

OSR ADMINISTRATIVE BOARD AGENDA

Conference Room  
One Dupont Circle  
Washington, D.C.

September 14, 1977  
9:00 am - 4:00 pm

- I. Call to Order
- II. Consideration of Minutes . . . . . 1
- III. Report of the Chairperson
- IV. ACTION ITEM
  - A. Executive Council Agenda
- V. DISCUSSION ITEM
  - A. OSR Annual Meeting . . . . . 22
- VI. INFORMATION ITEMS
  - A. OSR-GSA Counseling Survey Results
  - B. OSR Report Articles\*
- VII. Old Business
- VIII. New Business
- IX. Adjournment

\*Draft copy for the OSR Report will be distributed at the meeting.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

June 21 and 22, 1977  
AAMC Headquarters  
Washington, D.C.

<u>Chairperson</u>	--Thomas Rado, M.D., Ph.D.
<u>Chairperson-Elect</u>	--Paul Scoles
<u>Northeast Regional Chairperson</u>	--Peter Shields
<u>Representatives-at-Large</u>	--Robert Cassell
	--Margaret Chen
<u>Immediate-Past-Chairperson</u>	--Richard Seigle, M.D.
<u>AAMC Staff</u>	--Robert Boerner
	--Judith Braslow
	--Joseph Giacolone
	--Steven Grossman
	--Joseph Keyes
	--Diane Newman
	--Bart Waldman
	--John Repke

Guest

I. Call to Order

The meeting was called to order by Tom Rado at 1:00 pm.

II. Consideration of Minutes

The minutes of the March meeting were approved without change.

III. Report of the Chairperson

Tom Rado reported that he had not been included in any Executive Committee deliberations since the March meeting. He questioned whether OSR was being excluded from Executive Committee discussions. It was subsequently pointed out by staff that there had, in fact, been no Executive Committee conference calls during the past quarter.

Dr. Rado also expressed concern about the appointment of housestaff members to the AAMC Task Force on Graduate Medical Education. He noted that OSR had submitted four nominations for these positions and that the Chairman of AAMC had appointed individuals not included on the OSR list. He voiced particular dismay about the fact that both appointees were known to concur

with AAMC's opposition to the Thompson Amendment (HR 2222). Dr. Rado expressed the opinion that in light of the composition of the Task Force, it was likely that their deliberations and conclusions about housestaff unionization and about other issues would be entirely predictable and would offer no new solutions to problems that currently exist in the graduate medical education system.

Dr. Rado asked the Administrative Board to consider in depth the Interim Report of the Task Force on Medical Student Financing to the Executive Council. As a member of the Task Force, he voiced his strong support of the report with one minor objection. The guaranteed student loan program proposed by the Task Force as a long term recommendation includes a provision for interest subsidy for students with demonstrated financial need. Dr. Rado voiced concern that without clarification of what constitutes "demonstrated need," it is feasible that middle income students at high-tuition schools would not only accrue a substantial debt burden but would also have to make unreasonable interest payments while in school. Bob Cassell also raised the objection that the maximum borrowing levels of \$10,000 per annum specified in the proposed program would be unrealistically low in three or four years. The board generally agreed with this objection although it was understood that banks would probably be unwilling to lend more than this amount. The board also agreed that with a few minor exceptions the report was excellent and deserving of very deliberate consideration by the Executive Council.

Dr. Rado expressed concern that an OSR representative had not been invited to attend the June 22nd meeting of the Executive Committee with HEW Secretary Califano. The meeting had been arranged to discuss hospital cost containment and other issues of mutual concern. Since the Executive Council had agreed to include an OSR representative in any Executive Committee deliberations that directly concern medical students in lieu of adding an OSR representative to the Committee, the board decided to request that the OSR Chairperson be invited to attend future meetings of this nature.

Dr. Rado reported that an experimental issue of OSR Report was mailed in bulk to all OSR representatives in May. The Report included a mail-back questionnaire, the results of which were included in the Administrative Board agenda. Based upon the positive feedback from OSR representatives and other medical students on the newsletter, the board decided to request the Executive Council to fund three additional issues during the next academic year. It was agreed that the format, general content, and distribution method of the first issue was successful and should be continued in future issues.

#### IV. Report of the Chairperson-Elect

Paul Scoles reported that he attended the AMSA national convention in March and addressed the House of Delegates about the importance of student groups working with rather than against each other. He particularly criticized the biased, distorted nature of numerous New Physician

articles about the OSR. Mr. Scoles also attended a meeting of the Consortium of Medical Student Groups held in conjunction with the AMSA meeting. He noted that the consortium nominated Scott McCord to the NIRMP Board of Directors and considered revisions to their Document of Understanding which would be discussed later in the meeting.

#### V. AMA-RPS Meeting

Rich Seigle reported that he attended the annual session of the AMA-Resident Physician Section. Major items discussed included issues related to the impaired physician, the local structure of the AMA-RPS, and hospital cost containment. Dr. Seigle stressed the importance of the last issue as it relates to medical students and housestaff and stated that he would be introducing a resolution later in the meeting to recommend that cost containment techniques be a part of the undergraduate medical school curriculum.

#### VI. Quality Assurance & Peer Review

Joseph Giacalone, Staff Associate in the AAMC Department of Health Services, provided a description of a current AAMC project to promote the teaching of concepts and skills of peer review to undergraduate medical students. AAMC will sponsor institutional workshops aimed at helping schools establish programs to introduce in the medical school curriculum the techniques students will use later in their practice to set standards of care and to evaluate their own as well as their peers' performance. The board stressed the importance of involving students in the workshops and asked that they be kept informed of the project's development.

#### VII. OSR Regional Meetings

Diane Newman reported that the OSR Western Region met in Asilomar, California, April 24-27 and considered such issues as financial aid, the provision in PL 94-484 for U.S. students studying medicine abroad, strengthening the OSR, and the Bakke case. The Western OSR also proposed that AAMC explore the feasibility of publishing a directory of graduate training programs similar in format to the AAMC Medical School Admissions Requirements book. Ms. Newman also reported that the Central Region OSR met in French Lick, Indiana, May 3-5. The Central OSR conducted a variety of surveys of its membership to collect information on such topics as counseling systems, tuition increases, and electives. The Central OSR also discussed NIRMP, financial aid, and the selection process for OSR representatives at the local schools. A program about Men in Medicine was sponsored by the Central GSA, and the Administrative Board expressed an interest in sponsoring a similar session at the OSR Annual Meeting.

#### VIII. Recess

The Administrative Board recessed at 5:00 until 9:00 am the following day.

IX. Reconvene

The Administrative Board reconvened at 9:00 am on June 22.

X. OSR Counseling Survey

Rich Seigle reviewed the responses received to date to the OSR survey about counseling systems available for medical students. The questionnaires that were returned were almost exclusively from Central region OSR and GSA members. The Administrative Board recommended that the other regions be resurveyed to obtain a more representative national data base.

XI. Executive Council AgendaA. Minutes of the Previous Meeting

Bob Cassell expressed concern about the summary of the Executive Council's discussion on reduced-schedule residency programs. At its March meeting, the Executive Council voted to table a proposal that it endorse the development of reduced-schedule positions. The Council's action was based on the opinion that the AAMC should not *encourage* residents to seek part time positions coupled with the feeling that a reduced-schedule program can be arranged on an individual basis when a resident's personal situation warrants it. Tom Rado stated that while he shared Mr. Cassell's concern about the Executive Council's action, he felt that the minutes accurately reflected the discussion which took place. Bart Waldman indicated that the issue will be discussed at a future Executive Council meeting when staff has accumulated more data on the subject. The Administrative Board agreed to express its strong support of the concept of reduced-schedule training when the item again comes before the Executive Council.

B. LCME Accreditation Decisions

**ACTION:** *On motion, seconded, and carried, the OSR Administrative Board recommended that the Executive Council endorse the following LCME accreditation decisions;*

*Fully Developed Schools -- Howard University School of Medicine; Full accreditation for 7 years with a progress report due in 1978-79.*

*University of Texas Medical Branch at Galveston;*

*Full accreditation for 7 years.*

*University of Pennsylvania School of Medicine;*

*Full accreditation for 8 years.*

*University of Tennessee College of Medicine;*

*Full accreditation for 3 years with yearly progress reports.*

*Provisionally Accredited Schools -- Wright State University School of Medicine; Provisional accreditation for 1 year for a class size of 48 matriculating in Fall 1977.*

*Request for Provisional Accreditation -- East Carolina University School of Medicine; Provisional accreditation*

for 1 year for a first year class of 28 students entering in Fall 1977 and 32 students entering in Fall 1978.

C. Election of Provisional Institutional Members

ACTION: *On motion, seconded, and carried, the OSR Administrative Board recommended that the Executive Council recommend the election of Texas A & M University College of Medicine and East Carolina University School of Medicine to Provisional Institutional Membership in the AAMC by the Assembly.*

D. Election of COTH Members

ACTION: *On motion, seconded, and carried, the OSR Administrative Board endorsed the election of Rancho Los Amigos Hospital and Downey, California to COTH membership.*

E. Approval of Subscribers

ACTION: *On motion, seconded, and carried, the OSR Administrative Board recommended the approval of University of Oklahoma Tulsa Medical College and Morehouse College School of Medicine as Subscribers.*

F. AAMC Position on the Withholding of Professional Services by Physicians

The OSR Administrative Board considered a recommendation that AAMC appoint a small working group to examine the ethical issue involved in the withholding of professional services by physicians. The working group would be asked to develop a policy statement on the withholding of physician services to be presented to the Executive Council for consideration in September. The board noted that the OSR approved a resolution in November about students' rights and responsibilities during physician strikes and expressed the feeling that this particular aspect of the issue should be addressed by the proposed working group.

ACTION: *On motion, seconded, and carried, the OSR Administrative Board supported the appointment of a working group on the withholding of professional services by physicians and recommended that a student be included as a member of the group.*

G. Specialty Recognition of Emergency Medicine

At the last Administrative Board meeting, the OSR supported the subsequent position taken by the Executive Council that CCME should be the body to recognize new specialties and that the financial and patient care implications of a new specialty board should be taken into consideration before granting recognition. The Executive Council

also appointed a study group to consider the substantive issue of whether emergency medicine should be recognized as a separate and distinct specialty. Since that meeting, the Liaison Committee on Specialty Boards recommended to its parent organizations (AMA & ABMS) the approval of the new board. Since AAMC has two votes on ABMS, the Executive Council was being asked to take a position on whether AAMC should support or oppose specialty recognition of emergency medicine.

The OSR board discussed the substantive issue of whether emergency medicine should be recognized as a specialty at length. It was felt that emergency medicine does not represent a special body of knowledge but rather a distinct practice setting. The board felt, on the other hand, that while it would be difficult to identify a special fund of knowledge which emergency physicians as specialists should have mastered, it is important to in some way certify the competence of physicians who strictly practice in the emergency room setting. The OSR also discussed the implications for physician reimbursement by third-parties if emergency medicine were granted specialty recognition. The board decided to postpone taking a position on this issue until after the study group's recommendations were known and asked that Dr. Rado and Mr. Scoles convey to the Executive Council the concerns expressed by the board.

#### H. Draft Response to the GAO Report

The board discussed the staff summary and analysis of the GAO report (Addendum 1) with particular attention to the recommendation that the Coordinating Council on Medical Education (CCME) develop and operate a system to regulate/control the production of the various types of physician specialists. The OSR board's major concern with this recommendation related to whether it is feasible or appropriate for any group to regulate and control specialty mix. Several members of the board expressed frustration over the paradoxically decreasing interest in helping medical students finance their education and increasing expectation that medical students be socially conscious and enter the less lucrative primary care specialties. There was general agreement, however, that if specialty regulation is imminent, it would be more appropriate for the CCME as a private agency to perform this function rather than a federal agency. The board also agreed with the staff recommendation that the CCME should accept the responsibility for recommending the appropriate distribution of residencies among the specialties, but not for carrying out or enforcing the recommended distribution.

ACTION: *On motion, seconded, and carried the OSR Administrative Board endorsed the staff recommendations with regard to the GAO Report, "Problems in Training an Appropriate Mix of Physician Specialists."*

### I. Interim Report of the Task Force on Medical Student Financing

The Administrative Board discussed further the Interim Report of the Task Force on Student Financing which had been briefly discussed the previous day during Dr. Rado's report. Rich Seigle recommended that the report be distributed to OSR representatives, but since it was an interim report intended for the Executive Council and not for general distribution, the board decided instead that the major recommendations of the report would be highlighted in the next Chairperson's newsletter.

**ACTION:** *On motion, seconded, and carried, the OSR Administrative Board supported the recommendations included in the Interim Report of the Task Force on Medical Student Financing with the suggestion that the maximum debt levels of the proposed loan program be increased. The Administrative Board also voted to extend its appreciation to Dr. Bernard Nelson, Chairman of the Task Force, for his time and effort in an area of critical importance to medical students.*

### J. Graduate Medical Education Task Force Membership

**ACTION:** *On motion, seconded, and carried, the OSR Administrative Board adopted the following statement:*

*The OSR Administrative Board is disturbed and disappointed over the recent appointments to the AAMC Task Force on Graduate Medical Education. Neither of the resident physician appointments was drawn from OSR nominations. The physicians recommended by OSR were interested and qualified and represented views that would have broadened the perspective of the task force deliberations and added credibility to the task force's findings.*

*We further feel the appointments showed lack of concern for inclusion of differing viewpoints on HR 2222. Both resident physicians recommended to the task force testified against passage of this bill. While this is only one of many issues facing the task force, the ideological implications of this bill are crucial, and we question the ability of the task force to judge this issue fairly.*

*We encourage the task force members to remain aware of this problem and be responsive to housestaff views and representatives in other forums. We further urge the Chairman of the Association to make an additional appointment to the task force drawn from the OSR's resident physician nominations.*



## XII. OSR Annual Meeting

The Administrative Board finalized plans for OSR activities at the AAMC Annual Meeting to be held November 5-10 in Washington, D.C. (See Addendum 2). After discussion of several potential discussion session topics, the board decided upon: curriculum and evaluation, minority affairs, women in medicine, men in medicine, special problems of municipal teaching hospitals, educational stress/counseling for medical students, financial aid, reduced-schedule residency programs, health legislation, medical school accreditation, gay people in medicine, and career counseling for medical students. The comments received from last year's meeting participants led the board to conclude that a format which would allow representatives to attend sessions about three or four of the topics would provide maximum opportunity for members to become informed about current issues.

The Administrative Board also discussed various ideas for its program session on Monday, November 7. The program will focus on graduate medical education in keeping with the overall theme of the AAMC Annual Meeting and will include presentations on the history of graduate medical education, the rights and responsibilities of house officers, how the individual functions within the graduate medical education system, and the future of graduate medical education. Several speakers were suggested, and staff will work with Dr. Rado and Mr. Scoles to make the final program arrangements.

In reviewing the other activities scheduled for the Annual Meeting, the board expressed an interest in participating with the three councils in one of the joint council sessions about the transition from undergraduate to graduate medical education. It was agreed that Dr. Rado should request the addition of an OSR representative to the panel to address the transitional period from a student's point of view.

## XIII. Northeast Region Meeting

Peter Shields reported that the Northeast OSR met in Annapolis, Maryland, May 11-14. In addition to joining GSA for sessions about student health services, financial aid, and NIRMP, the OSR held separate meetings to discuss hospital cost control, counseling systems, and housestaff unionization. Dr. Dan Asimus, President of PNHA, and Dr. James Bartlett, Medical Director of Strong Memorial Hospital, attended the OSR meeting and presented opposing points of view regarding whether housestaff should be included as employees under the National Labor Relations Act.

## XIV. Consortium of Medical Student Groups' Document of Understanding

The Administrative Board reviewed proposed revisions to the Consortium's Document of Understanding. The Consortium of Medical Student Groups is an informal body organized to facilitate the exchange of information and communication among the national groups that represent medical and osteopathic students. The Document of Understanding describes the nature of the organization and addresses such operational matters as exchanging publications and making joint committee nomin-

ations. The majority of the revisions suggested at the past Consortium meeting were minor and unobjectionable. One proposed revision, however, dealt with the formulation and communication of Consortium policy. Since the Consortium does not exist to develop policies on behalf of all medical students and since it is inconsistent with the nature of the OSR to belong to a policy-making organization other than the AAMC, the Administrative Board did not approve that revision. The board recommended instead that a section be included in the Document specifying that the Consortium will facilitate the input of participating groups to the development of positions and testimony of the groups which choose to develop policy or testify independently. A copy of the Document of Understanding, as approved by the OSR board, is attached as Addendum 3.

XV. OSR Annual Meeting Resolutions

John Repke, OSR representative from New York Medical College, was asked by the Administrative Board at the March meeting to examine what action the board should take with regard to an Annual Meeting resolution about the rights and responsibilities of medical students during hospital strikes and other job actions at teaching hospitals. Mr. Repke reported to the board the results of his research on this issue and after considerable discussion the OSR board adopted the following resolution:

Medical Student Rights and Responsibilities

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

*WHEREAS, housestaff 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 feels it would be highly inappropriate for students to be pressured or permitted to perform the job of housestaff without supervision by interns and residents.*

*BE IT ALSO RESOLVED, that the OSR urges the development of AAMC policy recommending that schools not exact reprisals against students who respect housestaff picket lines.*

The Administrative Board agreed to refer this resolution to the COD Administrative Board and to the AAMC Executive Council. Dr.

Rado pointed out that if the Executive Council appointed a working group on the withholding of physician services, this issue should be considered a part of that group's charge.

Dr. Rado noted that the other Annual Meeting resolutions had been discussed and acted upon at the March board meeting. He also indicated that he would provide a report on the status of those resolutions at the OSR Business Meeting in November.

XVII. New Business

ACTION: *On motion, seconded, and carried, the OSR Administrative Board approved the following recommendations regarding the teaching of issues related to hospital cost containment based upon their discussions of this topic the previous day:*

A. *SPECIFIC RECOMMENDATIONS FOR TRAINING PHYSICIANS IN COST CONTAINMENT:*

1. *Faculty should present diagnostic tests in terms of the cost benefits of utilization.*
2. *Costs of services should be made known to students during clerkships so that there is an awareness of the cost involved in utilization of specific services.*
3. *Charts should be audited in terms of cost effectiveness.*
4. *Students should become familiar with new requirements in PSRO utilization review, especially in the average length of stay and cost of total admissions for specific diseases.*

B. *OSR RECOMMENDATION ON EDUCATION RELATED TO COST CONTAINMENT:*

*The physician should become intimately aware of the issue of cost containment during his/her medical training. Physicians can have an enormous impact on cost containment by examining their utilization of services, laboratories, and procedures. The arena of medical education, which influences medical practice in the future, is best suited for this training.*

*The OSR Administrative Board recommends that*

*AAMC formulate a position on the role of medical education in training future physicians in the reasonable utilization of services within the context of cost containment. The OSR board also urges that a student be included in the formulation of that policy.*

XVIII. Adjournment

The meeting was adjourned at 4:30 pm.

A Summary and Analysis of  
"Problems in Training an Appropriate Mix  
of Physician Specialists",

A Draft of a Proposed Report  
by the  
General Accounting Office

This study, undertaken by the General Accounting Office (GAO), on their own initiative focused primarily on the present and future adequacy of the number of physicians practicing in primary care and in other specialties. Where data was available, the report examined the past, the present and the current trends. Where judgment, opinion, intention, and prediction were involved, the GAO staff queried professional organizations, program directors, Federal Agencies, State officials, etc. in a thorough fashion. In their analysis note was taken of the various types of response rates. Direct and indirect involvement of the Federal Government in specialty distribution was also discussed.

"FINDINGS OF THE GAO REPORT"

The GAO Report is a lengthy but readable document of just over 100 pages with two short appendices. The following are its major findings and conclusions.

Physician Supply. While there is wide divergence in views on the aggregate need for physicians in the USA today and the possibility of their over-production, there is a broad consensus within the medical profession that more primary care physicians should be trained. This consensus is based not on studies and data but on indirect evidence of a declining proportion of generalists in the USA to a level below that in other countries and a growing conviction, predicated partly on experience abroad, that most medical problems can be handled by generalists. The magnitude of the need for primary care specialists is not exact, due in part to the uncertainties about the impact of highly trained assistants on the need for physicians and about the extent to which nominal specialists and sub-specialists function as primary care providers. Recently, however, there has been a trend away from non-primary to primary care specialties in the distribution of graduate medical education (GME) positions and an expansion of positions in family medicine.

Available studies suggest an over-production of certain specialists (surgery, neurosurgery, urology and cardiology). The GAO's survey of professional organizations revealed that none believe that their specialty is overpopulated; the prevailing convictions are not data-based, but rest on intuitive and impressionistic assessments of what is and what ought to be.

Regulation of Specialty Education. The number and distribution of GME positions is not logically determined by national need but simply represents the summation of the individual decisions of thousands of program directors, and reflects the personal aspirations of these individuals, the funds available to them, the educational needs of their institutions, their institutions requirements for patient care and local traditions. The resultant reflects little or no coordination or planning beyond individual institutions.

Federal agencies (DOD, VA, DHEW) that directly or indirectly support GME also pursue their own program objectives with little concern for broad national needs. The VA has reluctantly accepted a Congressional mandate to produce more physicians through VA-operated medical schools at a time when the perception is growing that the nation is facing an oversupply of medical graduates. Moreover, the VA has failed to pursue an important national goal by not establishing GME programs in family medicine.

No entity---public or private---has overall responsibility to see to it that the number and type of physicians in the U.S. is matched to the approximate number needed.

Need for Planning/Controlling Education in Specialties. Most professional organizations expressed the view that the "play of the market" has resulted, and will continue to result, in an optimal distribution of physicians by specialty, and that formal mechanisms to control or regulate this distribution are unnecessary. On the other hand, most GME program directors thought some degree of regulation or control was desirable.

Of those who favored regulation/control, most felt that the Coordinating Council on Medical Education (CCME) was the most appropriate organization. The CCME has not yet decided what, if any, role it should play in this area.

#### RECOMMENDATIONS OF THE GAO REPORT

The GAO Report concluded with unusual simplicity by offering what is basically a single recommendation, to be carried out by one of two possible performers. Their recommendation was that the Secretary, DHEW, ask the CCME to enter into a contract to develop and implement a system which would assure the training of the optimal number and mix of specialists. Should the CCME decline, the Secretary should assume responsibility for the basic task. If additional legislative authority is found necessary to carry out the function, it should be sought from Congress.

The Report also recommended that the Secretary determine national needs for physician extenders and modulate the projected number and mix of physicians to utilize the available services of physician extenders.

In the interim: the DHEW should emphasize funding of programs to increase the supply of primary care physicians and the VA should emphasize GME programs in general internal medicine and family medicine; and the Congress should re-examine the wisdom of expanding medical education under VA auspices, as initiated in P.L. 92-541.

When the necessary studies have been completed and recommendations formulated by the CCME/DHEW, the Congress should respond appropriately by steps to either encourage or discourage expansion of GME programs.

#### CRITIQUE OF THE GAO REPORT

On the whole, this report represents a sound analysis of the situation. Its basic recommendation is essentially identical to one conclusion of the AAMC's "Tosteson" Committee, later embodied in Title XVII of S.992, "the Health Manpower Act of 1975" written by the AAMC and introduced for the Association by Senator Kennedy and others in March of 1975; a similar provision was included in Title XVII of H.R. 2956. The specifications for this bill were endorsed by the Executive Council at the time and the specific proposal, that the CCME undertake the regulation of the number of GME "positions" by specialty, has been reaffirmed on two subsequent occasions.

There are a number of minor flaws here, there, and elsewhere in the Report, most of which will be transmitted to the GAO. Several matters of tone, implication and underlying policy deserve recognition and comment:

- The report is characterized by a pervasive over-optimism about the degree of precision with which "need" can be defined and about the feasibility of regulating the manpower development process to attain any pre-determined level of "need".
- The regulation/control that will have to be imposed to achieve the objectives sought will impact the continuum of medical education with considerable force. The unplanned and uncoordinated situation which currently prevails is typical of private sector phenomena. The report fails to recognize that the proposal recommended would radically transform the character of the medical education process.

#### THE ISSUE FOR THE AAMC

The major issue for the AAMC is how, as a sponsor of the CCME, to respond to the request of the Secretary, DHEW, should he accept the recommendation of the GAO Report and request the CCME to develop and operate a system to regulate/control the production of the various types of physician specialists. Since the Association for some time has publically favored the type of regulation proposed for the CCME it is probably safe to assume that the AAMC would respond positively should the Secretary actually make such a proposition to the CCME.

However, the Executive Council may wish to consider modulating its views in the light of events which have transpired since 1974. An examination of NIRMP experience reveals that position offerings in primary care specialties, excluding obstetrics/gynecology, have increased by 2134 (32%), including 858 (81%) in family medicine, 1004 (23%), in internal medicine and 272 (20%) in pediatrics. Over the same period, offerings in general surgery have decreased by 104 (4%). While these data are not definitive, they suggest a trend toward primary care specialties and, in time, an expansion in primary care practitioners. Moreover, the position becomes tenable that, once a fairly broad professional consensus develops on national goals and objectives, voluntary adjustments to realize them follow rapidly.

If the trends since 1974 are viewed as evidence of socially desirable events, accomplished without establishing formal machinery but solely by responsible voluntary professional actions, the need for the formal system proposed in S.992 becomes less urgent and some of the disadvantages of such a system deserve more serious consideration. Among those raised in previous discussions, should the CCME undertake the assignment, were the following:

- The CCME would be faced with a difficult task, and with unrealistic expectations for performance.
- Acceptance would convert the CCME into a quasi-government organization, funded by the DHEW to perform a national task. While initially the CCME's preoccupation would be with studies and recommendations on specialty distribution, it would likely eventually become involved with regulation to achieve the goals it had established.
- In all probability, CCME recommendations would impact on the traditional modes of medical care delivery in hospitals, effect hospital financing, and inevitably result in an expansion of regulatory scope, possibly involving the character of the practice of physicians.
- The scope of the CCME assignment would probably be extended, since geographic and specialty distribution are difficulty separable. The GAO now has in preparation a companion volume on the geographic distribution of physicians and one can safely predict recommendations for mechanisms to insure an optimal geographic distribution, possibly by involvement of the private sector.
- The details of the process to be established are presently not defined. An objective desirable in principle could prove operationally unacceptable. The consequences of alternative operational schemes---national vs regional vs institutional goals; combining geographic with specialty goals---cannot be predicted.



- The principle that allocation decisions of the CCME be independent of accreditation decisions of the LCGME is of great importance. Whether or not the CCME could do this job and simultaneously honor this principle is a matter of some uncertainty.
- The CCME might acquire responsibilities considered within the domain of entities created by P.L. 93-641, and find itself engaged in jurisdictional disputes and power struggles.
- In carrying out its responsibilities, the CCME would be dependent upon adequate support from DHEW which might itself wish to exert more direct control over specialty distribution and therefore try to starve the operation into poor performance.
- The magnitude and importance of some of the problems now faced on the issue of an independent CCME staff will be escalated. The task, adequately funded, would provide long term substantial income for the operation of the CCME, but by the same token might enhance the difficulty that the parent organizations would face to maintain control over the staff.
- The parent organizations of the CCME will be required to develop and maintain an unprecedented degree of unity in the pursuit of this objective or risk the collapse of a program which is central to the total national medical care program and key to the career aspirations and development of all medical graduates.

#### RECOMMENDATION TO THE EXECUTIVE COUNCIL

It is recommended that the Executive Council review the position of the AAMC on the question of private sector regulation of the numbers of specialists trained by graduate medical education programs, and

- Support the proposal in the GAO Report that the CCME accept the responsibility for recommending the appropriate distribution of residencies among the specialties of medicine, but not for carrying out or enforcing these recommendations;
- Recommend to the Secretary, DHEW that the Graduate Medical Education National Advisory Council (GMENAC) be abolished when and if the CCME accepts the proposal;
- Recommend that the development of regulatory apparatus be deferred until obviously needed;
- Recommend that, should regulatory apparatus be required, the CCME be invited to participate in its design.
- Recommend that, should regulatory apparatus be required, it be effected by mechanisms that are completely separate from the LCGME accreditation process.

OSR TENTATIVE 1977 ANNUAL MEETING SCHEDULEFRIDAY, NOVEMBER 4th

7:00 - 9:00 pm                      Administrative Board Meeting

SATURDAY, NOVEMBER 5th

9:00 - 10:30 am                      Regional Meetings  
10:30 am - 12:30 pm                  Discussion Sessions  
2:00 - 5:30 pm                        Business Meeting  
5:30 - 6:30 pm                        Reception

SUNDAY, NOVEMBER 6th

8:00 - 10:00 am                      Discussion Sessions  
10:00 am - 12 noon                    Discussion Sessions  
1:30 - 4:30 pm                        Business Meeting  
4:30 - 5:30 pm                        Regional Meetings  
7:00 - 10:00 pm                       Consortium of Medical Student Groups

MONDAY, NOVEMBER 7th

9:00 am - 12 noon                    AAMC Plenary Session  
12 noon - 1:30 pm                    New Administrative Board Meeting  
7:00 - 9:00 pm                        OSR Program

TUESDAY, NOVEMBER 8th

9:00 am - 12 noon                    AAMC Plenary and Assembly

## ORGANIZATIONAL RELATIONSHIP;

DRAFT

## A DOCUMENT OF UNDERSTANDING

PURPOSE: *The purpose of this document of understanding is to set forth working principles for inter-relations between the various medical students groups; and, to promote broader understanding, communication, and interaction on issues of concern to medical students.*

I. PARTICIPATING GROUPS: *For the purposes of clarity and representation of any viewpoints or concerns expressed by the body, members participating in the document of understanding will be referred to as the Consortium of Medical Student Groups. In this manner, each entity will maintain its individual identity and yet be allowed to develop consensus viewpoints which can be expressed on behalf of medical students. The following groups participate in the document of understanding:*

- 1) Organization of Student Representatives of the Association of American Medical Colleges (OSR)

OSR is the official mechanism for medical student input to the affairs and policy-making decisions of the AAMC.

- 2) American Medical Student Association (AMSA)

AMSA is the independent student voice representing medical students.

- 3) Student National Medical Association (SNMA)

SNMA is the independent voice representing the views and concerns of minority medical students.

- 4) Student Business Session of the American Medical Association (SBS)

SBS is the official mechanism for medical student input to the affairs and policy-making decisions of the AMA.

5) *Student Osteopathic Medical Association (SOMA)*

*SOMA is the independent student voice representing osteopathic medical students.*

*Additional groups requesting participation in the Consortium may submit requests through any of the above listed participating groups. The unanimous consensus of representatives to the Consortium will be necessary to obtain representation.*

II. COMMUNICATION FLOW:

## 1) Exchange of Communications

- a. *The officers of the respective student groups will regularly make available appropriate communications.*
- b. *Minutes will be compiled and distributed by the Host Group.*

## 2) Creation of Leadership Flow

- a. *The Consortium will meet at least four times a year (probably at the national meeting of each group). Each group can send a maximum of three representatives to meetings of the Consortium. Other individuals may be allowed to observe; however, all decisions of the body will be restricted to the designated representatives.*
- b. *A copy of each group's publications will be forwarded to each member of the Consortium.*
- c. *Exchange of ex-officio and/or invited guests during deliberations of the governing boards of each group will be strongly encouraged as seen fit by the President/Chairperson of the group.*

III. INTERNAL APPOINTMENTS: *Each group participating in the Consortium will solicit applications from the membership of the other groups by forwarding appropriate materials to the President/Chairperson. It will be the President's/Chairperson's responsibility to distribute the application forms and information; and, to*

forward all requested materials to the member of the Consortium requesting the applications. All appointments to committees, task forces, study groups, and/or liaisons of each group participating in the document of understanding will be made available to the other members of the Consortium.

IV. INTER-ORGANIZATIONAL APPOINTMENTS: All appointments to committees, task forces, study groups, and/or liaisons by the Consortium of Medical Student Groups will adhere to the following principles:

- 1) Applications will be solicited by each participating group for all appointments made by the Consortium; and, will be reviewed by the voting representatives;
- 2) The Consortium members require a summary of information and/or curriculum vitae be concurrently submitted with the application in order to adequately access the qualifications of the various candidates.
- 3) Individuals selected by the Consortium for any committees, task forces, study groups, and/or liaisons will be forwarded to the appropriate body by a member of the Consortium designated at the time of the appointment. Letters announcing the selection of an individual for the above mentioned purposes will make specific mention of each participating group in the Consortium.
- 4) All appointments will be made through the unanimous consensus of the representatives (Section II, 2a) to the Consortium.
- 5) For the purposes of the document of understanding, the following position(s) will be considered by the Consortium of Medical Student Groups:
  - a. National Intern and Resident Matching Program At-Large Medical Student Representative.

V. DEVELOPMENT AND IMPLEMENTATION OF POLICY:

- 1) Cross Pollenization
  - a. Leaders of each group participating in the Consortium of Medical

*Student Groups will review the policy of the other groups.*

- b. *Efforts will be made to place policy of the five groups in cross indexing.*
- c. *The names, addresses and phone numbers of all elected representatives on the governing bodies of the Consortium members will be made available to each participating group in the document of understanding.*

2) Action on Federal Legislation

- a. *The Consortium will not develop its own policy statements and will not testify or take positions on public issues. However, the Consortium will facilitate the input of all participating groups to the development of positions and testimony of those groups which choose to develop policy or testify independently.*
- b. *The assignment of specific responsibilities for each group will adhere to the following general guidelines:*
  - 1. *AMSA, SNMA and/or SOMA will deliver testimony.*
  - 2. *OSR and SBS will input and participate where possible.*
  - 3. *OSR and SBS will provide input to parent positions.*

VI. Amendment

The Document of Understanding may be amended by a two-thirds majority of the groups represented in the Consortium.

ORGANIZATION OF STUDENT REPRESENTATIVES

SATURDAY, NOVEMBER 5

- 9:00 am Regional Meetings:  
Northeast  
Central  
Southern  
Western
- 11:00 am Discussion Sessions:  
Student Financial Aid  
Health Legislation  
Legal Implications of Admissions  
Medical Student Stress
- 2:00 pm Business Meeting
- 5:30 pm Reception

SUNDAY, NOVEMBER 6

- 8:00 am Discussion Sessions:  
Health Legislation  
Career Counseling  
Withholding of Physician Services  
Minority Affairs  
National Intern and Resident Matching Program
- 10:00 am Discussion Sessions:  
Student Financial Aid  
Medical School Accreditation  
Curriculum and Evaluation  
Women in Medicine
- 1:30 pm Business Meeting
- 4:30 pm Regional Meetings:  
Northeast  
Southern  
Central  
Western

MONDAY, NOVEMBER 7

2:00 pm

Discussion Sessions:  
Reduced-Schedule Residencies  
Gay People in Medicine

3:30 pm

Men in Medicine  
The Impaired Physician

7:00 pm

OSR Program Session