases in numbers and types of allied health professionals and interest in the concept of the "health care team." With continued augmentation in the numbers of allied health professionals, such as nurse practitioners and physician's assistants, and with continuation of recent interest in the "health care team," there will be increasing pressure to provide interdisciplinary continuing education programs.

2. Internal Problems

There are a number of problems internal to the system of continuing medical education in the United States, which limit its ability to respond to the external pressures enumerated above. Some of these problems are:

A. Great variation in the motivation of practicing physicians to participate in continuing medical education. The acquisition of a commitment to lifelong learning through continuing medical education is often a stated but not achieved goal for undergraduate or graduate medical education. However, until the learners in these phases of the continuum become more active participants in their own educational planning, development and evaluation, this situation is likely to persist. Until recently, participation in continuing medical education has been purely voluntary and largely dependent upon the internal motivating factors of each practicing physician rather than upon external forces. While this situation is changing rapidly, internal motivating factors are still the primary determinant of participation or non-participation in continuing medical education.

B. Embryonic stage of the theory and technology of continuing medical education.

1) Inadequacy of efforts made to identify the continuing medical education needs of practicing physicians and to direct educational programs to those needs. Most continuing medical education activities use the "shotgun" rather than the target-oriented approach and are based on instructor perceptions of physician needs rather than on a careful analysis of those deficiencies in patient care which could be remedied by education.

2) Inappropriate educational methods used in most continuing medical education programs. Much continuing medical education is episodic in nature, involves the student as a passive rather than as an active participant, and is conducted away from the practice setting. Great emphasis is placed on the transmission of factual material with little effort being made to assure the improvement of performance desired by the learner or the instructor.

3) Inadequate evaluation of the effectiveness of most continuing medical education programs. When attempts at evaluation are made, they consist usually of measuring the participants' satisfaction and occasionally evaluating the factual knowledge gained. Assessing the degree to which the continuing medical education activity improves patient care is rarely attempted or achieved. Efforts to develop effective evaluation procedures have been hampered by their cost and by difficulties in isolating the influence of a given continuing medical education activity on the physician from other influences to which he is exposed over the same time period.

C. Relative inaccessibility of continuing medical education to many physicians. Inaccessibility results from a number of factors, including the time demands of medical practice, the relative unavailability of continuing medical education in rural areas, and the lack of readily available educational materials at the time the physician recognizes the need.

D. Inadequate funding for research and development by present methods of financing continuing medical education. Most continuing medical education is funded from fees paid by the participants. This method of financing has provided little surplus for use in research and development. In general, private foundations and governmental agencies have been reluctant to support research and development in continuing medical education.

E. Absence of incentives, rewards or recognition in most medical schools for faculty members for participation in continuing medical education activities. However, increasing rewards from extra institutional sources for participation as instructors in continuing medical education activities are beginning to erode institutional efforts.

F. Lack of structure for continuing medical education. The "system" of continuing medical education in the United States is in reality a "non-system." Many groups are involved (including university medical schools, professional societies, hospitals, drug companies, commercial groups, etc.) but at present there is little effective coordination of their activities. The LCCME should provide a focus of coordination and supervision.

G. Inadequacy of the accreditation process of providers of continuing medical education. Accreditation, as now operated, is not based on the demonstration of the need, appropriateness or effectiveness of the program(s) being evaluated and requires to be evaluated critically.

ROLE OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IN CONTINUING MEDICAL EDUCATION

From the foregoing section it is apparent that there are irresistible pressures and associated challenges for the further development of continuing medical education. For the membership of the AAMC, the pressures will necessitate a greater involvement in continuing medical education, but the inherent problems will render this involvement both challenging and frustrating. Although the members of the AAMC should and certainly will respond individually, they can be assisted significantly by a more active leadership role of the Association. This role as perceived by the Task Force includes at least the following four charges:

1. Promotion and encouragement of and participation in research in all aspects of continuing medical education: Research in education is a primary and traditional thrust of the Association cutting across undergraduate, graduate and continuing education. Although research in medical education is not the exclusive province of the AAMC, the Association is particularly well equipped to provide a focus and a forum. This role is discharged at both national and regional meetings, through publications, and at workshops. Furthermore, the Association has an established record of attracting research grants and contracts from governmental agencies and foundations, especially those that require interinstitutional cooperation.

2. Assistance and encouragement in the application of the principles of continuing medical education: It is perceived that a commitment to continuing medical education should be promoted during medical school. The AAMC can play a role in fostering this development through assistance in curriculum design, dissemination of educational innovations and participation in the accreditation process.

3. Provision of a forum for the discussion of educational, fiscal, political and administrative issues: A need exists for a forum for a discussion of educational, fiscal, political and administrative issues involved in continuing medical education. This is one of the major drives behind the creation of a new organization for continuing medical education. Just as other medical school administrators and faculty members in areas as diverse as admissions, business affairs, development and the various biomedical disciplines feel the need to meet and interact with colleagues about shared problems, those involved in continuing medical education desire a similar forum.

4. Participation with other groups in formulating policy and programs and serving as a vehicle to convey to the government the views of medical schools on continuing medical education: As continuing medical education becomes more the object of legislation, governmental regulations and professional society standards, there is a need for ways to provide input about these matters from medical college faculty. The Association has already established effective communication channels which can be employed additionally to serve the interests of continuing medical education.

MECHANISMS FOR THE ASSOCIATION TO CARRY OUT ITS ROLE

The role of the Association in continuing medical education described in the preceding section implies heightened levels of activity by the medical schools, their faculties and the Association. The Association will be called upon to collaborate closely with the directors of continuing medical education appointed by the medical schools and to interact with other voluntary and governmental agencies involved in continuing medical education. As a member of the Liaison Committee on Continuing Medical Education, the AAMC will need to develop policy and respond to issues as they arise at the national level. Finally, it may undertake studies and promotional programs in collaboration with its membership.

The AAMC Task Force recommends that the Executive Council authorize:

1. Creation of a Group on Continuing Medical Education: The role of a "group" in the Association is "to facilitate direct staff interaction with representatives of institutions charged with specific responsibilities and to provide a communication system between institutions in the specific area of a group's interest." In keeping with the "group" structure, a Group on Continuing Medical Education should be created to 1) serve as a national and regional forum for review of issues confronting faculties engaged in continuing medical education; 2) serve as liaison between AAMC staff and constituents; 3) alert the Association to areas in need of further review; and 4) integrate continuing medical education programs with the other two phases of the continuum of medical education. To accomplish these tasks, the Group on Continuing Medical Education should be composed of directors of continuing medical education programs at medical schools and should organize regional and national programs. To promote the concept of an educational continuum, it is also essential that mechanisms for liaison between the Group on Continuing Medical Education and the Group on Medical Education be developed.

2. Appointment of an ad hoc Committee on Continuing Medical Education to recommend to the Executive Council policies for promulgation at the national level: In the immediate future the Association will be called upon to review issues and problems regarding continuing medical education and to formulate policy recommendations, particularly as they relate to the establishment and functioning of the Liaison Committee on Continuing Medical Education. A committee for this purpose should be appointed immediately, and the need for its continuation after two years should be reviewed by the Executive Council.

3. Assignment of Staff Resources to Continuing Medical Education Programs: Program initiation depends on close collaboration between constituency and staff. Liaison between Association activities and those of other professional organizations and the government also requires staff effort. The expansion of the AAMC's role in continuing medical education can be enhanced considerably through the commitment of staff resources to this effort.

ISSUE: WHAT IS THE ASSOCIATION'S POLICY WITH REGARD TO THE ADMISSION OF WOMEN TO MEDICAL SCHOOL?

PRESENT STATE OF POLICY DEVELOPMENT:

The Association encourages all students, men and women alike, who are considering attending medical school to evaluate carefully both their qualifications for and commitment to a career in medicine. The Association strongly opposes the use of admissions policies which discriminate against women and is committed to working toward removing any barriers which make it more difficult for women to have a successful career in medicine.

PROGRESS TOWARD ACCOMPLISHMENT:

In an effort to address both past and present problems with regard to women in medicine, the Association has designated one staff member to have primary responsibility for identifying the issues and problems in this area. Specifically, this individual will do the following:

a. Liaison between the Association and outside groups and organizations when the nature of the subject or issue is of general interest to the Association.

b. Supervision of an information clearinghouse function within the Office of the President for inquiries not directed to a specific department or division.

c. Liaison with offices within the Association on developing new strategies and programs for women in medicine.

As recipients of federal funds, most, if not all, medical schools are subject to the proscription of Title IX of the Education Amendments of 1972. Title IX provides that no person shall on the basis of sex be subjected to discrimination under any education program or activity receiving federal financial assistance, except under limited circumstances.

The enrollment of women in first-year medical school classes has risen from 9.1 percent in 1969-70 to 13.7 percent in 1971-72, 19.7 percent in 1973-74, and 23.8 percent in 1975-76. This reflects the fact that for each of the past five years, the percentage of women applicants accepted to enter medical school has exceeded the percentage of male applicants accepted. (41.6 percent of women applicants during the years 1969-74 were accepted as compared with 38.1 percent of male applicants.)

With this increase in the number of women entering medical school, the Association has begun to devote more attention to particular problems faced by women students in pursuing medical study and having full and equal opportunity for professional development. In response to this concern, a joint committee of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has been asked to examine the extent of the problem and make policy recommendations.

AAMC DEPARTMENT/DIVISION PRINCIPALLY INVOLVED: Office of the President

OSR REPRESENTATION ON EXECUTIVE COUNCIL

At its January meeting, the OSR Administrative Board requested that the OSR be granted a second voting seat on the Executive Council. The board members felt that increasing representation on the Council would enhance OSR's credibility both within and outside the Association. They pointed out that their constituency frequently questioned whether their single vote on the Executive Council was indicative of the Association's level of receptivity to medical student views. The OSR Administrative Board brought their request to the COD Administrative Board and stressed that increasing the number of student votes on the Executive Council would be a gesture viewed very positively as reflective of the AAMC's commitment to medical students.

The COD Administrative Board discussed the OSR request at its January and March meetings. During those discussions, COD members expressed concern about the proliferation of requests from various groups within and outside the Association for changes in the governing structure of AAMC and composition of the Executive Council. On the other hand, it was generally agreed that the addition of a second seat on the Executive Council would augment the efficiency of the Council's deliberations if a mechanism could be worked out that would guarantee a greater degree of continuity in OSR participation on the Executive Council.

In March, a joint committee of COD and OSR board members (Dr. Gronvall, Dr. Krevans, Mr. Seigle, and Dr. Rado) met with AAMC staff to discuss ways by which both goals--increasing OSR Executive Council representation and ensuring continuity of that representation--could be met. The joint committee agreed that any system which would ensure continuity would require that at least one of the two Executive Council representatives had served in that capacity the previous year. It was acknowledged that while such a system would guarantee continuity, it would, by definition, limit the infusion of new people with new ideas into leadership positions and might foster the self-perpetuation of leadership which was not the most representative of the membership. It was also acknowledged that it is often difficult for medical students to commit themselves for a two or three year period of service although such a commitment would be necessary in a system designed to ensure continuity.

It was agreed that the system that would work best for the OSR and for the Executive Council would strike a balance between the need for continuity within the Executive Council on the one hand and the negative effect within the OSR if their leadership structure were inflexible to such an extent as to make it virtually impossible for new people to become involved in the Organization. The committee developed several options for consideration by the OSR and COD Administrative Boards, and these are outlined below. It was understood that any recommendations regarding a change in the composition of the Executive Council would require a Bylaws change and would thus require review by the Committee on Governance and Structure and approval by the Assembly. The options for OSR and COD consideration are:

I. *The OSR would elect a Chairperson-Elect who would automatically assume the office of Chairperson in the second year. Both the Chairperson and Chairperson-Elect would be voting members of the Executive Council.* With this option, the OSR would return to a system it once had and which the three

councils currently have. It would require that the Chairperson-Elect be a 1st, 2nd, or 3rd-year student so that he or she would be an institutional representative when serving as Chairperson.

While this option would provide optimum continuity, it could cause problems for the OSR if the Chairperson-Elect were not functioning well. In order to prevent an individual who had not functioned adequately in the first year to automatically assume the office of Chairperson and to continue as an Executive Council member, it would be advisalbe to include a mechanism which would allow for the removal of the Chairperson-Elect (e.g., the Administrative Board be empowered to prohibit the Chairperson-Elect from serving a second year by a two-thirds vote).

II. *The OSR would continue to elect both a Chairperson and Vice-Chairperson for one year terms, but neither would sit on the Executive Council. Two representatives would be elected specifically to serve on the Executive Council, and each would be elected in alternate years for two-year terms. The two Executive Council representatives would be members of the OSR Administrative Board in the same capacity as the Representatives-at-Large currently serve; no further expansion of the OSR board would be required.*

With this system, one Executive Council representative each year would have had a year's experience of serving on the Council. The potential problems associated with an individual who is not functioning well to automatically continue into a second year of office are not as great with this option as with the first option since the individual would not be continuing in both capacities of Chairperson and of Executive Council representative. The potential drawback of this system would be the decentralization of OSR leadership since neither of the traditionally highest-ranking officers of the OSR would be members of the Executive Council. This system might also cause communication problems since it would not always be clear who should be consulted on matters relating to the Organization between meetings.

III. *The Chairperson and the Immediate-Past-Chairperson would serve on the Executive Council.* In order for AAMC to maintain its tax-exempt status, this option would have to include the provision that the Chairperson be a 1st, 2nd, or 3rd-year student when elected so that he or she would be an institutional representative when serving on the Executive Council as Immediate-Past-Chairperson. It is likely that the Chairperson would be a third-year student in order to have the background and experience to assume this office. This could present a problem in that the time commitments during the third year are usually such that it would be difficult for a third-year student to also serve as OSR Chairperson.

IV. *The Chairperson and two Representatives-at-Large would sit on the Executive Council, but only the Chairperson and one Representative-at-Large would vote. Each Representative-at-Large would be elected, in alternate years, to two-year terms, and the Representative-at-Large in the second year of office would vote on the Council.*

This option would provide continuity without eliminating the possibility for new people to become involved in leadership roles within the Organization. It would also permit the Chairperson to be an Executive Council representative, and would therefore not cause the potential problems mentioned under Option II. The potential drawback with this system involves the financial and operational considerations related to the further expansion of Exeuctive Council composition.

V. One alternative in addition to the ones outlined above would be to retain the status quo. Each of the other options is based upon modification of the present system, and before modifications are recommended, consideration should be given to the advantages and disadvantages of the current system. At present, the OSR has two members on the Executive Council. Although only one member votes, both are given the privilege of the floor and both are included in Executive Sessions. While it may be advantageous in terms of OSR's credibility as viewed by the student constituency to increase their voting representation on the Executive Council, it is very unlikely that an Executive Council decision would ever be altered by one vote.

RECOMMENDATION

That the OSR Administrative Board consider these alternatives and recommend its choice to the COD Administrative Board which in turn will make a recommendation to the Executive Council.

STUDENT NOMINEES FOR AAMC COMMITTEES

The NIRMP Board of Directors and the AAMC Ad Hoc Committee on Continuing Medical Education currently have openings for student representatives. The OSR Administrative Board should review the requirements for service on these committees as outlined below and make nominations for the positions to the AAMC Chairman.

NIRMP Board of Directors

Usually meets annually to establish policy and consider all aspects of the matching program. The AAMC student representative to the Board will serve a three-year term beginning July 1, 1976. The NIRMP Bylaws require that this representative be a medical student who is beginning his or her fourth year in the fall of 1976.

AAMC Ad Hoc Committee on Continuing Medical Education

This committee was appointed by the Executive Council in March in response to the recommendations of the Task Force on Continuing Medical Education to review all issues and problems relating to the area of Continuing Medical Education. It is anticipated that the Committee will meet 4-5 times per year for two years, and the student representative appointed to this committee should be prepared to serve a minimum of two years.

STUDENT SERVICES FEES

At the 1975 Annual Meeting, the OSR requested that information be distributed to the membership regarding the Administrative Board's decision that the AAMC student services fee structure was appropriate. Mark Cannon submitted a statement which provided an account of the past year's dialogue about MCAT and AMCAS fees. Upon review of this statement, Dr. Gronvall, Chairman of the Council of Deans, expressed the opinion that Dr. Cannon's statement was an overly-detailed account of an issue which had been considered and disposed of numerous times by the Executive Council. It was his opinion that there was considerable sentiment among members of the Council against reiterating the points raised by the OSR during the previous year.

Dr. Gronvall recommended that staff prepare a more concise version of the statement and that the OSR Administrative Board review both before any document is distributed to the OSR. Since both statements report the internal deliberations of the Executive Council, it is recommended that the OSR Administrative Board consider the statements which appear on the following pages, and reach a decision about what should be disseminated.

The AAMC Division of Student Services is concerned with the administration of the Medical College Admission Test (MCAT) and the American Medical College Application Service (AMCAS). At the OSR annual meeting in November, 1974, the chairperson, Daniel L. Clarke-Pearson, recommended that the OSR attempt to determine whether the fees charged to applicants for these services are in line with the AAMC's cost of operating them. From January through November, 1975, the OSR Administrative Board engaged in a continuing dialogue with the AAMC in relation to this question. The consensus ultimately reached by the Board on November 1, 1975, was that present levels of MCAT and AMCAS fees are appropriate. I reported this conclusion to the OSR in my address that day. At that time, there was some discussion of this issue on the floor of the OSR, and the Organization passed a motion requesting that I write an account, to be communicated to the OSR, of the OSR-AAMC discussions and conclusions. The account follows below.

At the OSR Board meeting in January, 1975, a request was made to the AAMC staff that three OSR Board members who had a particular interest and expertise in this area be permitted to study the AAMC's financial records relating to MCAT and AMCAS. This request was denied. It was decided by the staff that this was an issue of concern to all constituent bodies of the AAMC, and therefore plans were made to discuss the financial records with the Executive Council later in the week. I, as a member of the Executive Council, and Vice Chairperson Cindy Johnson, as a guest, were present at the Executive Council meeting. A series of projection slides, relating to the AAMC's finances with particular emphasis on the student services, were shown. The MCAT and AMCAS finances (income and costs) were analyzed for each of the previous ten years. The conclusion presented was that over this period, the student services had in fact been a slightly money-losing proposition. Some members of the Council expressed the concern that further increases in test and application fees should be considered. Among the considerations were the following:

(1) Unexpected occurrences of various sorts, such as a sudden drop in number of

AMCAS applications filed or in number of students taking the MCAT, would be disastrous to the financial picture.

(2) There were lawsuits pending against AAMC as a result of the administration of the student services, and, in spite of insurance coverage, these could have turned out to be very costly to the Association. It was felt that such liability should be borne within the fees.

(3) The MCAT fee had remained constant at $20 from 1968 until 1975, in spite of skyrocketing costs, and was increased only to $25 in 1975.

At that time, I expressed my feeling that such a slide presentation and discussion was inadequate for me to fully appreciate the significance and implications of the data. I requested the opportunity for Cindy and me to examine the data at length after the meeting. This request was granted by the Council.

Cindy and I studied the AAMC's financial accounts in detail and discussed them at great length that afternoon with Dr. John A. D. Cooper (AAMC President), Dr. Sherman Mellinkoff (AAMC Chairman), and Mr. Trevor Thomas (Director, AAMC Office of Business Affairs). Following this review, the major question we had was in relation to the fact that MCAAP expenditures were included in the costs of student services. (MCAAP, the Medical College Admissions Assessment Program, is the project to revise the MCAT and possibly create new admissions assessment methodologies.) These expenditures totalled $1.25 million, and I noted that this expense was what rendered the net balance of student services very slightly negative. In fact, exclusive of this MCAAP expenditure, the net balance for student services was slightly positive each year. At the next OSR Board meeting, I presented this information,

and we discussed the propriety of charging the MCAAP costs to the student services. The Board's conclusion was that it is appropriate to include in test and application fees the costs of development of new tests and methodologies.

Additional weeks of cogitation yielded one further concern in my mind. The bulk of the student services costs, as broken down by the AAMC, fall under two categories: direct and indirect costs. The direct costs include all materials, postage, salaries, and other costs that apply specifically to MCAT and AMCAS development and administration. The direct costs apparently are relatively simple to calculate; as I learned in January from my examination of the records and from my discussions with Drs. Cooper and Mellinkoff and Mr. Thomas, the AAMC has been doing this very precisely. I took no issue with this category.

The indirect costs include overhead (rent, electricity, etc.) and the general functioning of the Association (salaries and materials that are not directly related to any individual activity). In order to precisely calculate this category, it would be necessary to "follow around" every staff member of the Association and determine exactly how much effort each one devotes to student services. This would be unfeasible and uneconomical. Therefore, rather than making a precise calculation, the AAMC uses what is an accepted accounting practice; indirect costs are estimated as 25% of the estimated gross income derived from each activity each year. While I realized that this is entirely legal, I questioned, given the specifics of this situation, whether it is just. I communicated this question in a letter of September 2, 1975, to Dr. Cooper, in which I went on to state:

"In recent years, student services have accounted for 40-45% of the Association's gross income. Since indirect costs are estimated as a percentage of the gross income, this means that 40-45% of the Association's overhead is estimated as the indirect

costs involved in the student services. I have already granted that we could not precisely calculate the correct figure, but I feel it is intuitively obvious that 40-45% of the Association's overhead is an overestimate. Clearly, less than 40-45% of the Association's office space, less than 40-45% of the Association's electricity, less than 40-45% of the time of the Executive Council and the Administrative Boards, and less than 40-45% of the time of staff members such as yourself, are devoted to MCAT and AMCAS."

"Thus, it appears that student services income is being utilized to disproportionately finance the general operation of the AAMC. It is legal, but is it ethical? I think not. I feel that we should be able to find a more appropriate method for estimating indirect costs, and that the MCAT and AMCAS fee structures should then be re-examined."

"The direct beneficiaries of the general activities of the Assocaition of American Medical Colleges are the medical schools, the academic societies, the teaching hospitals, and the medical students. If other funds should be required to permit a decrease in MCAT and AMCAS fees, I would suggest that they should come from the direct beneficiaries, via increases in institutional fees."

Dr. Cooper responded with a letter in which he suggested that I bring up my concern at the Executive Council meeting later that month. Prior to the Executive Council meeting, I presented my new concerns to the OSR Board. Opinion was divided. Some members felt this issue had already been adequately discussed. By a vote of 4-3, the Board moved that I should indeed proceed by presenting the concerns to the Executive Council. At the Executive Council meeting, copies of my letter to Dr. Cooper were distributed. Dr. Cooper presented data indicating that 39.36% of the Association's space and 40.4% of its personnel were devoted to student services. This was close, he said, to the 40-45% figure that I was citing, and, therefore, the accounting procedure was reasonable. I replied that these figures included medical

student services as well as pre-medical student services, and that I felt only the pre-medical student services costs should be considered when establishing reasonable MCAT and AMCAS fees. The Executive Council did not agree that this was a significant point. A motion was then passed (with my abstention) that the Executive Council "receive" my letter. No other action was taken. However, it was suggested by one member of the Executive Council that the issue clearly was not yet settled in the minds of students and that discussions with the OSR Board should be continued. Drs. Cooper and Mellinkoff expressed a willingness to do so.

At the OSR Board meeting on November 1, 1975, Dr. Cooper and Mr. Thomas presented additional data indicating that only a small portion of the space and personnel devoted to "student services" went for medical student services as opposed to premedical student services. Considerable discussion followed. The Board (with the exception of one member) then reached a consensus that the year's dialogue had clearly shown the present levels of MCAT and AMCAS fees to be appropriate. I requested that the AAMC continue to be receptive to future OSR inquiries on this vital matter.

Mark Cannon
Immediate Past Chairperson

The AAMC administers the MCAT and AMCAS as services to medical school applicants. At the 1974 Annual Meeting, Dan Clarke-Pearson, Chairperson, recommended that the OSR attempt to determine whether the fees charged for these services are in line with AAMC's cost of operating them. The OSR Administrative Board discussed this issue with AAMC throughout the next year, and the consensus ultimately reached by the Board was that present levels of MCAT and AMCAS fees are appropriate. I reported our conclusion at the 1975 Annual Meeting, and the OSR approved a motion requesting that I distribute an account to the representatives of our discussions and conclusions. The account follows.

At its January meeting, the AAMC Executive Council discussed this issue at OSR's request. Cindy Johnson and I were present at that meeting and viewed a series of slides relating to AAMC's finances with particular emphasis on student services. The MCAT and AMCAS income and costs were analyzed for the previous ten years. The conclusion presented was that over this period, student services had in fact been a slightly money-losing proposition. Some members of the Council suggested that further increases in test and application fees should be considered. Among the considerations were:

(1) Unexpected occurrences such as a sudden drop in numbers of applicants through AMCAS or in numbers taking the MCAT would be disastrous to the financial picture.

(2) Lawsuits pending against AAMC as a result of the administration of student services could turn out to be very costly to AAMC despite insurance coverage. It was felt that such liability should be borne within the fees.

(3) The MCAT fee had remained constant at $20 from 1968 until 1975, in spite of skyrocketing costs, and was increased only to $25 in 1975.

After the presentation, Cindy and I studied the AAMC's financial accounts in detail and discussed them at length with AAMC officers. Following our review, the major question we had was whether MCAAP expenditures should be included in the costs of student services. (MCAAP, the Medical College Admission Assessment Program, is the project to revise the MCAT and possibly create new admissions assessment methodologies.) At its next meeting, the OSR Board concluded that it <u>is</u> appropriate to include in test and

application fees the costs of developing new tests and methodologies.

Additional weeks of cogitation yielded a further concern in my mind. The bulk of student services costs fall under two categories--direct and indirect costs. The direct costs (materials, postage, etc.) are relatively simple to calculate, and AAMC has been doing this very precisely. The indirect costs include overhead (rent, electricity, salaries not directly related to an individual activity, etc.). In order to precisely calculate this category, it would be necessary to "follow around" every staff member--an infeasible and uneconomical proposition. Therefore, AAMC uses an accepted accounting practice, and figures indirect costs as 25% of the estimated gross income derived from each activity each year. While I realized that this is entirely legal, I questioned whether it is just. I communicated this question in a letter to Dr. John A. D. Cooper, AAMC President.

Dr. Cooper responded by suggesting that I bring up my concern at the next Executive Council meeting. With the support of the OSR Board, I raised this issue at the Septembe Executive Council meeting. Dr. Cooper presented data showing that the amount charged as overhead for student services is very close to the actual percentage of space and staff time devoted to student services. I pointed out that the percentages he cited include space and staff time associated with services for medical students as well as for premedical students, and that I felt only the premedical student services costs should be considered when establishing MCAT and AMCAS fees. The Council took no action on the matter other than to acknowledge receipt of a copy of my letter to Dr. Cooper.

At the OSR Board meeting on November 1, 1975, Dr. Cooper and Mr. Thomas, Director of the AAMC Division of Business Affairs, presented additional data indicating that only a small portion of the space and personnel devoted to "student services" went for medical student services as opposed to premedical student services. Considerable discussion followed after which the Board reached a consensus that the year's dialogue had clearly shown the present levels of MCAT and AMCAS fees to be appropriate.

OSR ANNUAL MEETING SCHEDULE

Wednesday, November 10	9:00 -11:30 am	Administrative Board Meeting
	12:30 - 4:30 pm	Orientation & Business Meeting
	4:30 - 6:30 pm	Regional Meetings
Thursday, November 11	8:00 -12:00 noon	Discussion Sessions (5)
	1:30 - 5:00 pm	Business Meeting
	7:00 - 9:30 pm	Program Session
	9:30 -11:00 pm	Reception
Friday, November 12	8:30 - 9:30 am	Regional Meetings
	9:30 -12:30 pm	Discussion Sessions (4)