ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board

AGENDA

Conference Room, Suite 200
One Dupont Circle, N.W.
Washington, D.C.

September 24, 1980
9:00 am - 5:00 pm

I. Call to Order

II. Consideration of Minutes of the June Meeting.....1

III. Report of the Chairperson

IV. ACTION ITEMS

A. Executive Council Agenda

V. DISCUSSION ITEMS

A. Finalization of Plans for Annual Meeting

B. Reorganization of the Consortium of Medical Student Groups

C. Resolutions from OSR Spring Meetings.....8

VI. INFORMATION ITEMS

A. Update on Health Manpower Legislation

B. Report on Due Process Project

VII. Old Business

VIII. New Business

IX. Adjournment

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

June 25, 1980
AAMC Headquarters
Washington, D.C.

Chairperson	-- Dan Miller, M.D.
Chairperson-Elect	-- Lisa Capaldini
Regional Chairpersons	-- Susan Haack (Southern)
	-- Louis van de Beek (Northeast)
Representatives-at-Large	-- Arlene Brown, M.D.
	-- Claudia Morrissey
	-- Stephen Sheppard
	-- Greg Melcher
Immediate-past-Chairperson	-- Peter Shields, M.D.
AAMC Staff	-- Janet Bickel
	-- Robert Boerner
	-- Judy Braslow
	-- John A. D. Cooper, M.D.
	-- Mary Cureton
	-- August Swanson, M.D.
	-- Kat Turner

I. The meeting was called to order at 9:15 a.m. on June 25.

II. Annual Meeting Program

Dr. Miller reported that Dr. Ludwig Eichna had accepted the OSR's invitation to speak at the Saturday morning program titled "Curricular Reform vis-a-vis the New Biology"; Dr. Eichna, former chairman of medicine at Downstate, became a full-time medical student at Downstate in 1975 in order to heighten his understanding of his own dissatisfactions with the course and results of medical school education. The Board decided that the panel should also include a student, a consumer advocate (toward the end of exploring society's interface with the product of medical school curricula) and an M.D. knowledgeable about curricular reform and psychosocial aspects of the New Biology. The Board chose from eleven suggested topics to develop discussion sessions on the following themes*: Triumphs in Flexible Scheduling (Dr. Brown), Alternative Health Care Systems (Mr. Melcher), Nuts and Bolts of Curricular Reform (Ms. Haack), Sociobiology (Ms. Morrissey) and Understanding the NRMP Match. The first two of these will take place on Friday evening, October 24, and the last three on Sunday morning, October 26. The Board also searched for ideas for a site for the OSR reception other than the Hilton Hotel; Dr. Brown will explore one possibility.

*In parenthesis is the name of the Board member who volunteered to be responsible for arranging for speakers.

III. Update on Health Manpower Legislation

Ms. Braslow, AAMC Legislative Analyst, summarized for the Board the current status of health manpower legislation. The House Interstate and Foreign Commerce Committee reported out H.R. 7203 (the Waxman bill) which represents only minor tinkering with the present legislation (P.L. 94-484); it has not yet come before the floor for vote. Negotiations in the Senate have been more chaotic; the two proposals under consideration (Kennedy's and Schweiker's) although miles apart, have now been melded into one bill (S. 2375); it is not yet possible to evaluate the merit of this bill because authorization levels have not been set and there is still no agreement about how available funds would be allocated among the programs. It appears likely that Congress will not be able to agree on a health manpower bill before the November elections and, therefore, that for FY 1981 present programs will be funded under a Continuing Resolution. If this occurs, AAMC hopes to see an amendment to the Continuing Resolution which would raise HEAL borrowing limits and up the interest rate in order to keep this loan program going; at present, banks are reluctant to lend under HEAL because of the 12% interest ceiling. Another issue currently before the Senate committee presently considering S. 2375 is a series of amendments one of which would make chiropractic students eligible for HEAL loans. AAMC opposes these amendments on the grounds that there has been no opportunity for public debate of the amendments; that chiropractic's scientific merits are dubious at best; and that, given the present constraints on funds available for institutional support and financial aid, there ought not to be any expansion of the base of those eligible for such funds. Ms. Braslow also reported some changes in the Senate bill which were received subsequent to the AAMC summary accompanying the June 9 "pink memo" from Dr. Cooper.

IV. Fall OSR Report Topic

Ms. Bickel suggested that the Fall issue of OSR Report might be devoted to an overview of the current health manpower situation and present recently available evidence that without external incentives physicians are moving to previously underserved areas. The Board approved this idea with the suggestion that information also be provided about opportunities that medical students can take advantage of during school to gain experience in rural and other shortage areas.

V. Cheating in Medical School

Last March, Dr. Schofield, Director, Division of Accreditation, wrote a memo to the OSR Administrative Board bringing to the students' attention an article in the February 1980 issue of the Journal of Medical Education, titled "Cheating in Medical School" and asking for their thoughts on the severity of the problem and how the LCME might approach this matter. The Board members agreed that the incidence of cheating varies from class to class and school to school and, thus, that the results reported in the article may not be representative. They also stated that it is not a new phenomena and is probably not increasing and that most of those who cheat arrived in medical school with that predisposition. They felt that at schools with pass/fail grading systems the incidence is likely to be lower. They expressed the view that it is very difficult to monitor for unethical behavior but schools should have a published honor code and that violations should be handled via due process procedures. While preventive rather than

punitive measures should be the goal, rigorous proctoring of examinations and the like presupposes cheating, creating an unhealthy atmosphere; however, such measures may be appropriate in some schools. The Board felt that students should be encouraged to "self-police" and to employ peer group pressure as necessary. Finally, they suggested that as part of the orientation process, students should hear a discussion of medical ethics, beginning with their conduct in medical school.

VI. The minutes of the March OSR Administrative Board meeting were approved with the following amendment to Mr. Wold's comments as found in the second sentence of the last paragraph on p. 2: "He said he could not conceive of there being more graduates of the NHSC scholarship program than medical assignment sites in the Corps."

VII. Chairperson's Report

Dr. Miller reported that at the last Consortium meeting, held in March in conjunction with the AMSA convention in Philadelphia, a major topic of discussion was reorganization and revitalization of the Consortium. Two meetings per year were thought to be sufficient; they will be alternately hosted by AMSA and OSR but the chairmanship of the meetings will rotate among all participating medical student groups in an attempt to avoid the dominance of one. Also, the meetings will be more topically organized, with less time spent on reporting of activities, and greater efforts will be made to mail agendas and supporting information in advance of the meetings so that participants can come better prepared. Dr. Miller next reported on the Northeast Graduate Medical Education Information Project. At the Northeast OSR meeting in May, a memo was distributed (and later mailed to those not in attendance) outlining the goals and timetable of this attempt to share information received from alumni on residency programs. The first step is each school's identifying a student project coordinator who was to notify Dr. Miller if the OSR-developed survey form or the school's own form is to be used; he had thus far heard from nine schools, four of which have requested and been sent sufficient copies of the OSR form. Dr. Miller also briefly summarized the June meeting of the GSA Steering Committee; Dr. Graettinger gave a presentation on upcoming revisions in the matching process and asked for OSR's help in dispersing information about the new designations. Finally, Dr. Miller noted that the second request for due process guidelines had yielded an additional 36 responses, for a total of 100; Dr. Brown is working on a report for the September Administrative Board meeting summarizing the information which has been received.

VIII. Nomination of Student Participant on the Liaison Committee on Medical Education

The Administrative Board considered the eighteen applications received for the position of student participant on the LCME; it was asked to submit three names to the AAMC Chairman, who makes the final appointment:

ACTION: The OSR Administrative Board nominated the following students for the LCME opening:

Serena-Lynn Brown '82, Univ. of Pittsburgh School of Medicine
Margaret Durbin '82, Univ. of California, Davis, School of Medicine
Geoffrey Gates '81, Mayo Medical School

IX. Relationships with the National Board of Medical Examiners

Dr. Swanson gave a brief history of the NBME and reviewed with the Board the Association's present concerns about changes which are occuring. In 1973 the Goals and Priorities (GAP) Committee of the NBME recommended that the Board develop an examination to evaluate whether medical students had acquired the knowledge and skills needed to enter the graduate phase of their medical education. There was protracted debate within the AAMC constituency, but finally the concept of a Comprehensive Qualifying Exam (CQE) was endorsed with the reservation that the three-part examination system of the National Board should be continued until a suitable examination had been developed to take its place and has been assessed for its usefulness in examining medical students and graduates in both the basic and clinical science aspects of medical education. It was assumed that the constituency of the AAMC would be broadly involved in the assessment of any proposed comprehensive qualifying exam prior to its implementation. Dr. Swanson reported that at their annual meeting in March, a prototype of the proposed exam was exhibited to the Board, of which he is a member; the vast majority of items are from existing Parts I, II, and III questions. He noted that this opportunity to review the exam was inadequate and expressed concerns that unless the academic faculties are fully apprised of the characteristics of the CQE, the cooperative relationship between the Board and medical school faculties would be jeopardized. He and the other AAMC representative on the Board urged the development of a plan for greater involvement of faculties in an assessment of the prototype exam. Another issue of concern to the AAMC is a recent change in the governing structure of the Board; a centralization of policy making in a small Executive Committee, removal of ex-officio membership of test committee chairman and a more than doubling of the number of members in the at-large category may estrange faculties and make it difficult to recruit qualified test committee members.

Dr. Swanson continued that in a related development, the Federation of State Medical Boards has proposed that states require a two-phased licensing procedure. Passing the first phase would qualify a newly graduated physician to care for patients in a supervised education setting. This limited license would require passing an examination called the Federation Licensing Exam I (FLEX I). Full licensure for independent practice would be granted only after two or more years of graduate medical education and would require passing a second examination (FLEX II). The Federation has indicated that FLEX I could be the CQE and the National Board has indicated a willingness to provide the CQE to be used by the Federation as FLEX I. Unresolved is whether the Federation would control policies regarding the content, weighting and scoring of the exam or whether these policies would be retained by the National Board. Were the Federation to assume policy control for FLEX I, as it currently does for the FLEX exam, the control of the content and characteristics of the CQE would be removed from the academic community. Since the NBME has, from its inception, had a unique collaborative relationship with the nation's medical school faculties, there is the possibility of an adverse impact on the role and function of the Board in the future.

The OSR Administrative Board supported the recommendation before the Executive Council that an ad hoc committee be appointed to examine these issues. Members of the Board felt that the related issue of schools' reliance on National Boards for evaluation purposes should also be examined. Dr. Swanson

noted that this will be one of the areas dealt with in the Study of the General Education of the Physician. In response to a question regarding why schools are provided with their students' scores if the purpose of the National Boards is certification for licensure, he noted that scores have been shared with faculty since the inception of the NBME and that such feedback is an aspect of the traditionally cooperative relationship between the Board and medical school faculties.

X. Medical Sciences Knowledge Profile Program ad hoc Evaluation Committee

Ms. Turner explained that the MSKP program was introduced in 1980 to replace the Coordinated Transfer System which the AAMC had sponsored since 1970 as a service to those medical schools interested in placing U.S. citizens studying medicine abroad in positions of advanced standing. MSKP was instituted when the National Board made the decision to stop offering Part I of the Boards to individuals not enrolled in a U.S. medical school. By late August, data on the administrative experience with MSKP, the characteristics of the 2,144 registrants and their scores will be available. In order to assess the first year's experience and to determine what data generated by this first administration should become public knowledge, it is recommended that a seven to eight member ad hoc committee be appointed to evaluate the program. The Administrative Board supported this recommendation.

XI. Resident Conference on Evaluation

The Administrative Board reviewed the plans for the resident conference on evaluation, which will be held January 9 and 10, 1981, at the Washington Hilton Hotel. It will involve 36 senior residents from the specialties of internal medicine, pediatrics, family practice, surgery, obstetrics and gynecology, and psychiatry, and 18 representatives from the specialty boards and colleges of those specialities. A memorandum soliciting nominees to attend the conference has been sent to deans and OSR representatives.

XII. Tax Treatment of Residents' Stipends

Ms. Turner explained that the Internal Revenue Code provides that fellowship and scholarship grants to non-degree candidates may be excludable from taxable income to the extent of $300/month to a total of $3600 per year for up to three years. The applicability of this provision to housestaff stipends has been denied by the IRS. In order to be consistent with its policy that residents are primarily students and in view of the defeat of HR 2222, the AAMC is considering challenging the IRS on this matter; however, there are many reasons to approach this option cautiously, including Congressional reluctance to give additional breaks to potential high income earners. Members of the Board noted that while it would be advantageous for residents to have such a tax break, that is, to be considered students for this purpose, this stance is in conflict with OSR's traditional position that residents are primarily employees. It was decided that before making a recommendation on this subject, the Board would discuss this issue with its constituents.

XIII. A Position Paper: The Expansion and Improvement of Health Insurance in the U.S.

Ms. Turner told the Board that since this paper was considered by the Executive Council in March, the Councils discussed it at their spring meetings but that only one change in the text had been made. Members of the Board raised many concerns with the paper that it had in March, including: questioning how the poor can be expected to buy catastrophic insurance even if insurance companies would participate, as a social responsibility, in regional "pools" (p. 3, paragraph 2); that the AAMC's recommendations are reactionary and offer no suggestions on using financing as a means to improve health care delivery; that the paper does not address fundamental problems with the system, that it is a "bandaid" approach and thus a lost opportunity to affect the system in a positive way. Dr. Miller noted that given the approach adopted, the beginning of the paper should state more clearly why the Association has chosen not to tackle the more difficult issues underlying the present health insurance system. Dr. Shields, who served on the committee which reviewed and recommended changes in the AAMC's 1975 policy statement on national health insurance, reminded the Board that the paper is not intended to be the final word on the subject.

ACTION: The OSR Administrative Board voted disapproval of the paper as the basis for AAMC's policy on national health insurance.

XIV. Amendments to Senate Health Manpower Legislation

Amendments to S.2375 have been proposed which would add schools of chiropractic to the list of institutions eligible for certain health manpower programs (see item III, p. 2). Ms. Turner noted that a letter from AAMC, AMA and other health professions organizations had already been sent to the chairman of the Senate committee considering these amendments urging their disapproval. Some members of the Administrative Board objected to the Association's not recognizing chiropractic as a legitimate health profession.

ACTION: The OSR Administrative Board approved the position opposing these amendments but only on the grounds that present scarce monetary resources should not be further dilluted.

XV. Nomination of Students to AAMC Committees

For the MSKP Program ad hoc Evaluation Committee (see item X, p. 5), the Board considered applications on file from OSR members who had indicated an interest in evaluation. For the ad hoc Committee on NBME (see item IX, p. 4), due to the complexities of the issues and the background already provided members of the Board, it was felt that a Board member should be nominated for this student opening.

ACTION: The OSR Administrative Board voted to nominate: James Deming, Univ. of Miami School of Medicine, for the MSKP Committee, and and Louis van de Beek, Hahnemann, for the NBME Committee.

XVI. Universal Application Form for Graduate Medical Education

Dr. Miller reported that one of the issues discussed by the GSA Steering Committee in June was funding of the Universal Application Form for Graduate Medical Education which the AAMC has developed. The Board recommended that the cost of printing and supplying these forms to schools for the use of senior students be met by adding $1 to the NRMP fee which was $5 last year; this method seemed more appropriate than expecting the medical schools to pay for the form.

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

Western:

#1)The socialization of the physician begins during the individual physician's high school years. Discussions by college pre-professional advisors and by medical students who meet with pre-med college students indicate that by the time students enter college they have strong impressions of a highly-competitive, grade oriented process for selection of medical students.

While the achievements of these students in their science courses may be high, it is suggested that the premature narrowing of their interests prevents them from openly considering their own potentials and other career pathways.

Since the primary goal of these pre-medical students is to fulfill what they perceive to be the demands of the medical schools, it is apparent that whatever medical schools may say or do will affect the outlook of high school and college students considering medical careers.

Therefore, we urge that the OSR suggest the AAMC consider the possibility of developing an information program to be made available to high school counselors. Such an informational program could assist career counselors in their attempts to encourage students to broaden their outlook. Such a packet might include information regarding pre-medical curricular issues, financial considerations, the diversity of approaches to preparing for a medical career, and the importance of considering other careers.

#2)At the start of the junior year, medical students have completed two years of intensive basic sciences laced with a few clinical experiences. Usually, instruction has included how to take a medical history and perform the physical exam. Rarely, though, do medical students receive adequate introduction to the clinical procedures that they must master during the final two years of school. A list of such procedures follows the end of this proposal. Fortunate students have had some prior experience or have an experienced person available to instruct them the first time these procedures are performed. Many juniors, however, receive no instruction and are expected to learn by trial and error. Such encounters between needle weilding students and reluctant patients can be traumatic to both parties. A quick and effective solution would be to provide a few days of instruction prior to the beginning of the junior clerkships. By receiving introductory instruction on these skills in a low pressure environment, the medical student will be more competent, feel more confident and less stressed embarking on the clinical years. It is proposed that the OSR work with the Group on Medical Education of the AAMC to encourage medical schools to assure that students are prepared to perform effectively the following procedures before starting the clinical experience:

Venipuncture and culture, IV lines, "shots", CPR, arterial blood sampling, spinal taps, suturing, intubation, EKG, and regional anesthetics.