OSR ADMINISTRATIVE BOARD AGENDA

Conference Room
One Dupont Circle
Washington, D.C.

March 30, 1977
9:00 am- 4:00 pm

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

January 11 and 12, 1977
AAMC Headquarters
Washington, D.C.

Chairperson	--Thomas Rado, Ph.D.
Vice-Chairperson	--Paul Scoles
Regional Chairpersons	--Cheryl Gutmann (Central)
	--Jim Maxwell (Southern)
	--Peter Shields (Northeast)
	--Chris Webb (Western)
Representatives-at-Large	--Robert Bernstein, Ph.D.
	--Margaret Chen
	--Robert Cassell
Immediate-Past-Chairperson	--Richard Seigle
AAMC Staff	--James D. Bentley, Ph.D.
	--Robert J. Boerner
	--Judy Braslow
	--John A. D. Cooper, M.D.
	--Thomas J. Kennedy, M.D.
	--Joseph A. Keyes
	--Diane Newman
	--Dario Prieto
	--James R. Schofield, M.D.
	--August G. Swanson, M.D.
	--Bart Waldman

I. Call to Order

The meeting was called to order by Tom Rado at 9:00 a.m.

II. Consideration of Minutes

The minutes of the September meeting were approved without change.

III. Report of the Chairperson

Dr. Rado reported that he had been contacted twice since the Annual Meeting for input on Executive Committee deliberations regarding the Thompson Amendment and the FTC challenge to the LCME's status as an accrediting body. He noted that both these items would be discussed thoroughly later in the meeting during review of the Executive Council agenda.

Dr. Rado outlined his ideas about directions and priorities for the OSR during the coming year. He expressed the view that OSR's primary goal for the year should be to strengthen its position within AAMC and its relationship to local medical student bodies. He stressed the importance of utilizing

staff as well as other channels such as committees with student members to accomplish OSR goals. He also mentioned several areas which he perceived as critical ones which would require attention during the coming year: graduate medical education, financial aid, NIRMP, women in medicine, minority affairs, medical student stress, and licensure and certification.

IV. Orientation to AAMC

Dr. John A.D. Cooper, AAMC President, discussed with the board the history of medical education in the U.S. and provided an outline of AAMC's programs. He also reviewed the process by which the governing bodies of the Association develop and carry out policy decisions.

In response to a question about whether mechanisms exist for constituent groups to formally dissent from AAMC policies, Dr. Cooper noted that the primary purpose of the Association's deliberations was to arrive at a consensus which most closely represents the views of all segments of academic medicine. He pointed out that compromise was essential in this regard and that dissenting opinions of a particular segment of academic medicine could be expressed by the independent groups which represent only that particular constituency, e.g., the American Hospital Association or AMSA.

Dr. Thomas Kennedy, Director of the AAMC Department of Planning and Policy Development, reviewed the Association's activities related to the collection, storage, and release of data about the medical schools. He also discussed AAMC efforts to work with the federal government in developing and implementing legislation and to keep the constituency abreast of developments on the national level.

V. Medical School Accreditation

Dr. James Schofield, Director of the AAMC Division of Accreditation, described the process by which medical schools are accredited by the Liaison Committee on Medical Education (LCME). Following a general discussion of medical school accreditation and the students' role in the process, the board discussed the LCME Guidelines for Functions and Structure of a Medical School (Addendum 1). Dr. Schofield pointed out that the guidelines which appeared in the Executive Council agenda incorporated many changes which had been recommended by the councils and the OSR during previous review. He also stated that the AMA House of Delegates had approved this revised document and that the LCME urgently needed a set of guidelines that amplified the policies set forth in "Functions and Structure of a Medical School." The Administrative Board noted that most of the OSR-recommended changes had not been included in the revised document. While they agreed about the necessity of adopting the guidelines without further delay, there was consensus that OSR should continue to encourage the inclusion of their previous recommendations during future review of the document.

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the LCME Guidelines for Functions and Structure of a Medical School.*

The Administrative Board also discussed with Dr. Schofield the OSR resolution

about student representation on the LCME (Addendum 2). Dr. Schofield expressed the opinion that in view of recent challenges to the status of the LCME as an accrediting agency, it might be inappropriate at this time to make any change in the composition of the liaison committee. He also pointed out that membership on the LCME would require an extensive time commitment to attend meetings, to participate in site visits, and to read massive background materials and site visit reports on each school being reviewed. The OSR board endorsed its previous position that students should be represented on the LCME since medical students are most directly affected by the accreditation process. The board also concluded that the time commitment required would be no more excessive than the time commitment involved in serving as an OSR officer.

VI. Executive Council Agenda

A. Ratification of LCME Accreditation Decisions

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the LCME Accreditation Decisions.*

B. LCGME Bylaws

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the LCGME Bylaws.*

C. LCCME Bylaws

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the LCCME Bylaws.*

D. GSA Rules and Regulations

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the proposed changes in the GSA Rules and Regulations.*

E. Guidelines for the Minority Affairs Section

The OSR Administrative Board spent considerable time discussing each of the staff recommendations for changes in the Guidelines for the Minority Affairs Section (MAS) which had been proposed by the GSA Minority Affairs Committee and approved by the GSA Steering Committee. In general, the board felt that the revisions recommended by staff would reduce the power and effectiveness of the Section. Consideration of the various recommendations was limited by the fact that the reaction of the minority affairs officers who had originally drafted the guidelines had not yet been received. Since it was expected that their reactions to the proposed changes would be known by the time of the Executive Council meeting, there was consensus that the OSR should support the recommendations of the minority affairs officers during the Council's deliberations. Staff pointed out that while there were numerous revisions being proposed, the majority of the revisions were intended to make the GSA-

MAS Guidelines consistant with the GSA Rules and Regulations and with established AAMC operating procedures.

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the staff recommendations regarding the GSA Minority Affairs Section with the following exceptions:*
Recommendation 1: Endorsed only the deletion of the phrase: "to serve in an advisory capacity to the AAMC Office of Minority Affairs in setting programmatic goals, objectives, and priorities, as well as"
Recommendations 4-9: Abstained from taking action until recommendation of the GSA Minority Affairs Committee is received.
Recommendations 11-15: Not endorsed
Recommendation 17: The OSR Administrative Board endorsed this recommendation but urged the Executive Council to provide some level of funding to support the Section.

F. Regents of the University of California v. Bakke

ACTION: *On motion, seconded, and carried, the OSR endorsed the recommendation that AAMC seek permission to file an amicus curiae brief if the Supreme Court agrees to review the Bakke case.*

G. Specialty Recognition of Emergency Medicine

The OSR board discussed the question of whether emergency medicine should be recognized as a specialty. It was acknowledged that there is a trend towards the use of hospital emergency rooms as primary care centers by a growing number of people. It was also acknowledged that emergency medicine is unlike other established specialties in that it represents an occupational setting rather than a distinct body of medical knowledge.

ACTION: *On motion, seconded, and carried, the OSR Administrative Board agreed not to adopt a position on whether emergency medicine should be recognized as a specialty. They agreed to support AAMC's previous position that prospective specialties be required to conduct an impact study assessing how its establishment would affect the nation's total health expenditures as well as the overall quality of patient care.*

H. Uniform Application Process for Graduate Medical Education

ACTION: *On motion, seconded, and carried, the OSR Administrative Board reaffirmed its support of a uniform application process for graduate medical education programs and endorsed the creation of a task force to develop a pilot application form.*

VII. Graduate Medical Education

Dr. August Swanson, Director of the AAMC Department of Academic Affairs, and Dr. James Bentley, Assistant Director of the AAMC Department of Teaching Hospitals, led a lengthy discussion of the history and current status of the graduate medical education system. Dr. Swanson provided an historical overview of the accreditation process for residency programs and spoke about current efforts of the Liaison Committee on Graduate Medical Education (LCGME) to strengthen the institutional basis of graduate programs. He noted that one of the major problems with graduate medical education has been that programs essentially have been operating and have been accredited independently. The LCGME intends to rewrite the General Requirements this year in order to place a greater emphasis on the educational setting institutions are providing for their various programs.

During this discussion, the board pointed out that one important focus for an AAMC task force on graduate medical education should be to define which aspects of graduate training programs are educational and which are service-oriented. Dr. Bentley discussed with the board the myriad of problems relating to the financing of graduate medical education, and it was agreed that this also would be a major focus for the task force.

VIII. Recess

The OSR Administrative Board recessed at 5:00 p.m.

IX. Reconvene

The OSR Administrative Board reconvened at 9:00 a.m. on January 12.

X. NIRMP

Cheryl Gutmann reported that in her discussions with Dr. Graettinger, Executive Vice-President of NIRMP, several issues emerged which the OSR should consider during the coming year. One of the major threats to the viability of NIRMP remains to be violations initiated by students as well as by program directors. She urged the board to consider ways by which OSR could provide an impetus for students to honor the match results. She noted that other concerns that should be examined during the year were problems relating to non-participation of programs and logistical problems relating to distribution of materials. Ms. Gutmann reported that Dr. Graettinger is most interested in working with the OSR on problems related to NIRMP. She also mentioned that she would be attending the January meeting of the GSA Committee on Professional Development and Advising where many of these issues will be discussed.

XI. Student Nominees to AAMC Committees

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

Health Services Advisory Committee--Daniel Miller
Data Development Liaison Committee--David Diamond
Journal of Medical Education Editorial Board--Richard Harper
Resolutions Committee--Richard Seigle
Flexner Award Committee--Donald Widder
GSA Committee on Financial Problems of Medical Students--Robert Tomchik
GSA Committee on Medical Education of Minority Group Students--Richard Gomez
GSA Committee on Professional Development and Advising--William Meade/Joan Kishel
GSA Medical Student Information Systems--Nancy Hardt/ Barbara Carpenter

The Administrative Board also discussed nominations for the two proposed AAMC task forces on graduate medical education and on health manpower legislation. The board agreed to recommend that two OSR representatives, Cheryl Gutmann and Robert Cassell, be members of the proposed task force on graduate medical education and that Peter Shields and Paul Scoles be members of the proposed task force on health manpower legislation.

XII. Administrative Board Members' Reports

A. Health Legislation

Robert Bernstein reported that the working group on health legislation is in the process of gathering information about existing and proposed health legislation. He indicated that some of the areas where they will direct their efforts include renewal of health manpower legislation, health planning legislation, and national health insurance. He also stressed the importance of OSR's participation on the proposed task forces on graduate medical education and health manpower legislation.

B. Curriculum and Evaluation

Robert Cassell noted that at the Annual Meeting, the OSR approved a resolution recommending that copies of each medical school's evaluation forms be collected, compiled, and made available to OSR members. Mr. Cassell stated that since many students at the local schools are working on assessing or improving their own school's evaluation procedures, such a compilation would prove to be extremely helpful in gaining new ideas and perspectives. He urged the Administrative Board to proceed with the project in the near future. Dr. Swanson pointed out that the AAMC Division of Educational Measurement and Research is undertaking a new program to assist schools in improving their curricular evaluation process and their procedures for student evaluations. Dr. Swanson also pointed out that the AAMC Curriculum Directory is a useful resource for students interested in exploring the types of curriculum and evaluation procedures used at other medical schools.

C. Minority Affairs

Margaret Chen reported that she has established contacts with the Chairman of the AAMC Task Force on Minority Opportunities in Medicine and with officers of the Student National Medical Association. She indicated that she hopes to work closely with these individuals during the coming year on minority affair issues.

D. Stress in Medical Education

The members of the working group on stress (Margaret Chen, Chris Webb, and Richard Seigle) each presented their assessment of this issue and proposed various ways by which OSR could accomplish the goals of helping students cope with the stress inherent in medical education and of reducing or eliminating unnecessary stress factors. There was considerable discussion about the various types of stress medical students experience. Among the approaches suggested for OSR programs in this area were:

1. Survey medical students nationally about stress related to the medical school experience using a survey instrument similar to one previously used at the University of Colorado.

2. Survey medical schools to determine what types of counseling systems and special programs are being offered to help students cope with stressful experiences.

3. Develop a program package that local OSR members can use in holding seminars or discussion sessions about stress.

4. Explore policies on allowing students the option of taking one year off between admission and matriculation to medical school.

5. Submit an article to the Journal of Medical Education summarizing the concepts presented in the OSR/COD Annual Meeting Program on stress.

ACTION: *On motion, seconded, and carried, the OSR Administrative Board approved the recommendations of the working group on stress.*

E. OSR Communications

Paul Scoles reported that one of the discussion items at the AAMC Executive Committee Retreat was strengthening the OSR. It was decided at that meeting that one approach to elevating the OSR's image on the local school level would be to increase communication between the OSR officers and the local OSR representatives and between OSR and local medical student bodies. He indicated that staff was in the process of exploring the feasibility of issuing a newsletter, similar in content to the Bulletin Board, to all medical students. Other approaches suggested included:

1. Include with OSR mailings a reaction form for OSR members to return to increase their input to the Administrative Board's deliberations.

2. Develop information packages OSR representatives could use to hold periodic meetings and discussion sessions about OSR activities and national medical education issues.

3. Plan regional meeting discussions about ways to increase the effectiveness of OSR communications.

XIII. Housestaff Collective Bargaining

At the AAMC Executive Committee Retreat it was decided that the AAMC would oppose the legislation introduced by Representative Thompson which would amend the National Labor Relations Act (NLRA) to cover housestaff as employees. Tom Rado and Paul Scoles reported that they were present during these discussions and urged the Retreat participants not to oppose such an amendment.

The board discussed AAMC's policy on this issue in depth. It was acknowledged that positions within AAMC about whether housestaff should be defined as employees under the NLRA were polarized with OSR being the only constituent group strongly supporting the Thompson Amendment. Staff reviewed the rationale behind AAMC's position. The major points raised were: (1) that the structure, process, and rules covering negotiations under NLRA would significantly harm the educational nature of graduate medical education; (2) that unionization of housestaff under the rules of the NLRA would not improve the quality of education or patient services in marginal or clearly service-oriented training programs; (3) that inclusion of housestaff under the NLRA would promote the service nature of programs and would alter the relationship between program directors and housestaff to the point where housestaff would be regarded strictly as employees; and (4) that other approaches, such as the accreditation process, would be more effective mechanisms for dealing with programs of poor educational quality.

The OSR board members pointed out that without the protection of the NLRA, housestaff have no effective mechanisms for improving the quality of their programs. They stated that while the accreditation process may be a long-range solution, house officers desire a solution that will immediately improve the quality of their educational programs. Several members also pointed out that in many programs, the "collegial" relationship does not exist between residents and program directors and informal negotiations often prove to be ineffective. The Administrative Board agreed that while it may be inappropriate for the National Labor Relations Board to decide educational issues, a compromise amendment might be supported whereby certain labor-related issues are defined as bargainable and other educational issues are resolved through informal negotiations. Staff pointed out that if housestaff are covered under the NLRA, negotiations on *all* matters will have to be conducted according to the rules of the Act.

The OSR Administrative Board agreed that since other mechanisms for enhancing the quality of graduate medical education have proven to be ineffective, AAMC should reconsider its position and support legislation to include housestaff under the NLRA.

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

The graduate medical experience is inextricably tied to both education and service. The experience is educational in that it is a voluntary means for specialty training and attainment of licensure. It is service because housestaff provide patient care and participate significantly in the training of medical students.

The means which presently exist for the resolution of problems and inequities in graduate educational programs are less than perfect. The mechanisms available for resolving issues related to housestaff employment are generally unsatisfactory. Past experience has shown that there is no clear motivation for the voluntary development of a satisfactory mechanism. Inclusion of housestaff under the NLRA would accomplish this end.

The OSR Administrative Board resolves that:

1. *The AAMC should continue its laudable efforts to improve the educational component of the housestaff experience, particularly through its participation in LCGME, and further resolves that*

2. *The AAMC should actively support the passage of the Thompson Amendment to ensure protection of housestaff under NLRA.*

XIV. Adjournment

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

GUIDELINES FOR FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

I. INTRODUCTION

The introduction to the document, "Functions and Structure of a Medical School," as approved in June 1973, contains the statement, "the concepts expressed here will serve as general but not specific criteria in the medical school accreditation process. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education."

The Liaison Committee on Medical Education, in response to requests for more specific guidance, and based on its experience gained by surveying medical schools, offers these guidelines, not as specific criteria in the accreditation process, but as guides to those who are considering the development of new medical schools, those responsible for the conduct of approved programs of medical education, and for those participating in the accreditation process on behalf of the Liaison Committee on Medical Education.

II. DEFINITION AND MISSION

The several resources that constitute a medical school are referred to in subsequent parts of these guidelines. A medical school must be organized as a definable academic unit with responsibility for the educational program of not less than 32 months duration leading to the M.D. degree. There are a variety of organizational patterns among institutions of higher education and a single organizational structure cannot be prescribed for a medical school. It is necessary that there be a clearly identified faculty which provides the organizational structure for the full spectrum of undergraduate medical education.

The faculty is that body of scholars which is charged with the responsibility for selecting students, initiating and appropriately revising the curriculum, determining the progress of students, and providing the continuum of medical education.

The desirability of participation by the faculty of the medical school in educational, research and service activities of other academic divisions of the university, or participating in the activities of affiliated hospitals and other institutions for the provision of patient care, should not detract from the faculty's primary responsibility to the medical school. When the faculty of a medical school participate in the activities of another academic unit of the parent university or other institutions, joint appointments are appropriate. These joint appointments should be accomplished by a clearly understood description of the responsibilities of the individual faculty member to the medical school and to the other academic unit or institution.

The details of the organization of the medical school, and the responsibilities and authority of its administrators, councils and committees and the relationship of the school to the parent university, and to other academic units within the university and within the medical center, should be defined in writing. These definitions may be incorporated into the by-laws of the school, or the statutes of the university.

The medical school, either separately or as a part of the university or another appropriate corporate entity must be legally recognized and authorized by the geographic jurisdiction in which it is located to confer the M.D. degree.

The four inherent responsibilities (undergraduate medical education, advancement of knowledge, graduate programs in basic medical sciences and clinical medicine, and continuing education) of a medical school as listed in the document, "Functions and Structure of a Medical School," relate to the continuum of education throughout professional life. The first three of these responsibilities are interrelated and emphasize the primary responsibility of the medical school to its undergraduate medical students. For example, the responsibility of the medical school to its medical students should not become subservient to other related or unrelated activity. This principle is particularly applicable to the activities of the faculty, but also to the apportionment of all resources available for support of the activities of the medical school. In general, as the responsibilities of the medical school increase in both amount and diversity, the concomitant enhancement of faculty and other resources is essential if the principal responsibility which is to the medical students is to be properly discharged.

The faculty of a medical school should participate in the development and advancement of knowledge through scholarly activity which may be in the biological, behavioral, social, or clinical sciences, and may be basic or applied, and related to clinical medicine, to the delivery of health care, or to the educational process of the medical school.

Research or other scholarly activity by members of the faculty is necessary for the effective teaching of medical students. Research activity produces an environment of inquiry which affords the medical student an opportunity to obtain an education rather than technical training, and fosters life-long habits of scholarship. These considerations are in addition to the importance of research to graduate programs, to patients for whom the faculty is responsible and for the benefits to society resulting from the advancement of knowledge.

Advanced degree programs in the basic medical sciences are important for the education of basic medical scientists of the future and for the recruitment and maintenance of a competent faculty.

The presence of graduate students and post-doctoral fellows contributes to the intellectual environment. Universities considering the establishment of a medical school should give careful consideration to the necessity of graduate programs in the biomedical sciences. Universities or state educational systems that have imposed limitations on the development of new graduate programs, should, when considering the development of a medical school, realize that the absence of graduate programs may deter the development of the medical school.

A program of graduate medical education is essential for the education of students in clinical medicine. The residency program is necessary for the recruitment and retention of a competent clinical faculty and adds a vital dimension to the educational environment for the teaching of clinical medicine to medical students. Although it is not necessary to have an approved residency program in every speciality, it is highly desirable to have approved programs corresponding to the major clinical clerkships.

Although not an integral part of the educational program for medical students, continuing education is a responsibility of the medical school. The extent of this responsibility will be influenced by the resources of the medical school and by the total resources for continuing medical education in the area in which the school is located. The development of programs of continuing education requires a commitment of resources that should not be made at the expense of the principal responsibility of the school to its undergraduate medical students.

Adequate facilities for the educational, research and service functions of the medical school must be available. Since financial resources, both for capital and operating expenditures are of critical importance, an adequate budget identified and dedicated to the programs of the medical school is necessary.

It is desirable that the medical school, to the extent practical, identify and meet selected health needs in its community, and the response to these needs can serve as models for students. Opportunity for addressing these needs should be carefully evaluated to determine if the medical school is the most logical resource or if the need can be better met by other organizations.

The medical school as a part of a medical center will receive numerous requests to respond to the needs of the medical center, other divisions of the university, affiliated research and clinical institutions and the community or geographic area surrounding the medical school. In response to such requests it is necessary for a medical school to develop a clear definition of its total objectives, realizing that a first priority must be assigned to the responsibility for the education of medical students. Decisions regarding participation in medical center, university, or community programs should be based on their consistency with the objectives and the availability of resources of the medical school. Such decisions should be based on a

concensus of the faculty and administration of the medical school. In many decision arenas, student input is desirable and will facilitate a more compatible atmosphere. In general, the involvement of faculty and administration of the medical school in activities which do not have an educational or research component deserves a low priority.

III. EDUCATIONAL PROGRAM

The educational program of an approved medical school must include a minimum of 32 months of planned required and elective activities.

If the medical school considers applicants for admission with advanced standing, procedures and standards should be established by the faculty for the evaluation of these applicants. These standards must be equivalent to the requirements established for regularly enrolled students. An applicant for admission with advanced standing should be required to provide evidence of having attained the academic objectives of the identifiable segment of the curriculum for which the applicant seeks credit with advanced standing toward the M.D. degree.

The objectives, the curriculum, and the pedagogy utilized for each segment of the curriculum should be subjected to both internal and external periodic review and evaluation.

Although the faculty has the unique responsibility for the content and implementation of the curriculum, the value of assistance from experts in expressing objectives, the techniques of teaching and learning, and the evaluation of student learning, should be appropriately recognized.

The need of every medical student to acquire a foundation of knowledge in the biomedical sciences is self-evident. It is also evident that this foundation necessitates learning objectives related not only to a knowledge of biomedical sciences which are a prerequisite for the study of clinical medicine, but must encompass those fundamentals which will serve as a basis for life-long learning of a constantly changing and expanding body of knowledge.

The foundation of knowledge in the biomedical sciences should include, but not necessarily be limited to all of the major disciplines of the biological and behavioral sciences. Biochemistry, Pharmacology, Physiology, Anatomy, Pathology and Microbiology are the traditional generic fields of the biomedical sciences usually considered essential for the education of the physician. These should be taught in sufficient depth and breadth to insure that there is a fundamental knowledge for ongoing continuing medical education. The faculty should identify students who have had extensive preparation in one or more fields basic to the study of medicine prior to entering medical school and, if possible, offer such students advanced level courses in that field.

The study of clinical medicine can best be accomplished with an emphasis on the problems of patients. It is a responsibility of the faculty to insure that each student is provided with an opportunity to observe and to participate in the expert care of patients with a broad spectrum of disease in each of the major disciplines of medicine. In addition to the traditional clerkships in medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry, many institutions offer interdisciplinary clerkships and/or clerkships in family medicine. The continued competence of the physician in future years will require that the student utilize the fundamentals of both biomedical and clinical knowledge to evaluate and understand current literature so that as a physician he will understand advances in biomedical sciences and their applications to clinical medicine.

The clinical phase of the curriculum should provide an opportunity for the study of both mental and physical disease, as well as preventive medicine, and the socio-economic aspects of health and disease, in both well and sick persons and groups. This instruction should relate both to hospitalized and to ambulatory patients. The objectives of the clinical phase of medical education should be described for each of the major disciplines, insuring that there is achievement of comprehensive knowledge in each of these disciplines.

More difficult but important components of the objectives of the curriculum should relate to student learning regarding the social and economic aspects of the systems for delivering medical services.

Some medical schools establish as a goal that a high proportion of their graduates will elect practice for primary care. Such a goal does not lessen the importance of each student receiving instruction in each of the major clinical disciplines.

It must be understood that the goals of every medical school should be to provide an education in medicine which will make it possible for each student upon completion of the curriculum to enter graduate medical education capable of assuming patient care responsibility in a supervised setting.

Students should be afforded the opportunity to supplement the general nature of these studies of the biomedical and clinical disciplines in the required curriculum with carefully prepared and adequately supervised elective studies as part of a tailored program to meet the varied interests of the student. This requires the presence of well informed and able advisors.

Students should also be provided an opportunity when appropriate to extend the duration of their undergraduate education when necessary to attain curricular objectives.

Experimentation in medical education is to be encouraged but requires a carefully defined hypothesis, protocol, duration, and methods for evaluating the results of the experiment.

IV. ADMINISTRATION AND GOVERNANCE

A medical school has many advantages if it is a division of a university. The university provides the legally recognized and responsible governing body. The graduate school of the university may provide assurance that graduate programs conducted by the faculty of the school of medicine will be of a high quality. The university, through its system of governance provides mechanisms to assure both appropriate process and high quality in the selection, appointment and promotion of faculty, and for the selection, promotion, and graduation of students.

If a medical school is not a component of a university, then the school of medicine should have, as its legally recognized governing body, a Board of Trustees which is representative of the community to which the school is responsible. It is appropriate that in the governance of the medical school, provision be made for members of the Board of Trustees, or through boards of visitors, to exercise expertise at the policy level regarding administration, finance, the appropriateness of new programs, and the sometimes complicated relationship which must exist between the school of medicine, other health schools, hospitals, government, and the public.

In the selection of trustees or visitors, it is important that individuals so selected have no financial, or other inappropriate relation to the program and activity of the school of medicine. There should be assurance that there is no conflict of interest regarding financial, administrative, or academic affairs of the school.

Officers and members of the medical school faculty should be appointed by, or on the authority of, the Board of Trustees of the medical school or its parent university.

The chief official of the medical school, who is ordinarily the dean, should be selected with regard for the responsibilities of this office. In the selection of a dean of a medical school, a search committee to propose nominees may include representatives of the university faculty, the medical school faculty, and other appropriate individuals. It is important to have a description of the duties of this officer, which may vary according to the governing mechanisms of the university and its divisions. Provision in the selection procedure should be made for evaluation of previous experience, since the responsibilities of the dean usually require experience in scientific, academic, clinical, administrative and educational programs. Knowledgeable consultants from outside of the institution may be of value in the evaluation of prospective appointees and are of particular importance when a university is considering the establishment of a school of medicine as a new academic venture.

The organizational place of the school of medicine within the university, and within a medical center which may include other health professional schools and hospitals, will determine the responsibility of the dean of the school. In any event it is essential that the dean have an adequate staff. Ordinarily assistance should be provided by means of a capable business officer and such associate or assistant

deans as may be necessary for student affairs, academic affairs, graduate education, continuing education, and research affairs. These associate or assistant deans will work with appropriate committees of the medical school faculty, and medical center.

Universities with multiple responsibilities in the health fields in addition to the school of medicine may sometimes appoint a vice-president for health affairs, or a similarly designated official. If such an individual is interposed between the school of medicine and the chief administrative officer of the university, it is important that there be clear written description of the authority and responsibility of the vice-president for health affairs, the dean of the school of medicine, and of the faculty of the school of medicine, and other components of the medical center and university.

Careful consideration should be given to the relationship of biomedical science faculty with multiple responsibilities to several health related schools in a complex university. Choice must be made between the provision of a basic science faculty in each of the several schools, with or without joint appointments of individual members of the faculty, or an appropriate administrative framework so that a single basic science faculty may serve the needs of several health related academic units of the university. In determining an appropriate organizational pattern, emphasis should be placed on the recognized importance of the continuum of medical education and the collegiality of the entire medical school faculty responsible for undergraduate medical education.

The administration of a school of medicine is made more complex when there are branch campuses of the school of medicine. Reference is made to guidelines developed by the Liaison Committee on Medical Education relating to branch campuses.

There is no single pattern of organization that can be recommended for the medical school and its faculty. Experience has indicated the utility of departmental organization for the recruitment, retention and professional development of faculty, for faculty morale, for the conduct of graduate biomedical programs, for clinical residency training programs, and for the provision of medical services necessary to the teaching program. However, other organizational structures may be considered.

Departmental organization should not be an obstacle to different grouping of faculty members when desirable for the implementation of the curriculum, or for the conduct of interdisciplinary research. Although it may be inappropriate to designate departments as major, or minor, it is appropriate to note that an excessive number of academic departments within the school of medicine may unduly complicate the administration of the school.

The organization of the medical school ordinarily includes committees that permit the expertise of the faculty to be directed toward the objectives of the school. Usually there are committees which concern themselves with admissions, promotions, curriculum, the library, animal care, and research. An appropriate procedure for the designation of committees should be defined and should include a definition of their function, authority, and if advisory, the direction

of their advice.

The governance of the school of medicine is the responsibility of the dean, with the advice of the faculty. This may be accomplished with the support of committees which include department chairmen or elected representatives of the faculty or a combination of both. Experience has shown that participation by responsible students on committees can be both useful and desirable. Consistent with the policy for governance of a school, and its parent university, there should be clear definitions of the responsibilities of these groups and the extent that their deliberations are advisory, or decide policies and actions of the medical school.

In summary there should be written definitions of the responsibility and authority of all committees, administrators, departmental chairmen, and faculty. There should be a clear description of the delegations of authority from the governing body to university officers, and through them to committees.

The relationship of the medical school to the clinical resources necessary for the teaching of medical students and the attainment of the other goals of the school is an important part of the administration of a medical school. Regardless of whether the clinical facilities are owned by the parent university, or by the medical school, or owned by other authorities, it is important that precise and acceptable Articles of Affiliation be available. Affiliation agreements should clearly define the responsibilities of each party. The degree of authority necessary for the discharge of faculty responsibilities will vary with the extent that the affiliated clinical resource participates in the educational programs of the school. Most critical are the clinical resources in which the basic clinical clerkships are conducted. In these institutions, the administators, chairmen, and senior clinical faculty must have a role that is consistent with their responsibility for the instruction of students during their basic clinical clerkships.

V. FACULTY

The determination of the number of faculty needed by a medical school must be based upon the need for a "critical mass" in each discipline and the total responsibilities of the faculty for undergraduate, graduate and continuing medical education, for scholarly pursuits and for service. It is the responsibility of the school to provide a sufficient number of faculty who are either full-time or who have made a finite commitment of time to teaching to make certain that the educational obligations to the student are fulfilled. It follows then, that the number and kinds of faculty will relate to the stated objectives and goals of the school of medicine. The faculty must have demonstrated competence in the biological, behavioral, and clinical sciences as evidenced by teaching ability, ability to advance knowledge, and in clinical disciplines, competence in patient care.

Modern education of both undergraduate and graduate medical students requires an academic environment which provides close day-to-day interaction between biomedical scientists and clinicians. Only in such an environment can those skilled in teaching and research in the biomedical sciences maintain an acute awareness of the relevance of their disciplines to clinical problems. Such an environment is equally important for clinicians, for from the basic biomedical sciences comes new knowledge which can be applied to clinical problems. By providing a setting wherein clinical and basic scientists work closely together in teaching, research and health care delivery, academic health centers uniquely serve to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

Schools of medicine and their parent universities should promote the development of balanced health science faculties composed of both biomedical and clinical scientists. It is recommended that organizational patterns be adopted which reduce the isolation of biomedical disciplines from each other and assure close interaction between them.

In each of the major biological, behavioral and clinical sciences, provision should be made for faculty members who possess, in addition to a general knowledge of their disciplines, an appropriate expertise in the most important subdivisions or subspecialties within each of these disciplines. The number and kind of subspeciality capabilities will depend upon the extent of the commitment of the medical school to graduate and to clinical programs. Certainly for the adequate provision of patient care as a base for clinical teaching, it is necessary that provision be made for the availability of subspecialists as required for a meaningful experience at the undergraduate, graduate, and continuing medical education level.

It is axiomatic that candidates for a faculty position should be competent within their disciplines. The maintenance of competency requires that the faculty members have the qualification for, and a commitment to, continuing scholarly activities which will also contribute to the educational environment of the medical school. It is imperative that the members of the faculty have and maintain the capability to be effective teachers.

Effective teaching requires concern for pedagogy and a familiarity with the construction of a curriculum consistent with learning objectives, and subject to internal and external formal evaluation. The administration and the faculty should be conversant with appropriate mechanisms for the measurement of student performance in accordance with stated educational objectives and established national norms.

In addition to a "critical mass" of experienced and competent full-time faculty, physicians practicing in the community may make a significant contribution to the educational program of the medical school. This contribution will depend upon their areas of expertise, their commitment to medical education and their availability in relation to the extent of their practice commitments. Practicing physicians appointed to the faculty, either on a part-time basis or as volunteers, should be effective teachers while serving as role models for students and providing a valuable insight into contemporary

methods of providing patient care. Practicing physicians are most effective members of medical school faculties when they are appropriately involved in the deliberations of an academic department and of the medical school. Their effectiveness also relates to the degree to which they are involved in the defintion of educational goals and objectives.

There should be a clear policy for the review of candidates for the faculty, and for the evaluation of faculty performance, particularly in relation to promotion, rank, and tenure. There should be formal statements describing the procedure and qualifications for faculty appointments, both at the junior and at the senior level for voluntary and part-time faculty, as well as for full-time faculty. Each prospective appointment should receive individual consideration. The selection process should involve the faculty, the appropriate departmental chairmen, and the dean, the role of each varying with the rank of the appointee, the degree to which administrative responsibility may be involved, and the procedures for governance of the individual school. Each appointee should receive a clear definition of the terms of appointment, responsibilities, lines of communication, privileges and benefits and applicable policy on practice earnings.

The search for an appointment of new faculty should be in conformity with all fair employment practices. Nominations should be requested from a number of sources. The vitality may be enhanced when the faculty represents a diversity of educational background and experience. Recruitment is most effective when there is a precise statement of the responsibilities expected of the appointee. The policy statement for the recruitment and appointment of new members of the faculty should contain provisions to insure a fair and accurate evaluation of the candidate's ability. In the case of new schools, and when existing schools lack expertise in the area for which competence is to be recruited, consultants from outside of the university and its medical school faculty may be of definite value. Special problems may be encountered when the effectiveness of a potential appointee necessitates participation in the provision of patient care within a clinical faculty. The responsibilities of senior faculty for the quality of education in clinical disciplines will require participation in the determination of the quality of patient care in the institution in which they will teach. At the same time, the medical staff of a hospital in which such faculty members will discharge their responsibilities to the medical school, have an inherent responsibility and organizational integrity directed toward the quality and quantity of care available to patients within the hospital. The function, responsibility and authority of representatives of the medical school, and of the hospital, must be committed to mutually acceptable written policy statements, if the recruitment and retention of competent clinical faculty is to be assured.

It is necessary that there be clearly defined policy statements describing effective patterns for participation by the faculty in the governance of the school. This participation utilizes the capability of the faculty and provides information appropriate for the direction of faculty activity toward the achievement of the goals of the school.

As noted under the section on administration, the faculty will ordinarily participate through the departmental chairmen in a major advisory committee to the dean, and commonly there is a committee which represents all faculty and provides advice to the dean and administration of the school of medicine. There may be variation in the definition of responsibility and authority of the components of the organization of the faculty, but clear definitions of these roles should be publicized in a statement of faculty bylaws and a handbook of operating procedures.

VI. STUDENTS

The academic, physical and financial resources of the school, and the availability of qualified students, limit the number of students that can be effectively educated by the faculties of a school of medicine. These critical resources include the number and variety of faculty, the number and size of classrooms and laboratories, adequate office and laboratory space for the faculty, and the availability of an adequate spectrum of clinical resources sufficiently under the control of the faculty to insure the breadth and quality of bedside and ambulatory clinical teaching.

The need for shared resources for graduate students, or for other students within the university for which the medical school is responsible, should be considered when determining the number of medical students for whom the faculty can be responsible. The size and variety of programs of graduate medical education, both as a responsibility and as a supplement to the teaching program, and responsibilities for continuing education, patient care, and research, must be carefully considered in determining the number of medical students that is appropriate for a school.

As part of the accreditation process, the Liaison Committee on Medical Education may, after considering the adequacy of the resources available within and to the medical school, indicate a maximum number of students who may be enrolled at each level.

Criteria and procedures for the selection of students for the study of medicine should receive careful attention by each school. These criteria and procedures should be described and publicized, and should be available to each applicant. For the effective study and practice of scientific medicine it is critical that students be selected who possess the intelligence, integrity, and personal and emotional characteristics appropriate to the effective physician.

The selection of students for the study of medicine is a responsibility of the medical school faculty or a duly constituted committee. Persons or groups external to the medical school may assist in the evaluation of applicants but the final responsibility cannot be delegated external to the medical school.

In the selection of students there should be no discrimination on the basis of sex, creed, race or national origin, and compliance with both written and implied public policy should be assured. There must be no secret factors in the selection process.

It is essential that the selection procedure be so designed that there will be freedom from political, financial, or alumni influence in the selection of students.

For many years there has been a trend to restrict the academic requirements for admission to medical school to those pre-medical courses considered essential. The LCME considers this trend both well-established and highly desirable.

There must be a safe and permanent system for keeping adequate student records. They should include summaries of admission credentials, attendance, the measurement of the performance of the student, and the degree to which the student has met the requirements of the medical school curriculum. Care must be taken that these records adequately reflect each student's work and qualifications; a qualitative evaluation of each student in each course should become a part of the record. It is urged that the school develop techniques for life-long records of its students and graduates.

A system for the maintenance of student records should insure and be compatible with the statements of the Liaison Committee on Medical Education concerning the confidentiality of medical student records and must avoid any secret record keeping system. A spirit of fairness and "due process" should provide the student with access to, and an opportunity to challenge the accuracy of, his records.

Student counselling consists of both the timely provision of appropriate information to the students, and the capability to respond to his requests for information and for assistance with regard to his academic, financial, and personal problems. Continuing effort is necessary if students are to be appropriately informed regarding the goals and objectives of the school, and the expectations of the faculty with regard to student performance and behavior. Students must make decisions regarding their choice of future programs of graduate medical education, and the type and location of their future careers. It is important that they receive appropriate information and guidance to permit informed and considered decisions. Provision must be made to provide the individual student an opportunity to discuss academic performance, financial and personal problems, as well as concerns for the student's future career with respected advisors. Granting that rigid systems of assigned advisors are often poorly received by students, much is to be gained if there is a formal system that makes competent motivated members of the faculty available to the student according to the student's preferences and needs for advice and counselling.

A comprehensive health service should be available to the medical student and his family. Psychiatric services should be available. Medical records of medical students should be considered as confidential and should not be a part of the student's academic record.

VII. FINANCES

It is important, because of the uncertainty of many current sources of support for medical education, that a school of medicine seek its operating support from diverse sources.

In spite of the availability of financial support for specific objectives and programs of the school such as for research or the provision of clinical service, a balance should be maintained so that these activities do not expand to the extent that they will compromise the effective provision of educational programs required by the medical school.

Adequate direct support for the educational program is of critical importance. The availability of discretionary, unrestricted funds is important in maintaining balance and stability of the educational and research programs.

The budget should identify the extent of financial support for educational programs, for scholarly activity, and for service. The library should have a budget and if library services are provided by a resource which is not a part of the medical school, the budget of the library should identify the extent of support of library programs of the medical school.

The need for adequate financial aid for students is obvious. The school should develop and publicize formal statements describing the availability of financial assistance for students, and the procedures that will equitably apportion financial aid in accordance with the need of individual students.

VIII. FACILITIES

Facilities needed by a school of medicine will be determined by the goals and objectives of the school. Common to all schools will be the assured availability of buildings and equipment adequate for the implementation of the undergraduate medical school curriculum. Facilities must be available for the educational and research activities of the faculty and should be in proximity to the place of their educational activities.

The medical school must have adequate clinical resources to provide the clinical instruction of its medical students. Since undergraduate medical education usually requires the simultaneous and inter-supporting conduct of programs of graduate medical education, clinical facilities must be adequate for both parts of the continuum of medical education. Facilities required for the instruction of students in clinical medicine differ from those appropriate for the provision of medical care in a non-teaching setting in that full-time faculty should participate in the educational program and have, in appropriate proximity, facilities for research. A hospital which provides a base for the education of medical students must have adequate library resources, not only for the clinical staff, but for the faculty and the students.

The need for study areas, and for conferences and lecture rooms, is obvious. Ideally the facilities of the medical school should be in proximity. This is important with regard to the interrelation of the biomedical and clinical faculty and the effective utilization of classroom, laboratory, and library resources. When the facilities of a medical school cannot be in proximity, appropriate measures should be devised to minimize the resulting disadvantages.

The relationship of the medical school to its affiliated hospitals is extremely important. There must be adequate affiliation agreements. Guidelines regarding this relationship are noted under the heading, Administration and Governance.

The library should be appropriate for the goals and objectives of the medical school. The library committee of the faculty is helpful in advising the librarian and in the development of a formal procedure by which the faculty may make appropriate recommendations regarding the acquisition of library materials.

It is important that a professional library staff be responsive to the needs of the school of medicine. If the library which serves the school of medicine is a part of a medical center, or of the university library system, it is essential that the professional staff responsible for providing library services to the medical school be responsive to the needs of the school. Medical libraries have evolved to be more than the collection of volumes and serials. The librarian should be familiar with the resources for maintaining the relationship between the library and national library systems and resources, and with the expansion of the library to provide services in non-print materials. As the faculty and students served by the library become more dispersed, the role of departmental and branch libraries should receive consideration by the librarian and by the administration and faculty of the school.

The library should be considered as a community resource in support of continuing medical education.

Animal facilities are essential for the support of both education and research. Their design, capacity, and operation should relate to the needs of the school and must be in compliance with accepted standards.

IX. ACCREDITATION

Staff for the Liaison Committee on Medical Education is provided by the two parent organizations. Beginning in July of each odd numbered year, and continuing for one year, a staff member of the American Medical Association serves as Secretary of the Liaison Committee on Medical Education. Beginning in July of each even numbered year, a member of the staff of the Association of American Medical Colleges serves as Secretary of the Liaison Committee on Medical Education.

The staffs of both parent organizations, working through the Liaison Committee on Medical Education, are available to provide consultation to organizations considering the establishment of medical schools, as well as to administrators of existing medical schools, with the intent of enhancing the quality and availability of medical education.

The Liaison Committee on Medical Education has developed policy statements regarding complaints, and appeals, which may be obtained from the Secretary. A statement is also available which describes the procedures leading to the provisional accreditation of new schools.

The Liaison Committee on Medical Education publicizes the accreditation status of schools of medicine. The date of the last survey and the scheduled time of the next resurvey are also published. The report of a visit to a school for the evaluation of accreditation status is sent to the dean of the medical school, the chief executive of its parent university and the chairman of the trustees of the university after accreditation status is determined. These reports are not publicized by the Liaison Committee on Medical Education.

MEDICAL STUDENT REPRESENTATION ON LIAISON COMMITTEE ON MEDICAL EDUCATION

WHEREAS, The Liaison Committee on Medical Education (LCME) is the duly recognized body for the accreditation of medical schools; and

WHEREAS, The accreditation process was established to insure the highest of possible academic standards in U.S. medical schools; and

WHEREAS, Those most directly affected by the accreditation process are medical students; and

WHEREAS, Those directly affected by any type of review process should have some input into that process; and

WHEREAS, Medical students currently serve as members of numerous AAMC committees and task forces, the AAMC Executive Council, the National Intern and Resident Matching Program, and the National Board of Medical Examiners; and

WHEREAS, Medical student members of the above-mentioned bodies are very responsible and constructive members of these respective groups; and

WHEREAS, the Consortium of Medical Student Groups, composed of representatives of the AMA Student Business Session, American Medical Student Association, Student National Medical Association, Organization of Student Representatives of the Association of American Medical Colleges, and Student Osteopathic Medical Association, has listed the placement of a student representative on the LCME as a high priority and has an established mechanism for the selection of such a student representative; and

WHEREAS, A precedent has already been established by the Liaison Committee on Graduate Medical Education through its acceptance of a Resident member since 1974; therefore

BE IT RESOLVED, That the AAMC actively support the concept of a medical student member of the Liaison Committee on Medical Education; and

BE IT FURTHER RESOLVED, That this support shall be reported to the six AAMC members of the LCME and the three AAMC members of the Coordinating Council on Medical Education; and

BE IT FURTHER RESOLVED, That the Executive Council shall report back to the AAMC Assembly at the 1977 Annual Convention on the progress made toward achieving the goal of medical student representation on the LCME.

1977 ANNUAL MEETING SCHEDULE

SAT	SUN	MON	TUES	WED	THURS	
	OSR Groups Societies	PLENARY	PLENARY ASSEMBLY	Programs Groups Societies RIME	Groups Societies RIME	A.M.
OSR	OSR Groups Societies Programs	Council Business Meetings	Council Programs; RIME	Programs Groups Societies RIME	Groups Societies RIME	P.M.

Medical Student Rights and Responsibilities

WHEREAS, the status of house staff as students versus employees, and the right of house staff to collective bargaining privileges remains in question, and

WHEREAS, house staff organizations are increasingly finding it necessary to consider the use of strikes or other job actions to secure improved conditions for their patients and themselves, and

WHEREAS, the rights, duties and responsibilities of students in hospitals affected by such strikes are unclarified, and

WHEREAS, examples have been brought to the attention of the OSR of threatened reprisals directed against students who support such strikes or job actions,

BE IT THEREFORE RESOLVED, that OSR form a task force to examine and explore these issues, said task force to formulate a statement of student responsibilities and rights for presentation to 1977 regional meetings.

Support and Funding of Participation in OSR

WHEREAS, a significant number of AAMC member schools effectively limit student participation in the AAMC by failing to adequately fund the attendance of student representatives to OSR meetings, while supporting the attendance of representatives to the COD, the COTH, and the CAS, and

WHEREAS, the resultant lack of continuity of representation in the OSR seriously impairs informal participation by the OSR membership in AAMC affairs, and

WHEREAS, the Council of Deans has endorsed increased student representation on the Executive Council contingent upon adequate continuity of that representation,

BE IT RESOLVED that each AAMC member school should be urged by the Chairman of the COD to solicit, endorse, and adequately fund attendance of an OSR representative and an alternate representative to all national and regional meetings.

Medical School Transfer Policies

WHEREAS, it has been brought to our attention that there may be irregularities in the transfer process from two-year medical schools,

WHEREAS, there is no consistency in transfer between M.D.-granting schools,

BE IT RESOLVED that the OSR Administrative Board investigate this question, report to the OSR members and begin work on solutions if problems exist.

Curriculum and Evaluation

WHEREAS, one of the major concerns of the Organization of Student Representatives is medical school curriculum and the evaluation of the medical education process, and

WHEREAS, a number of medical schools have devised mechanisms for evaluation of course content and of teaching, and

WHEREAS, such evaluation mechanisms may be helpful to other schools in establishing their own evaluation mechanisms,

BE IT RESOLVED, that the OSR shall request from a Representative or Dean of each of its member schools, copies of that school's evaluation froms and/or a description of the school's evaluation process, and

BE IT FURTHER RESOLVED, that the OSR shall compile these forms and descriptions and shall make them available upon request to its members and to other interested parties.

Cigarette Sales at Medical Schools and Teaching Hospitals

WHEREAS, the medical profession is committed to the promotion of health and healthful habits, and

WHEREAS, the AAMC represents the institutions involved in medical education, and

WHEREAS, the AAMC thus has a responsibility for the promotion of healthful habits among the population at large, and

WHEREAS, there is a considerable body of epidemiologic data implicating cigarette smoking in the etiology of serious and life-threatening human disease,

BE IT THEREFORE RESOLVED, that the AAMC should encourage the prohibition of sale of cigarettes within medical schools and teaching hospitals.

NIRMP Monitoring

The OSR proposes that the following mechanisms be activated for the reporting of violations of NIRMP procedures for applying for residencies.

1) A specific AAMC staff member should be appointed for receiving and investigating complaints.

2) Complaints may be filed directly with the AAMC staff person or may be relayed to that individual by the local OSR representative from the school of the complaining individual. Complaints should be filed in writing. At the request of the reporting student, his or her name shall be held anonymous.

3) Violations will not be considered unless there is written evidence of such a violation.

4) Punishment for a first offense shall be a reprimand by the President of the AAMC. Punishment for a second offense shall be the release of the name of the guilty party to the general public.

5) The OSR Administrative Board shall be directed to explore other possible mechanisms for the investigation and redress of alleged violations and the protection of reporting students.

INTRODUCTORY STATEMENT AND RESOLUTION
COMMITTEE OF INTERNS AND RESIDENTS VS.
MISERICORDIA HOSPITAL MEDICAL CENTER

In April, the Committee of Interns and Residents (CIR) petitioned the New York State Labor Relations Board for recognition as the exclusive bargaining representative for interns and residents at the Misericordia Hospital Medical Center. Following an NLRB Advisory Opinion obtained by the hospital in which the NLRB claimed jurisdiction over the CIR petition, the State Labor Board dismissed the CIR petition stating, "the question of possible state jurisdiction here is certainly not free from doubt." To obtain a review of the State Labor Board's decision declining jurisdiction, CIR is challenging the decision in the New York State courts. While it is uncertain whether or not the case will be transferred to federal court, the AAMC Executive Council authorized the Association staff, in consultation with the AAMC attorneys, to join the Misericordia Hospital law suit as an amicus curiae in federal court on the procedural issue of establishing federal jurisdiction where the National Labor Relations Act and state labor laws are being simultaneously applied to the same institution. At the present time, the case is being litigated before the state court. The resolution to be brought before the OSR at this time is as follows:

WHEREAS, the AAMC Executive Council has empowered staff to study the feasibility of entering the case of CIR vs. Misericordia Hospital if it should be brought before the federal courts, and

WHEREAS, the OSR has taken a position opposing a related brief in a previous case, and

WHEREAS, the Administrative Board of OSR has appointed a task force to study problems relating to housestaff, therefore

BE IT RESOLVED, that (1) the Administrative Board be instructed to accumulate data on the New York State case and (2) from these data develop a position paper on this case prior to such time as the case is referred to the federal courts and the AAMC makes its final decision on preparation of an amicus brief, and (3) any proposed positions be circulated to OSR membership by the Administrative Board of OSR for further action.

PROPOSED OSR NEWSLETTER

At the AAMC Officers' Retreat, several approaches for strengthening the OSR were discussed. One assumption upon which this discussion was based was that many medical students are unaware of OSR's existence and are uninformed about its activities and accomplishments. In this context, the suggestion was made that issuing an OSR newsletter to all medical students might significantly enhance the image of the OSR as a viable and important medical student group. It was decided that if such a newsletter were published, it should be similar in content to the Bulletin Board and should be bulk-mailed in sufficient quantity to either the OSR representative or the student affairs officer at each medical school for local distribution. The obvious logistical problems involved in mailing and distribution raise the question of whether the newsletters would actually reach and be read by enough students to have an impact on OSR's visibility. Dr. Gronvall concluded the Retreat discussion by expressing the willingness of the COD board to pursue this suggestion further with the OSR board during the year.

For the purposes of discussion, samples of existing AAMC publications of varying format appear on the following pages. If the OSR and COD boards agree that AAMC should publish a newsletter for all medical students, the format might be patterned after one of these publications.

Questions that should be considered by the OSR and COD boards during discussion of this issue include:

1) Do the anticipated benefits to the OSR of increased publicity and visbility justify the increased expenditure involved in printing and mailing a publication to all medical students?

2) If the OSR and COD Administrative Boards decide that such a newsletter should be published, what format would be most appropriate and how should we recommend that distribution be handled at the local school level.

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the ADVISOR

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INFORMATION FOR PREMEDICAL ADVISORS ABOUT THE NEW MCAT

The 1977 dates for administration of the New Medical College Admission Test[SM] are April 30 and October 1. Registration materials will become available shortly after January 1, 1977, and will provide students final information on the test administration schedule and related details. The new test will require approximately six hours of testing time, with Science Knowledge and Science Problems sections administered in the morning, with a short rest break in between, and with Skills Analysis:Reading and the Skills Analysis:Quantitative in the afternoon, following a lunch break. The MCAT Questionnaire, formerly completed at the test center, will now be sent to the students at their homes along with certification of registration. Students will complete this important piece of information in their homes and return their questionnaire responses directly to the American College Testing Program, the organization responsible for the administration of the New MCAT.

The New MCAT Student Manual is on schedule for delivery about November 1, 1976. Complete descriptions of the test content are provided along with a practice test which illustrates items typical of the New MCAT and includes estimates of the time allotments and numbers of items in each section of the test. The Manual can be obtained by sending a remittance (no cash please) or institutional purchase order for $3.25 ($4.00 priority mail) to: Membership and Subscriptions, Association of American Medical Colleges, Suite 200, One Dupont Circle, N.W., Washington, DC 20036. Ask for New MCAT Student Manual.

Research on the New MCAT continues during 1976 and will form the basis of information needed to interpret scores. The six scores to be generated will be

(MCAT—Cont'd. on P. 3)

AAMC ANNUAL MEETING

IN GENERAL

"The Next Hundred Years" will be the theme of the AAMC Annual Meeting, November 11-15, in San Francisco. In addition to plenary sessions (on November 13 and 14) whose speakers will focus on developments in medical education since the formation of the Association in 1876 and forecasts for the future, several special programs will be of interest to advisors. A joint Organization of Student Representatives/Council of Deans program on "Educational Stress: The Psychological Journey of the Medical Student" is scheduled for the evening of Thursday, November 11. An open forum on Friday evening, November 12, will address "Women in Medicine: Just What Are the Issues?" The Group on Student Affairs (GSA) program, "Doctors≠People: Conflicts of Professional and Personal Roles of Medical Students and Physicians" will be held in the late afternoon of Sunday, November 14.

Two major sessions will be devoted to minority issues in medical education. A panel of leading medical educators will discuss "The Challenge of Medical Education—The Minority Medical Student" at a symposium on Thursday afternoon. The keynote speaker at Saturday's minority affairs program, "Contributions and Benefits of Minorities in Medical Education," will be The Honorable Yvonne Brathwaite Burke, current chairperson of the Congressional Black Caucus and the first Black woman ever elected to the U.S. House of Representatives from California.

In other activities, GSA committees, which include advisor representation, will meet on Friday, November 12. Immediately preceding Sunday afternoon's GSA program will be, the GSA business meeting where admissions and student affairs issues of national interest are considered by the full GSA membership; advisors are welcome to attend as observers. (MEETING—Cont'd. on P. 4)

FOR ADVISORS

The National Association of Advisors for the Health Professions will be meeting in San Francisco in conjunction with the AAMC Annual Meeting. All advisors are invited to the entire conference which runs from November 11 to 15 and which ranges from speeches of broad general interest in the health field to discussions of very specific medical school issues. One part of the AAMC program which will no doubt be particularly interesting to health advisors is the GSA program on Sunday afternoon, November 14.

On the evening of the 14th, from 6:30 to 8:00 p.m. in the California room of the San Francisco Hilton, the Western AAHP has organized a cocktail party (cash bar and munchies) where we can relax and talk over the conference.

For a somewhat more formal discussion of the issues raised by the conference and any other questions of current concern to advisors across the country, we have reserved Ballrooms 2 and 3 for Monday, November 15, from 9:00 a.m. to noon. At this time the Executive Committee will present its report on the current status of the national organization. Any resolutions or other matters which should be referred to the membership at large can be presented at this time.

We are not presenting a structured program, as we have no wish to preempt the appropriate territory of the regional groups. We do, however, look forward to a useful and intersting exchange of views.

Patricia Geisler
Chief Health Professions Advisor
Columbia University

ZEN AND THE ART OF GETTING INTO MEDICAL SCHOOL*

In the provocative book *Zen and the Art of Motorcycle Maintenance,* Robert Pirsig tells the story of the gifted scholar Phaedrus who went insane trying to define "Quality." Each year 119 medical school admissions committees are similarly required to define "Quality." The issue is not an abstract one, but an immediate, pressing, tangible, existential reality, for each committee must select a small number of matriculants from a large field of applicants. . . .

In quite another way, *Zen and the Art of Motorcycle Maintenance* reflects on the problems of admissions committees. For the dichotomy in the book's title also refers to the tension between the rational, scientific approach and the arational, artistic, holistic approach to life. It is an expression of a dominant modern theme of the two sides of the brain: the intellectual, verbal, causal left hemisphere and the sensuous, spatial, intuitive right hemisphere. . . .

One suspects in the end that among the approximately 1,800 members of admissions committees there is a very wide range of definitions of "Quality." If all of this is likely to drive the committee members Phaedrus-like into electroshock therapy, the responses of the 45,000 candidates for admission are even more complex. The students know they are going to be judged on "Quality," but for some there is the Kafkaesque experience of having no one to tell them what "Quality" really is. . . .

In the midst of all this confusion, there is the cry that the stress on premedical training is ruining the character of liberal arts education because of the narrowness of the endeavor and the competition leading to a variety of excesses. The issue is not a simple one. If we will agree that the essence of a liberal education is the unfolding of one's own sense of "Quality," informed by tutors, exemplars, and the writings of others, then we must assume that there will be many pathways to a liberal education. Breadth or narrowness is not the sole criterion; rather it is the search for meaning in a student's development. The danger of premedical training is that early in life an individual will surrender his personal, internal search for "Quality" and adopt a mask designed to impress admissions committees. The individual becomes all facade and no substance, a con artist at getting marks and letters of recommendation, but beneath it all a hollow human being. I feel that our medical schools have more than their fair share of such people. They are hard driving and success oriented, but one feels they may lack the ethical or intellectual dimensions of excellence. They have been unwilling even to listen for the beats of their own drummers. Those who have not worked out their own sense of self often show the greatest distress at the thought of not being admitted. As a reaction to such people, I have often been tempted to put a sign on my office door reading: "Anyone who is panicked about getting into medical school is unfit to be a physician."

In the end, the failure of admissions committees to adopt a uniform standard of "Quality" is probably the ultimate protection of a liberal education. For the existence of a precise image would provide an exact model for those willing to assume the mask of "Quality" and would disadvantage those who were seeking for their own sense of excellence. . . .

In part, today's problems are with the admissions procedure. The overwhelming number of applications make it very difficult to examine in full depth the dimensions of the candidates. . . .

There is a modest suggestion that I believe could be a step in the right direction: If students were encouraged to limit their applications to perhaps six, then the total number of pieces of paper to be processed by admissions committees would drop drastically, and the members could devote more effort to individual decisions. In addition, the students would focus on where they really wanted to go and realistically feel they have a chance of acceptance. The present buckshot procedure of trying to up the odds by throwing the dice the maximum number of times hardly encourages thoughtful selectivity. We are searching for very human attributes; we must somehow reduce the task to human proportions before much progress can be hoped for. . . .

*Excerpted from an essay in the June 1976 issue of *Hospital Practice* by Dr. Harold J. Morowitz, Professor of Molecular Biophysics and Biochemistry, Yale University. Reprinted with permission from HP Publishing Co., Inc.

ADMISSIONS POLICY CHANGES AT VERMONT

Applicants to the University of Vermont College of Medicine should be advised of revisions in the school's contractual arrangements for granting preference in admissions to residents of neighboring states. Effective immediately, a previous contract with Massachusetts has been discontinued. Conditions pertaining to residents of Maine, New York, and Rhode Island are listed below.

MAINE: Student agrees to practice in Maine for four years or pay back in dollars state's contribution. Requirement for graduation: some clinical training in Maine. Tuition based on needs analysis.

NEW YORK: Student agrees to practice in an underserved area of New York for three years or pay back in dollars state's contribution. Student pays out-of-state tuition.

RHODE ISLAND: Student bears full cost of education via long-term loan from Rhode Island plus personal contribution.

There are very few, if any, entering places available for residents of other states after the school's commitments to Vermont and the contractual states have been met. Further information is available from:

David M. Tormey, M.D.
Associate Dean for Admissions
and Student Affairs
College of Medicine
University of Vermont
Burlington, VT 05401

FINANCIAL AID UNCERTAINTY

As this issue of *The Advisor* goes to press, it is not certain what action will be taken by President Ford on the health manpower legislation approved by the House and the Senate shortly before Congressional adjournment on October 1. If the President signs this legislation (H.R. 5546), future medical students may expect an expansion of the National Health Service Corps (NHSC) under which recipients of NHSC scholarships will receive full tuition and fees plus a monthly stipend in exchange for a commitment to practice medicine in an underserved rural or urban setting. The legislation also provides for a new federally guaranteed loan program for students of the health professions under which some or all of the amount borrowed might be forgiven in exchange for later practice in a shortage area.

If the health manpower legislation is vetoed, then there will be no increase in federal financial assistance targeted to medical students for Fiscal Year 1977. Applicants who will be interviewed at medical schools this fall should be advised that uncertainty about federal programs, combined with unavoidable increases in tuition and other costs at this time, may make it difficult for the schools to provide definitive answers to questions about financial assistance available to students for the immediate future.

MCAT—Cont'd. from P. 1

on a 15-point equal interval scale and will not be reported in percentiles. Information will be provided to advisors in ample time to assist them in counseling students as they receive scores from the April 1977 administration. Further information can be obtained by writing: James L. Angel, Director, Medical College Admissions Assessment Program, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, DC 20036.

HEALTH PROFESSIONS ADMISSION TESTS

The following dates will be of interest to Health Professions Advisors. The address following the name of the test is the place to write for test applications and additional information. This summary was compiled by Helen Kittsley, University of Wisconsin-Milwaukee.

TEST	TEST DATE	APPLICATION DEADLINE
Medical College Admission Test (MCAT) American College Testing Program P.O. Box 414 Iowa City, IA 52240	Apr. 30, 1976 Oct. 1, 1976	Approx 1 month prior to test date
Dental Admission Test Program (DAT) Division of Educational Measurements American Dental Association 211 East Chicago Avenue Chicago, IL 60611	Jan. 8, 1977 Apr. 30, 1977 Oct. 8, 1977	Dec. 13, 1976 Apr. 4, 1977 Sept. 12, 1977
Optometry College Admissions Test (OCAT) The Psychological Corporation 304 East 45th Street New York, NY 10017	Nov. 6, 1976 Jan. 15, 1977 Mar. 19, 1977	Oct. 16, 1976 Dec. 18, 1976 Feb. 26, 1977
Pharmacy College Admission Test (PCAT) The Psychological Corporation 304 East 45th Street New York, NY 10017	Nov. 13, 1976 Feb. 12, 1977 May 14, 1977	Oct. 23, 1976 Jan. 22, 1977 Apr. 23, 1977
Colleges of Podiatry Admission Test (CPAT) Educational Testing Service 960 Grove Street Evanston, IL 60201	Sept. 25, 1976 Dec. 4, 1976 Feb. 12, 1977 June 18, 1977	Aug. 30, 1976 Nov. 8, 1976 Jan. 17, 1977 May 23, 1977
Veterinary Aptitude Test (VAT) The Psychological Corporation 304 East 45th Street New York, NY 10017	Nov. 6, 1976 Jan. 15, 1977 Nov. 12, 1977	3 weeks prior to test date
Graduate Record Examinations (GRE) Educational Testing Service Box 955 Princeton, NJ 08540	Dec. 11, 1976 Jan. 8, 1977 Feb. 26, 1977 Apr. 23, 1977 June 11, 1977	Nov. 10, 1976 Dec. 7, 1976 Jan. 26, 1977 Mar. 23, 1977 May 11, 1977

MSIS COMMITTEE REPORT

What kinds of information do medical schools need in order to make intelligent admission decisions? What information do their applicants have the right to withhold? What information about medical school applicants, students and graduates should be available to government and the public? These and other difficult questions having to do with the records of those who apply to and enroll in the nation's medical schools are the concerns of the Medical Student Information System Committee of the Group on Student Affairs of the Association of American Medical Colleges. The Committee has a rotating membership of admissions officers, student affairs officers, a premedical advisor and a medical student. It meets with members of the Association staff twice yearly in Washington, DC, and at the AAMC annual meeting.

Most recently the Committee has devoted its time to considering revisions in the AMCAS system and the MCAT questionnaire, as well as developing a new questionnaire for medical school graduating seniors.

As a result of the Committee's recommendations, the AMCAS application for the 1978-79 entering class will offer a new set of categories recommended by the federal government for describing ethnic identity, provide more space for personal comments, and have a separate form on which the applicant will record the items that are to go into the AMCAS computerized data base.

The Committee has engaged in extensive discussion about revising and expanding the questionnaire given to persons who register for the MCAT. Completion of the questionnaire would be optional, and individually identifiable information derived from it would not be available to medical schools; however, aggregate data, which would be available, would contribute to the development of a comprehensive "longitudinal" view of the medical school applicant—student—graduate—practicing physician population. Questions would elicit information about a person's academic, financial and social background, as well as his or her educational and career plans.

The other element that the Committee is considering as an addition to the body of information available about medical education is a questionnaire to be administered to graduating medical

(MSIS—Cont'd. on P. 4)

MSIS—Cont'd. from P. 3

school seniors. It would be designed to obtain information about the relationship between their medical school experience and professional expectations.

The possibility that future legislation may prohibit use of the Social Security number as a common identifier has also led the Committee to approve the implementation of procedures in 1977 to assign a unique number—known as the Medical Education Identification Number—to each person who applies to medical school. Normally it would be assigned at the time a person registers for the MCAT. Eventually this number will probably replace the Social Security identifier and, in so doing, diminish the chances of invasion of an applicant's privacy as well as increase the accuracy of the medical student records system.

Advisors of premedical students can play an important role in the Committee's deliberations. It is advisors who see first-hand the problems, pressures and anxieties with which applicants must deal. Advisors' comments on issues currently before the Committee as well as new suggestions for ways to improve the application process are welcome. Comments may be addressed to the undersigned or directly to MSIS Committee, AAMC, Suite 200, One Dupont Circle, N.W., Washington, DC 20036.

Lloyd W. Chapin
Health Professions Advisor
College Office
Emory University
Atlanta, GA 30322

USUHS JOINS AMCAS

The School of Medicine of the Uniformed Services University of the Health Sciences (USUHS) is accepting applications through AMCAS for the 1977 entering class. Established by federal law in 1972, USUHS accepted its charter class of 32 students this year. Anticipated first-year enrollment for 1977-78 is 68.

The basic objectives of the USUHS School of Medicine are (1) to develop students into competent, compassionate military physicians; (2) to create and foster an environment of learning that will inspire investigative curiosity and the advancement of knowledge; and (3) to provide the setting for the inculcation and furtherance of military-medical professionalism. Applicants must be citizens of the United States and must meet the physical and personal qualifications for a commission in the uniformed services. One year each of college English, General Chemistry, Organic Chemistry, Physics, General Biology, and Mathematics are also required in addition to MCAT scores and a baccalaureate degree. Graduates of the school may expect promotion to the rank of captain in the Air Force or Army, or lieutenant in the Navy or Public Health Service. Graduates are obligated to serve on active duty as medical officers for not less than seven years, not including time spent in internship or residency training.

The latest date for filing an AMCAS application to the USUHS School of Medicine is December 15, 1976. Since USUHS is not listed on the current AMCAS designation form, such applications should be accompanied by the "Addendum to the AMCAS Designation Form—Side 2" which is available from AMCAS.

MEETING—Cont'd. from P. 1

All major AAMC Annual Meeting functions will be held at the San Francisco Hilton Hotel. Advance registration and hotel reservations may be made by returning the forms included with the preliminary program (mailed in late August to all advisors) to AAMC by October 25. If this deadline cannot be met, advisors may make their own reservations at any other hotel in San Francisco and plan to register for the meeting at the AAMC desk in the Hilton upon arrival.

— S.P.D.

THE ADVISOR

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Editor: Suzanne P. Dulcan
AAMC Division of Student Programs
1 Dupont Circle, N.W., Washington, DC 20036

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COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 WINTER, 1977 VOL. 2, NO. 2

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.

BIOMEDICAL RESEARCH - UPDATE 1977. The 95th Congress faces a half-dozen expiring health-related legislative authorities. At least three major acts directly affecting biomedical research require renewal this Spring: National Cancer Act; National Heart, Lung, Blood, and Blood Vessel Act; and National Research Service Awards Act (research training).

Anticipating the need for increased interaction between the Congress and the academic community, the CAS initiated a network of public affairs representatives in November and held a workshop with these representatives and Congressional staffers in December. In addition, on January 19, the CAS Administrative Board met with Mr. Stan Jones and Dr. David Blumenthal, of the Senate Health Subcommittee staff, for a discussion of the academic concerns relating to biomedical research and technology transfer.

Indications are that the Carter administration would prefer a simple one-year extension of the expiring laws to allow time for formulation of new policies. Such extensions would be useful to Congress also since the overview of biomedical research which began last June did not progress as rapidly as expected. A year's delay would provide time for more extensive hearings and, hopefully, for revisions of the counterproductive provisions of present authorities.

Two factors are working against one-year extensions, however. First, supporters of the cancer and heart-lung-blood programs favor three-year renewals. Second, many in the research community are now quite comfortable with the present funding arrangements and fear that any changes may be for the worst. It is clear that Congress realizes that the pressure for categorical disease programs ("disease-of-the-month authorities") would be increased by the longer extensions of existing categorical disease programs. Congress has also become aware that categorical disease programs tend to push up health care costs and, because the NIH budget is not expansible, actually to decrease the funds available for support of biomedical research. The proposed NIH biomedical research budget will increase only about 2% to $2.505 billion which, in view of inflation, amounts to an actual decrease in most Institutes. In addition, OMB continues to press for elimination of general research support and institutional research training grants. For all these reasons, the next few months will see much activity by the Academic Societies, AAMC, and Congress.

Contact Tom Morgan, M.D., at AAMC, for more detail.

HOUSESTAFF AND THE NATIONAL LABOR RELATIONS ACT. Collective bargaining for graduate medical student unions under the provisions of the National Labor Relations Act (NLRA) has been sought by the Physicians National Housestaff Association (PNHA) since public hospital employees were included in the Act in 1974. The PNHA argument is that residents are at once both employees and students and that collective bargaining would be imposed only upon conditions of employment and not on educational issues.

To date, in 5 cases wherein housestaff unions have sought to bargain under the provisions of the NLRA, the National Labor Relations Board (NLRB) has dismissed the house officers' petitions in a decision of fact, finding "... that interns, residents and clinical fellows are primarily students ... not employees within the meaning of the Act." On January 19, 1977 Congressman Thompson (D-NJ) re-introduced a bill (first introduced last fall) that would include house officers under the provisions of the NLRA.

AAMC Stand. The AAMC filed an *amicus brief* in the cases before the NLRB in 1975 holding that the student-teacher relationship necessary to conduct effective graduate medical education could not be achieved through the adversarial relationship of employee-employer imposed by the NLRA. The AAMC position is that the resident is a student whose relationship with the hospital should be based on an educational rather than an industrial model and that adoption of the latter relationship would imperil the educational mission from several points of view:

- The fundamental relationship between the interns and residents and the program director and the teaching staff would be changed from one of student-teacher to employee-employer.
- The program director would no longer be able to shape each individual's training to suit the individual's educational needs but would have to deal with "employees" on a collective basis.
- Hospitals would be expected to bargain about issues over which they have no control.
- The educational emphasis of graduate medical education would be replaced by a new emphasis upon wages, hours, and terms and conditions of employment.
- As the programs at affected hospitals changed from ones with emphasis upon education to ones with emphasis upon the material elements of the employer-employee relationship, graduate medical education programs would face loss of accreditation.
- The NLRB would necessarily become the final arbiter of the content of graduate medical education by virtue of defining the scope of collective bargaining in affected programs.

House officers who are proponents of the Thompson bill are quite active at the national and local levels. Program directors are urged to discuss with their residents the claims by many that collective bargaining under the NLRA will improve patient care and graduate medical education. It should be emphasized that more stringent application of accreditation standards by the Liaison Committee on Graduate Medical Education (LCGME) can be used to upgrade or weed-out substandard educational programs.

Write August G. Swanson, M.D., at AAMC, for further details.

association of american medical colleges
Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

SUBJECT: Activities at AAMC
FROM: John A. D. Cooper, M.D.

WEEKLY REPORT #77-9
DATE: March 7, 1977

HEALTH LEGISLATION IS BEING RENEWED: As mentioned in the February 22nd Report (#77-7), Samuel Thier, Chairman of Medicine at Yale, testified for the AAMC at the hearings held by the House Subcommittee on Health and the Environment on renewal of the expiring health legislation in health planning, biomedical research and health services. At the mark-up held last week, the Subcommittee increased the authorization for research training from approximately $114 million to $137 million, an amount still less than what the AAMC has recommended as necessary to permit the Appropriations committees to maintain the program at its present level.

The Senate Subcommittee on Health also held its hearings on the proposed one-year renewal of expiring health legislation. The Administration was the only witness and, as expected, supported the extension. As a result no further hearings are scheduled. Last week the Association submitted a statement for the Committee's record, supporting the one-year renewal and, among other things, emphasizing the need for continued Congressional support of the National Research Service Award Program.

INCREASES IN MEDICAL SCHOOL TUITION SEEN: Many of the medical schools are being forced to increase their tuition fees because of the uncertainties of the level of Federal capitation support, esculating energy costs and general inflation. The schools over the last two years have seen a decrease of about 50 percent in Federal capitation.

Within the next few days we will be asking the schools to advise us of their expected tuition fees for next fall so that we will be able to provide data on the National trend.

Here is what a few schools, both publicly and privately supported, have told us their tuition will be this fall. Duke University School of Medicine - First and second-year students will pay $5050, up from $4225, and third and fourth-year students will pay $4400, an increase from $3900.

Eastern Virginia Medical School - Residents of Virginia will face a $500 increase taking the tuition for all four years to $4000; non-residents will pay $5300.

Northwestern University Medical School has been forced to raise its tuition for all students by $2505, bringing the new rate to $6855.

Georgetown University School of Medicine has announced a tuition of $12,500 for entering students, $10,500 for second year students, juniors will pay $8750 and seniors $8250. George Washington University School of Medicine will charge its freshmen $9000, sophomores $7500 and juniors and seniors $6000. These schools are in a unique situation since the District of Columbia does not provide support.

MEMBERSHIP ON SENATE COMMITTEES IS FIRM: Following the reorganization of the Senate committee system in February, the permanent assignment of senators to the committees and subcommittees of the Senate for the 95th Congress took place. The Weekly Report of December 6, 1976 (#76-41) included a report on those senators who had retired or been defeated for re-election in 1976. The new committee and subcommittee assignments of most concern to the AAMC are as follows:

1. Committee on Appropriations - Newly appointed to serve on the Committee on Appropriations are Democrats Quentin N. Burdick (N.Dak.), Patrick J. Leahy (Vt.), James R. Sasser (Tenn.), and Dennis DeConcini (Ariz.), and Republican Lowell Weicker (Conn.). Only Senator Burdick has been assigned to the Subcommittee on Labor-HEW.

THE UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY
601 ELMWOOD AVENUE
ROCHESTER, NEW YORK 14642

February 8, 1977

Mr. Robert J. Boerner, Director
Division of Student Programs
Association of American Medical Colleges
Suite 200, 1 Dupont Circle, N.W.
Washington, D.C. 20036

Dear Bob:

The student body at The University of Rochester School of Medicine and Dentistry, expressed through the deliberations and actions of the Student Senate, representing all students in the medical school, voted on January 24, 1977, to discontinue its membership in the Organization of Student Representatives in the AAMC. This decision was reached after thorough discussion, including the review of activities of OSR as seen by our representatives since OSR was started in 1971. Our students do not feel that OSR has accomplished anything particular for them. In contrast, they have discovered that AMSA fulfills a number of needs as seen by the students, that it provides a wider participation by students as individuals, and it has a better communications system.

I must say that my personal sentiments are with the students. In the relatively small number of sessions which I have attended, I have been impressed that the issues the students dealt with in OSR meetings were a duplication of things done better in other forums. I do think that the monitoring of discrepancies for NIRMP has been a positive step, but this can be continued in another way.

In contrast to our impressions of OSR, our impressions of GSA are very positive. I think it would be a great advantage to the whole effort if GSA had a vote in the Executive Council; it might be much more effective than the vote of OSR in the Executive Council.

Best wishes.

Sincerely yours,

William T. Van Huysen, M.D.
Associate Dean for Student Affairs

WTV:vs

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aamc association of american medical colleges

February 23, 1977

William T. Van Huysen, M.D.
Assistant Dean, Student Affairs
University of Rochester
School of Medicine & Dentistry
260 Crittenden Boulevard
Rochester, NY 14642

Dear Dr. Van Huysen,

I am taking the liberty of replying to your letter to Bob Boerner which expressed the wish of the University of Rochester School of Medicine to withdraw from the Organization of Student Representatives. The decision to withdraw is based, I fear, on a misunderstanding of the role of OSR, and on incomplete information on the duties and accomplishments of the Organization.

OSR is not organized to "do for" medical students the way AMSA is. It is clearly the function of neither OSR or AAMC as a whole to offer many of the services which AMSA's size, budget, and foundation can provide. We cannot be in the business of offering everything from white coats to insurance. We have not the staff to man or the funds to finance several publications. We cannot provide medical students with calendars, pamphlets, and so on. Rather, our role is to provide something AMSA cannot--direct student input to the planning and direction of medical education on a national level.

AMSA is an invaluable organization, providing an independent voice for medical students. But AMSA cannot have and does not attempt to have the direct voice that OSR has. And, in fact, the officers of both AMSA and OSR acknowledge that there is an important role for both organizations

I believe there is also evidence that the students of Rochester do not understand exactly what AAMC is. AAMC is not organized to provide services for individuals. Medical schools belong to AAMC and the component groups of the school are represented in the various Councils of the Association. AAMC attempts to "speak with one voice" for medical education, and the role a school has in that process is only as effective as the representation of all the various groups of the school in the Association.

I feel that clearly, Dr. Van Huysen, much of the blame for this misunderstanding on your campus must rest with you. By relinquishing the University of Rochester's place in the OSR, the students of Rochester have lost, among other things, representation on all AAMC task forces including those on financial matters, graduate medical education, and health manpower leg-

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islation. They have lost the direct voice in the AAMC's Executive Council provided by OSR's two votes. They have lost direct input into the accreditation deliberations of the LCME. (OSR is the only student group with such input through its two members on AAMC's Executive Council.) They have lost student representation on the committees of GSA. They have, in brief, allowed themselves to be disenfranchised from the national voice of medical education. However easy it may be to criticize the OSR, I doubt you would suggest the AAMC is an unnecessary organization.

AMSA has definite, vitally important functions. OSR has equally important functions. To suggest the disbanding of one because it overlaps with the interests of the other is analogous to suggesting the disbanding of the GSA because its interests overlap those of the American Association of Student Personnel Deans. Two voices are more effective than one, especially when they speak in different forums. Overlapping of interests is a poor excuse to relinquish a voice in one's own affairs.

Finally, to suggest that the GSA could more effectively represent the interests of students on the AAMC Executive Council is to suggest a return to the benevolent academic paternalism of the 1950's. While I don't doubt your good intentions, I also don't doubt that the students of Rochester, and in fact all medical students, are perfectly capable of thinking and speaking for themselves, in any forum. If the duty of the school administration to function in loco parentis is questionable at the undergraduate level, it is clearly inappropriate for them to do so at the medical school level.

I believe firmly that the students of the University of Rochester, when adequately informed, will not want to relinquish their voice in the AAMC, and I urge you and the Rochester Student Association to reconsider your decision.

Sincerely,

Paul Scoles/sm

Paul Scoles
OSR National Chairperson-Elect

PS/scm

cc: James W. Bartlett, M.D.
John A. D. Cooper, M.D.
James Higgins, University of Rochester OSR representative
Thomas A. Rado, Ph.D., OSR National Chairperson

OSR vs AAMC on NLRB: Students wilt in the heat

The Organization of Student Representatives (OSR) has flexed its tiny muscle — and the effort seems to have left it exhausted. The OSR took a stand against its parent organization, the Association of American Medical Colleges (AAMC), and was politely overruled. But the students are satisfied that they tried their best.

At issue was the AAMC's firm opposition to the Thompson Amendment to the National Labor Relations Act (see inside back cover). The amendment would specifically include interns, residents and clinical fellows under the protection of the act — and would in effect nullify last year's National Labor Relations Board ruling that housestaff are students, not employees (TNP, May, 1976). Rep. Frank Thompson (D-N.J.), chairman of the House Subcommittee on Labor-Management Relations, introduced his amendment in the last session of Congress in time only for hearings on the issue. He plans to re-introduce the legislation in this session. Eleven OSR members voiced their support of this legislation at a heated dinner debate with eight deans. Tom Rado, OSR chairperson, took the students' message to the AAMC Executive Council, of which he is a non-voting member. But the council voted unanimously to oppose the Thompson amendment. Rather than protest further, the OSR resigned itself to a back-seat position in the effort to get the amendment passed. The AAMC, meanwhile, has pledged its energies to defeating the Thompson amendment.

- The New Physician
March, 1977

association of american medical colleges

March 14, 1977

The Editor
The New Physician
1171 Tower Road
Schaumberg, IL 60195

Dear Editor:

The March issue of The New Physician carried an article entitled "OSR vs AAMC on NLRB" (Newsline) that was characterized by misinformation betraying journalistic incompetence and insulting innuendo which is both counterproductive and out-of-place in what purports to be a news story. It is necessary in the face of this type of reportage to set the record straight.

The support the Organization of Student Representatives (OSR) gave to the Thompson Amendment (reintroduced as H.R. 2222) was neither muscle-flexing nor exhausting. It is part of a long-standing position on housestaff collective bargaining which began two years ago with a position paper developed by OSR and communicated to the National Labor Relations Board (NLRB) in reply to the Association of American Medical Colleges' (AAMC's) amicus curiae brief. Development of the OSR position did, it is true, require more neurons than muscle cells, but it must be noted that written pro-housestaff positions were presented to the NLRB only by the Physicians National Housestaff Association (PNHA) and OSR. Our muscular colleagues in the other student groups were notable only in their inaction.

Presently, an unofficial agreement exists between the leaders of the American Medical Student Association, the American Medical Association Student Business Section, the Student National Medical Association, and OSR that if Mr. Thompson's committee holds hearings and requests student testimony, such testimony will be presented perhaps by the AMSA president on behalf of the Consortium of Medical Student Groups.

Finally, I would like to correct an error of fact. The decision to oppose H.R. 2222 was not made unanimously by the AAMC Executive Council. Both the OSR Chairperson-Elect and I are voting members and our dissenting votes are a matter of record. These are intensely political times and if the student voice is to be heard and given credence, it must be clear and unified. Recognize that in this and many other issues we are on the same side. Recognize too that each student organization has an important and non-redundant function in the medical education community. I urge The New Physician to use more gray matter, less involuntary muscle, and get on with the business of representing honestly the medical student viewpoint.

Sincerely,

Thomas A. Rado/ldn

Thomas A. Rado, Ph.D.
OSR National Chairperson

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