



association of american medical colleges

AGENDA

OSR ADMINISTRATIVE BOARD MEETING

September 10, noon - 5:00 pm

September 11, 9:00 - 5:00 pm

Conference Room, AAMC Headquarters

- I. Call to Order
- II. ACTION ITEMS
 - A. Approval of June Meeting Minutes.1
 - B. Revision of AAMC Policies re: Irregularities in Admissions.E.C.A. 23
 - C. Investor Owned Teaching Hospital Participation in AAMC.E.C.A. 33
 - D. Independent Student Issue. E.C.A. 40
 - E. Health Planning. E.C.A. 43
 - F. Commentary on the GPEP Report. E.C.A. 49
- III. DISCUSSION ITEMS
 - A. OSR Plans for 1985 Annual Meeting.8
 - B. OSR "Challenges" Paper (bring your copy from June)
 - C. Description of OSR Member Responsibilities.14
 - D. Dissemination of Physician Supply Information to Medical Students (Federal Register reprint enclosed).15
 - E. "Transition to Graduate Medical Education: Issues and Suggestions" (paper enclosed with agenda)
 - F. Medical Student Alternative Loan Program. .E.C.A. 84
- IV. INFORMATION ITEMS
 - A. Legislative Update from David Baime and Paul Elliott
- V. Old Business
- VI. New Business
- VII. Adjournment

* * * *

Joint Boards Luncheon, noon - 1:00 pm
September 12, Executive Room, Shoreham Hotel

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ADMINISTRATIVE BOARD MEETING

ASSOCIATION OF AMERICAN MEDICAL COLLEGES*
ORGANIZATION OF STUDENT REPRESENTATIVES
MINUTES

June 19, 1985
Washington, D.C.

Ricardo L. Sanchez, M.D., Chairperson
Rick Peters, Chairperson-Elect

Regional Chairpersons:

Vicki Darrow
Kim Dunn
John DeJong
Kirk Murphy

Representatives-at-Large:

Miriam Shuchman, M.D.

AAMC Staff

David Baime*
Janet Bickel
John A. D. Cooper, M.D.*
Paul Elliott, Ph.D.*
Robert Jones, Ph.D.*
Joseph Keyes*
Richard Knapp, Ph.D.*
August Swanson, M.D.*

*present for part of the meeting

I. Dr. Sanchez called the meeting to order at 9:00 a.m. He requested that the April meeting minutes, Section VIII, last paragraph be amended to reflect more clearly that so many different factors contribute to the "cost" of education in clinical settings that it is unwise to say until all the facts are in that having medical students and residents present results in less efficient patient care. Mr. DeJong requested that the last sentence of the first paragraph under Section II be amended as follows: "This [issue paper] is intended to be representative of OSR's scope and focus and should be particularly useful in relating to organizations that are poorly informed about OSR." The Board approved the minutes with these changes.

II. Annual Meeting Plans

Ms. Bickel asked for changes and additions to the meeting schedule appearing in the agenda and told the Board that all information about speakers and programs to appear in the final program must reach her by July 31. Some Board members expressed dissatisfaction with the title of the Plenary Session and promised to suggest wording more to their liking. In order not to give the impression that the Friday evening program "Student Leadership Workshop: More Pearls of Change" would replicate regional meeting sessions which employed role-playing vis-a-vis implementation of the General Professional Education of the Physician (GPEP) recommendations, students requested deletion of "more" from the title. Details of this session will be agreed upon at the September Board meeting but the main focus will be specific suggestions on implementing those GPEP recommendations and changes identified in the OSR "Issues" paper (see below) that the Board considers to be most important. Mr. Murphy reported that he is working on plans for the Friday night reception and on potential housing for OSR members via the George Washington OSR representative.

Ms. Bickel reviewed the list of speakers already contacted for the Saturday afternoon small group discussions. Suggestions for other speakers included:
1) Problems in Clinical Education (Peter Lawrence, M.D., U. of Utah):

2) Financing Graduate Medical Education (Louis Sherwood, M.D., Einstein); 3) Computer-Based Medical Education (Larry Weed, M.D.; Jack Myers, M.D., Pittsburgh); 4) Legislative Affairs (Jeff Stoddard, AMSA; health aides to Senator Hatch and Representative Ford; scholars from the Robert Wood Johnson Clinical Scholars Program). This last session will guide students in determining what is effective input to the health legislation process. All OSR members will be mailed materials in October addressing trends in student financial aid and AAMC positions on relevant legislation to help them prepare to visit their Congressmen while in D.C. for the Annual Meeting; the Saturday afternoon session will be particularly useful for those who have their appointments on Monday.

III. OSR "Issues" Paper

Mr. Peters distributed a revised draft of this paper which is intended to serve two main purposes: 1) to contribute to the on-going AAMC self-examination and be read by the Boards of the three Councils and 2) to assist OSR members in understanding the history, scope and potential of OSR and be discussed by them at the Annual Meeting. Dr. Swanson noted that the realities of price-based competition faced by teaching hospitals are exacerbating existing problems with clinical education and that some assertions in the section of this paper devoted to clinical education were indefensible; he advised sharing the paper with Dr. Knapp and with Dr. Rabkin to gather their perspectives on formulating more accurate, straightforward assessments of the problems. During additional discussion of educational costs in the clinical setting, Dr. Swanson said that in many ways ambulatory settings are preferable for the education of medical students but that such education must be subsidized. It was suggested that specific concerns held by Dr. Sanchez and Mr. Peters in this area could be a paper separate from the main "Issues" document.

In terms of the overall document, Mr. Keyes expressed the view that it was encyclopedic and did not reflect appreciation that others have been working hard on these problems for many years. He thought more caution was advisable in expressing solutions, given the technical and complex nature of many of the problems. Dr. Shuchman recommended offering brief descriptions of the controversial issues identified instead of implying that the OSR Board knows the best solutions and phrasing some of the OSR's suggestions in the form of questions instead of assertions. Other participants in the discussion agreed that students can make many observations that could be useful, e.g., "we find being on a crowded ward rounds unsatisfactory and uncomfortable because . . . or "we have trouble reconciling limited findings from studies showing that residents in clinical settings add costs with our own experience..."

It was also suggested that issues contained in this document are either open ones, on which debate is desired, or closed ones, to be considered stances, and that this difference may help in organizing the paper. Board members expressed the desire for more time to work on the paper and requested Mr. Peters to produce another draft which could be discussed on a Tuesday afternoon session preceeding the September Board meeting. Ms. Darrow reminded the Board of the importance of the document's including implementable and specific recommendations, especially in view of GPEP's generalities, and of retaining a provocative tone. The Board thanked Mr. Peters for all the work he has put into his paper and expressed the belief that a product will result which will be very valuable in creating an OSR agenda and in guiding new OSR members.

IV. Review of the AAMC MCAT Program

Mr. Keyes explained that this item was under discussion by the Councils because questions about the MCAT have been arising on a number of fronts. Dr. Swanson noted also that many medical schools admissions committees still misuse MCAT scores, e.g., adding them and using the total as an indicator, which runs counter to commonsense. The questions & issues identified by staff can be summarized as follows:

- * Is the MCAT so focused on science as to frustrate a liberal education? Is this inherent to the examination or a result of incorrect use?
- * Does the MCAT have an unavoidable role in stimulating the "premed" syndrome? Would changes in its use or design affect this situation? What impact would an essay component have? Changes in course prerequisites?
- * What role, if any, does a standardized test properly play in medical school admissions? Is there a need for more than letters, grades and interviews to assess candidates? How are grades from unknown or less prestigious institutions to be assessed?
- * Are coaching courses a problem? Are there way to alleviate the adverse effects of coaching courses?
- * Is the Association in a conflict of interest situation created by an undue dependence on revenue from the examination?

Dr. Sanchez asked if Board members had issues to add; students felt that these were appropriately open-ended and broad.

Next, the Board discussed the pilot MCAT essay project. Dr. Jones from the AAMC Department on Institutional Development, who has written a number of papers on the MCAT, explained that a committee is still examining all of the facets surrounding the possible addition of an essay. Board members raised questions about potential bias and social variability in interpreting applicants' essays and about criticizing the National Board of Medical Examiners (NBME) for influencing medical school curricula and at the same time expressing the hope that premedical students will broaden their college preparation because of proposed changes in the MCAT. Others suggested that evaluation mechanisms unavoidably influence behavior and that, since many premedical students appear to focus excessively on the sciences, adding an essay may send a message to premedical students about other endeavors being equally valuable and help to restore a balance. Dr. Jones also noted that there is no such thing as a neutral evaluation instrument and that the MCAT's influence is not concept-oriented as is the NBME's. Students asked questions about the effects of coaching courses on MCAT performance; Dr. Jones replied that the limited data available show that coaching courses do not invalidate the test. Here also Board members raised questions of social equity, but these exist at all levels, e.g., being able to afford a community college vs. an Ivy League college. Dr. Jones reminded the students that it is important not to leave discussion of the use of such tests to psychometricians because these issues require broad discussion and because it is crucial for the AAMC membership to appreciate what the MCAT program is intended to accomplish and problems in this regard. Staff suggested that OSR be provided more information on recent developments with the test, perhaps at an Annual Meeting discussion seminar.

V. Financing Graduate Medical Education

Dr. Cooper and Dr. Knapp provided the Board with an overview of the four bills presently before Congress which would limit Medicare's funding of direct medical education costs.

Senators Dole, Durenberger, and Bentsen have introduced a measure (S. 1158) that seeks to limit Medicare expenditures for graduate medical education and to use financial disincentives to persuade fewer medical students to enter and fewer institutions to offer subspecialty or lengthy specialty training programs. Senator Quayle has introduced a bill (S. 1210) that would provide a process by which a target would be set for the distribution between primary care and other residents. In the House, Congressman Regula and Tauke have introduced a bill (H.R. 2501) that would cap Medicare expenditures for graduate medical education, and most recently, Congressman Waxman introduced a bill (H.R. 2699) that would cap Medicare and Medicaid expenditures for medical education and provide financial incentives to promote a greater proportion of primary care positions.

Controversies attend provisions in each of these bills, especially with regard to the number of years of post-graduate training supported, the unit for purposes of counting primary care residents, the support of foreign medical graduates, and the inclusion in a hospitals' costs of Part B bills rendered for services provided by residents. Dr. Knapp stated that staff needs guidance on these issues and distributed a lengthy handout to the Board, including a summary of deans, academic societies and teaching hospital members' responses to a survey on financing graduate medical education.

VI. Health Planning

Dr. Knapp explained the need to review the AAMC's position on health planning which was approved in 1982. This position states that:

- * The Association supports the concept of community-based health planning.
- * The Association calls for repeal of P. L. 93-641 and its Amendments and endorses enactment of an entirely new streamlined federal health planning law.
- * The new statute should encourage the continuation of local health planning on a voluntary basis and mandate state level certificate of need (CON) review. The Association would not oppose limited federal technical assistance funding for the voluntary local planning component.
- * Compliance with the CON requirement would require establishment of state legal authority for CON review and development of a State Health Plan, and should be enforced through withholding of federal payments under certain health block grant programs. In addition, the federal government should make funds available to assist in the ongoing operation of these state programs, but its contribution must not exceed one-third of the yearly state CON program costs incurred.

Dr. Knapp said that in 1982 the Executive Council vote was split because there were so many points of view about mandated CON. The Council is being asked again now whether mandated state CON laws should continue to be supported.

VII. Investor Owned Teaching Hospital Participation in the Council of Teaching Hospitals

Dr. Knapp stated that under the current rules for determining membership in the Council of Teaching Hospitals, a hospital must qualify as a public hospital or a not-for-profit institution. Thus, hospitals owned or leased by investor owned corporations are excluded from membership in COTH. After extensive discussion with COTH members, the COTH Board concluded that COTH is organized to support the patient care, education, and research missions of teaching hospitals and that the ownership status of the hospital should not exclude hospitals sharing common interest in supporting these objectives. It therefore recommends that the AAMC bylaws be amended to permit individual for-profit hospitals to join the AAMC Council of Teaching Hospitals provided they meet membership requirements that apply to all other hospitals.

Dr. Sanchez asked for an assessment of the effect of bringing such hospitals into the AAMC fold. Dr. Knapp responded that presently there are so few that there will be no big impact and that COTH is hopeful about improved information-sharing with these investor-owned hospitals with a teaching mission.

VIII. Student Financial Assistance Programs

Mr. Baime told the Board that none of President Reagan's proposals to alter the Guaranteed Student Loan (GSL) program were adopted in either the House or Senate's budget resolutions, which are presently in conference. Funding levels for aid programs will probably be frozen at FY 1985 levels but Mr. Reagan had proposed much lower levels. With regard to health training legislation, Senator Hatch recently introduced S. 1283 which reauthorizes Title VII of the Public Health Service for three years. This bill incorporates virtually all of the program changes that were included in AAMC-supported legislation that was pocket-vetoed by the President last October. On May 15, the House approved H.R. 2410 which is almost identical to that passed and vetoed last year. Following are summarized important amendments successfully offered to H.R. 2140: 1) to reduce the interest rate on HEAL loans to T-bills plus 3.0 percent, while eliminating a provision that allowed simple interest only to be charged on the loans for the in-school period and two additional years; 2) to allow unused HEAL lending authority to be used in succeeding fiscal years, thus avoiding an impending credit crunch on the program; 3) and to require that HEAL checks be issued jointly to a borrower and the institution that the student is attending.

Mr. Baime recommended that every little input from medical students to their Congressmen helps and that students should emphasize: 1) funding the Health Professions Student Loan Program (HPSL) while reminding officials that the default rate for this program is now under 5 percent which is considerably less than the GSL's or NDSL's and 2) the need to allow unused HEAL lending authority to be used in succeeding fiscal years.

Next he turned to Title IV programs and distributed a letter from Dr. Cooper to Representative Ford, Chairman of the House Subcommittee on Postsecondary Education, outlining the AAMC's priorities on the GSL Program and loan consolidation. The AAMC will testify at a hearing in September. Finally

he raised the difficult question of the definition of "independent" student. Dr. Elliott explained why the Group on Student Affairs' Committee on Student Financial Assistance believes strongly that aid be need-based and that students must earn independence rather than it being 'awarded' based on age or any other factor. It is likely that this issue will be around for awhile and that, because of GSA's disagreement with other graduate and professional student organizations, it will appear on the AAMC Executive Council's agenda. At the September Board meeting will be discussed how these issues can best be summarized to help OSR members present them to their Congressmen.

IX. Nomination of Student-Participant to the Liaison Committee on Medical Education

The OSR Board considered the materials provided by Ms. Peggy Hasley, present AAMC appointee to this Committee, and concluded that it would prefer to see a junior appointed in order to maximize the student-participant's input. The Board carefully reviewed the 30 applications received for the position and found the following candidates to be the most acceptable:

- 1) Sharon Swindell, junior from Texas-Houston
- 2) Jeffrey Frank, senior from Southern Illinois
- 3) Charles Chung, junior from North Carolina
- 4) Harriet Williams, senior from Dartmouth
- 5) Jack McCarthy, senior from Cincinnati
- 6) Anthony Erdmann, junior from Columbia
- 7) Eugene Johnson, senior from Meharry
- 8) David Katzelnick, senior from Colorado

The Board ranked the following in order of choice:

- 1) Sharon Swindell
- 2) Anthony Erdmann
- 3) Jeffrey Frank

X. Preparation for Meeting with Council of Deans

Ms. Bickel explained that purpose of the joint session later in the day was the opportunity for the students and deans to share perspectives on the issues raised in the COD Chairman's memo, i.e., premature specialty matches, programs directors' requiring applicants to take electives at their institution and/or in their specialty, student nomenclature, and the role of medical schools in residency education. The OSR Board agreed that medical students should no longer be referred to as undergraduates and that "post-graduate resident" is preferable to either "post-graduate" or "resident" alone.

XI. Fall Issue of OSR Report

Ms. Bickel gave a status report on efforts to develop an article on medical student and physician/nurse relationships and received support and ideas from the Board for this article. Dr. Close observed that these relationships frequently exemplify water seeking its own level and that medical students could very much use help in seeing the nurses' point of view. Board members were urged to speak with colleagues who are RNs about problems in medical students/nurse relationships and to provide Ms. Bickel with any perspectives they obtain which may be used as quotations throughout the article.

Dr. Shuchman noted that she would like to prepare a short exploratory article for OSR Report on discrimination against women, racial minorities and gays in the residency selection process.

XII. The Board adjourned its meeting at 4:00 p.m. in order to join the COD Board.

XIII. Reports from OSR Regional Chairpersons on the Spring Meetings (submitted subsequently)

A) The Central Region OSR met on March 28-30 in Chicago, Illinois. Activities focused on acquiring leadership techniques included a leadership seminar, a role-playing session on implementing GPEP, and a section on legislative action. Informational sessions were also held and included financing graduate medical education, residency selection, and the use of animals in biomedical research. The region elected Joanne Fruth (Medical College of Ohio) to be its chairperson for the year 1985-86.

OSR ANNUAL MEETING PLANNING

The following two pages show the OSR sessions as they will appear in the final program which is distributed at the Annual Meeting. Following those are two pages describing student-originated exhibits which will be among the exhibits at the Annual Meeting. Since many OSR members do not find time or stay at the Meeting long enough to see the exhibit hall, the OSR Administrative Board may wish to discuss ways to make these exhibits on health fairs more available to OSR members.

Following are additional items which must be agreed upon:

- a) Agenda for the OSR Board meeting, October 25, 1:30 - 3:00 pm (Bancroft Rm., Washington Hilton).
- b) Agenda for meeting of Consortium of Medical Student Groups.
- c) Agenda for the Friday afternoon business meeting.
- d) Format and scenarios for Friday's Student Leadership Workshop.
- e) Plans for Friday and Saturday night receptions
- f) Format and leaders for OSR/AAMC "Future Challenges" discussion sessions.
- g) Preparation of OSR members to meet with Congressmen.

1985 OSR Annual Meeting Schedule (as of 8/21)

Friday, October 25

3:30 - 4:30 p.m. Regional Meetings

Dupont - Central

Edison - Northeast

Farragut - Southern

Chevy Chase - Western

4:30 - 5:30 p.m. Thoroughbred

Business Meeting

7:30 - 9:00 p.m. Thoroughbred

Student Leadership Workshop: "Pearls of Change"

Saturday, October 26

9:00 - 11:30 a.m. Jefferson West

Plenary Session

From Apathy to Panic and Beyond: Actions to Shape a Better Education

Introductions: John A. D. Cooper, M.D.

Lessons from History

Kenneth Ludmerer, M.D.

Lessons from the Health Care Environment

Arnold Relman, M.D.

Concluding Remarks: Richard H. Moy, M.D.

1:30 - 3:00 p.m. Small Group Discussions

Adams - Patient Interviewing as a Preclinical Student

Alan Kliger, M.D.

Harriet Wolfe, M.D.

Bancroft - Computer-Based Medical Education

Jack Myers, M.D.

Ricardo Sanchez, M.D.

Grant - An Experiment in Promoting Teamwork between Medical Students and
Hospital Administrative & Nursing Personnel

Patricia E. Caver

James A. Chappell, M.D.

Lin C. Weeks, R.N., M.S.N.

Edison - Curricular Integration of Health Care Cost Awareness and Ethics

Peter E. Dans, M.D.

Michael J. Garland, D.S.C. Rel.

Gail Geller

Hamilton - Preventive Medicine

Kimberly Dunn

Independence - Legislative Affairs Workshop

David Baime

John DeJong

Paul R. Elliott, Ph.D.

Jeff Stoddard

Jackson - Financing Graduate Medical Education

James Bentley, Ph.D.

3:30 - 5:00 p.m. Repeat of same discussion sessions
Nancy Seline

7:30 - 10:00 p.m. Regional Receptions

Sunday, October 27

8:30 - 9:30 a.m. Jefferson West - Meet the Candidate Session

9:30 - 11:30 a.m. "OSR/AAMC Future Challenges" Discussion Sessions

State - OSR Organizational Issues

Georgetown East - Issues in Admissions and College Preparation

Lincoln East - Issues in Basic Science Education

Lincoln West - Issues in Clinical Education

1:30 - 4:00 p.m. Ballroom East - Business Meeting

4:00 - 5:30 p.m. Regional Meetings

Farragut - Central

Grant - Northeast

Edison - Southern

Chevy Chase - Western

Monday, October 28

1:30 - 3:00 p.m. Conservatory - Workshop

Aid for the Impaired Medical Student: A Program That's Working at U. of Tennessee

James Stout

Hershel P. Wall, M.D.

3:15 - 5:00 p.m. Conservatory - Workshop

Literature and Medicine: The Patient as Art

John H. Stone, M.D.

THE FLORIDA KEYS HEALTH FAIR:
A COMMUNITY SERVICE PROJECT TEACHING CLINICAL SKILLS
T.J. Schachner, M.D., J.E. Crowell, J.H. Marston
University of Miami School of Medicine, Miami, Fla. (305) 549-7419

The Florida Keys Health Fair is an experience in which medical students from the University of Miami Medical School have offered annual health screening tests and health education programs to the residents of the lower Florida Keys since 1970. This student initiated and run community service project provides an opportunity to train preclinical students in clinical skills.

Training sessions for freshmen and sophomores, are given for each screening procedure offered at the Fair. It is our intent that each student gains, 1) a mastery of assigned screening skills, 2) an insight into the reasons for doing health screening, 3) an insight into the major health concerns of the targeted community and, 4) an understanding of health prevention practices.

In 1985, 140 medical students took part in the Fair, which spanned two sites, Big Pine Key and Key West, Florida, serving over 500 patients. In March, faculty and other health professionals from the University of Miami Medical School joined students and local volunteers in Big Pine Key and Key West to offer:

- a variety of health screening tests such as: Blood pressure, Skin cancer screening, Cervical cytology, etc.
- health education, provided individually at screening stations and in displays and group presentations.

Nine student committees and two student coordinators organize the Fair. The committees consist of Training, Publicity, Professional Contacts, Education, Registration, Set-up, Scheduling, Food and Lodging, and Follow-up. All freshman and sophomores perform committee work.

Health education is a major thrust of our health fairs. Patients take advantage of a wide variety of educational resources. These include counseling with health care professionals, displays, pamphlets, and large group presentations. After Health Fair day, the follow-up committee appraises patients of any abnormal laboratory results, tabulates data and updates charts kept on each participant.

The goals of the fairs are: 1) To educate participants about their health and its maintenance, 2) To detect potential disease problems at an early stage, 3) To check the adequacy of treatment for known health problems, and 4) To refer the patient back to health care facilities as needed.

The two fairs serve distinctly different populations. Our data show that the population of Big Pine Key is largely middle income, white, elderly and retired. In Key West, we serve a younger, racially mixed, lower income group of people.

Our data also indicate that Keys' residents 1) gain knowledge to improve their health, 2) had abnormalities identified, and 3) used the Fair to check the adequacy of their treatment. According to questionnaires the major reasons for student involvement were the desire to learn clinical skills and to gain experience with patients.

We believe that a Health Fair is a good vehicle for teaching preclinical students clinical skills and responsibilities. It is an easily duplicated experience which should enhance any student's medical school experience.

COMMUNITY MEDICINE HEALTH FAIR:
A STUDENT DESIGNED CURRICULUM
D.S. Resch, S. Hull, R.R. Deterding
Southern Illinois University School of Medicine
Springfield, IL, 217/782-2860

Learning about community resources and their proper utilization is part of most health professionals' education. Familiarization with these agencies can occur in many ways and at various times in one's education. However, introduction early in a student's education allows for early integration and utilization of these resources earlier in a physician's career. One method of introduction is through the following program.

This student-designed curriculum consists of monthly on-site visits to agencies by small groups of 5-6 students; monthly panel discussions with agencies, their clients and/or community physicians; and an annual Health Fair which serves as the focus of the program.

As the Fair is the focus, the program's goals and potentials are reflected in its design. The Fair's purpose is to promote among health care providers and students in the health care fields, an increased awareness of 1) the broad range of community health agencies available to assist their patients; 2) how these agencies interact with their clients; and 3) the services offered.

The Fair is a day-long event which is open to all students, faculty, area physicians, nursing students, other health professionals, and the community at large. The event begins with a keynote address, followed by time to view numerous displays set up by a variety of health care agencies. The displays allow students and others the opportunity to talk to agency representatives one-to-one and ask any questions they may have in regard to the agency. In addition, many of these involve clients of these agencies and their reactions to the agency. During the afternoon small group discussions pursue in greater detail the services and referral processes related to selected agencies.

In the two years this event has occurred, 89.5% of the students (n=136) thought the Fair was "an effective means of receiving information about agencies and/or organizations and the services they provide"; 91.7% stated they enjoyed the Fair; and 90% stated "the Fair was valuable in gaining a broad understanding of community health resources." The agencies' response (n=84) was equally favorable. Over the 2 years, 97.0% had 50 or more visitors over the day; and 100% stated they would return in following years.

This student-developed Fair was designed to be an integral part of the Community Medicine teaching experience. The overwhelming favorable response from the students and agencies suggests this format allows for an efficient and enjoyable means to present and become more aware of the broad range of community social services resources available.

DESCRIPTION OF OSR MEMBER RESPONSIBILITIES

As stated in the OSR "Challenges" paper, "in order to assist potential and new OSR members, the OSR Administrative Board is preparing an updated description of OSR member duties and functions; this will serve as a supplement to the OSR Orientation Handbook and be distributed to student affairs deans each fall with the OSR certification form."

Following are listed those responsibilities mentioned in the Orientation Handbook:

- 1) Action on requests to write letters to elected officials and to organize letter-writing campaigns
- 2) Distribution of OSR Report
- 3) Sharing information with other student leaders and with their student body

Following are points made by the OSR Administrative Board at its January meeting:

- 4) Submission to the Board of a report at the end of each student's term with a summary of achievements and activities (similar to the one required in many cases by the student council)
- 5) Students serving as AAMC committee members should maintain close liaison with the OSR Board.

For the September Board meeting, Board members may wish to review their notes from the year for additional ideas and be prepared to finalize a list of responsibilities which staff can expand upon so that a document can be distributed at the Annual Meeting.



**association of american
medical colleges**

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

July 19, 1985

(202) 828-0460

Thomas D. Hatch
Director
Bureau of Health Professions
Health Resources and Services
Administration
Rockville, Maryland 20857

Dear Tom:

Thanks very much for sending me a copy of the Federal Register listing of Primary Care Health Manpower Shortage Areas. I will bring this to the attention of our Organization of Student Representatives at its meeting in September to get suggestions on the best way to get this information to the medical students.

Sincerely,


John A. D. Cooper, M.D.

bcc: Janet Bickel (with incoming)

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Health Resources and Service
Administration
Rockville MD 20857
Bureau of Health Professions

John A.D. Cooper, M.D., Ph.D.
President
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036



Dear Dr. Cooper:

The Bureau of Health Professions administers programs that assist the training, development, and utilization of health professionals in this country. The National Advisory Council on Health Professions Education advises the Bureau on its programs. Recently, the Council, comprised of 20 non-Federal members, passed a resolution calling for the dissemination of pertinent physician supply information to medical students, interns, residents, fellows, and practicing physicians in the United States. The Bureau is supportive of the intent of this resolution to enhance the voluntary location selection by physicians by providing information on where additional physicians are needed.

To implement the Council's resolution, we are sending you our most recent listing of primary care Health Manpower Shortage Areas, as published in the February 15, 1985 Federal Register, in the hope that you will disseminate it widely to your constituents. For purposes of shortage area designation, primary care physicians comprise general or family practice, internal medicine, pediatrics, and obstetrics and/or gynecology.

Health manpower shortage areas (HMSAs) are designated by our Bureau, using published criteria and procedures. An area, population group, or facility must be designated as a HMSA in order to be eligible to apply for National Health Service Corps (NHSC) personnel, or to be an eligible service area for NHSC scholarship recipients to perform their obligated service. We are enclosing a summary statement which explains the criteria used for designating these areas.

We hope that you find this Federal Register listing useful. If needed, we would be glad to provide you with reprints for your use.

Sincerely yours,

Thomas D. Hatch
Director

Enclosures

Designation of Health Manpower Shortage Areas

- Summary -

Health manpower shortage areas (HMSAs) are designated by the Bureau of Health Professions, Health Resources and Services Administration, using criteria and procedures which were first published in the Federal Register as interim-final regulations in January 1978, and more recently in final form on November 17, 1980. An area, population group or facility must be designated as a HMSA in order to be eligible to apply for National Health Service Corps (NHSC) personnel, or to be an eligible service area for NHSC scholarship program or the health professions student loan repayment program. The procedures include a 30-day comment period for health systems agencies (HSAs), State health planning and development agencies (SHPDAs), and Governors, on any area, population group or facility in their State which is being considered for designation as a health manpower shortage area. Initially (in January 1978), a preliminary listing of areas which national data indicated might qualify under the criteria was compiled by the Bureau of Health Professions (BHPR) and distributed to the HSAs, SHPDAs, and Governors for review, together with the criteria themselves and relevant data on the areas involved. Designation of shortage areas since then has been carried out by BHPR on the basis of responses to that initial mailing and subsequent annual reviews, together with review of individual requests for designation of specific areas. Such requests generally come from the HSAs, but a significant number come from community groups or clinics seeking eligibility for placement of National Health Service Corps personnel. Lists of designated areas have been published in the Federal Register periodically, most recently on February 15, 1985.

The criteria for health manpower shortage areas are stated separately for each of seven manpower types: (a) primary medical care manpower (including primary care physicians in general or family practice, internal medicine, pediatrics, and obstetrics and/or gynecology); (b) dental manpower (including dentists and dental auxiliaries); (c) psychiatric manpower (presently including psychiatrists only); (d) vision care manpower (including optometrists and ophthalmologists); (e) podiatric manpower; (f) pharmacy manpower; and (g) veterinary manpower. For each manpower type there are three basic criteria: (a) the geographic area under consideration must be a rational service area for delivery of the type of care involved; (b) certain ratios or other types of criteria (or both) must be met by the area itself; and (c) manpower in contiguous areas providing the same type of care must be identified as overutilized, excessively distant, or inaccessible to the population of the area under consideration. Service areas designated include counties, groups of urban census tracts, and groups of rural county divisions.

In the case of primary care, the main ratio criterion is a population to-primary care physician ratio of 3500:1 or more, reducible to 3000:1 if high poverty rates, high infant mortality rates, or high fertility rates are present in the area.

Between January 1978 and the present, approximately 1900 primary medical manpower shortage area and 900 dental shortage areas have been designated, with lesser numbers of psychiatric and other shortage types. The National Health Service Corps' effort has been primarily in the area of placement of personnel in primary care and dental shortage areas, with some psychiatric placements. The other shortage types were defined primarily for purposes of the health professions loan repayment program.