

**Organization of Student Representatives
Administrative Board Retreat**

December 11 - 12, 1989

*"Don't be content with things as they are. Don't take
no for an answer. As long as you are generous and true, and
also fierce, you cannot hurt the world, as she was made to be
wooded and won by youth."*

Winston Churchill

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Introduction

This notebook has been designed to help you become the change agent you pledged to be when you ran for the position that enables you to serve on the OSR Administrative Board. We are privileged to be part of an association that can significantly influence the direction of medical education. But privilege entails responsibility. To be able to work effectively within the AAMC you need to know the players and understand the system. You especially need to be familiar with the mission statement and strategic goals of the association. I have taken information directly from the 1988-89 Annual Report and condensed it to give you a thumbnail sketch of the activities that have been designed to achieve the Association's strategic goals. Please consult this document for additional information on any topics which are of particular interest. Also included are updated lists of AAMC staff and committees. OSR projects and ideas will be met with a warmer reception if we can demonstrate how we are attempting to integrate within the goals of the Association.

The sections on "Environmental Assumptions" and "Legislative Goals" provide some background information that may help us with our own plans. Also included are reports from all of the regional chairs and from many of our committee representatives. Review of this material should give you a basic understanding of the OSR as it fits within the framework of the AAMC.

Identifying problems takes little effort. Working toward solutions requires thoughtful planning and steadfast action. For effective results our Ad Board must progress beyond mere problem identification and THINK STRATEGICALLY. Once we have prioritized the issues to be addressed, we need to assess the attitudes of other interested parties and determine areas for intervention as well as potential barriers. The goal of this retreat is to develop task-specific plans that we can accomplish within a determined period of time. At future Ad Board meetings we will continue to fine tune our plans as necessary and adopt new strategies as required.

With your help, this is going to be a productive year for OSR.

Time Table

Monday, December 11

(2nd floor conference room, 1776 Mass. Ave.)

8:30 - Continental Breakfast

9:00 - Call to Order - Agenda Items I - III. A.

10:00 - Begin Agenda Item III. B.

12:00 - Working Lunch

2:00 - Begin Agenda Item IV. A.

3:00 - Begin Agenda Item IV. B.

4:30 - Adjourn

7:00 - Meet for Dinner in Lobby of The Hampshire Hotel

Tuesday, December 12

(2nd Floor Conference Room, 1776 Mass. Ave)

8:30 - Continental Breakfast

9:00 - Call to Order
Finish Agenda Item IV. B.
Agenda Items V - VII.

11:00 - Question and Answer session with Dr. Petersdorf, Dr. Kettel,
Dr Swanson, Dr. Nickens, Dr. Beran, Brownie Anderson, Sarah
Carr, Janet Bickel

12:00 - Lunch

1:00 - Adjourn

Organization of Student Representatives Administrative Board Retreat

Monday, December 11, 1989

8:30 a.m. - 4:30 p.m.

Tuesday, December 12, 1989

8:30 a.m. - 1:00 p.m.

AGENDA

- X I. Call to Order
- X II. Information Items
 - X A. Expense Reports and Travel Arrangements
 - X B. Review of AAMC Structure and Governance
 - X C. Committee openings
 - X 1. National Board of Medical Examiners Liason Committee
 - X 2. Nominating Committee - to work with Chair-elect
- ✓ III. Discussion Items
 - ✓ A. Interests and priorities of Ad Board Members for 1989-90
 - ✓ B. Evaluation of Ongoing Organizational Activities.
 - ✓ C. Evaluation of Proposed New Activities.
- X IV. Action Items
 - X A. Ranking of Activities.
 - X B. Development of Strategic Plans.
- V. Old Business
- VI. New Business
- VII. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mission Statement

The Association of American Medical Colleges has as its purpose the improvement of the nation's health through the advancement of academic medicine. As an association of medical schools, teaching hospitals, and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research and health care, and assists its members by providing services at the national level that facilitate the accomplishment of their missions. In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance the search for biomedical knowledge, to advance health services research, and to integrate education and research into the provision of effective health care.

Adopted by the AAMC Executive Council
September 7, 1988



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

STRATEGIC GOALS

TO PROMOTE an environment in academic medical centers in which high quality medical education, biomedical research and patient care will flourish.

TO ATTRACT the most talented and broadly representative persons into medicine.

TO PROMOTE the intellectual, organizational and financial vitality of medical schools and teaching hospitals.

TO PROMOTE a community of interest in academic medicine.

TO PROVIDE representation about the Association's purposes, capabilities, positions to its constituents, the public and their elected and appointed representatives.

TO MAINTAIN the Association's intellectual and financial resources needed to achieve these goals.

November 22, 1988



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

LEGISLATIVE OBJECTIVES FOR 101ST CONGRESS

*FEDERAL BUDGET COMMITMENTS

- achieve the Coalition for Health Funding recommendations for function 550 (health) in the budget resolution
- achieve positive mention of NIH, ADAMHA and health manpower programs in Budget committee instructions to appropriations committee
- achieve positive mention of Medicare market basket hospital payment increase and indirect medical education adjustment in Budget Committee instructions to Senate Finance Committee and House Ways and Means Committee

*APPROPRIATIONS

- achieve NIH and ADAMHA appropriations at the level recommended by the Ad Hoc Group for Medical Research Funding
- oppose further reductions in health manpower support
- support increased funding of National Health Service Corps loan payment program
- achieve at least a \$600 million increase in the current services Veterans Administration medical care budget base
- support the VA appropriations recommendations of the Independent Service Organizations and the Friends of VA Medical Care and Research

*MEDICARE

- achieve at least market basket price increase in hospital payments;
- continue indirect medical education adjustment at current level;
- continue direct medical education payments in current payment formulation;
- return capital reimbursement to full cost payment level;
- increase percentage of dollars devoted to outlier payments;
- increase physician prevailing charges at the full 1989 Medicare Economic Index:

*MEDICAID

- continue to support expanded scope of mandatory benefits to a broader population of beneficiaries;
- special efforts should be made to increase the participation of pregnant women and children in low income families

*BROADER HEALTH INSURANCE COVERAGE

- support employer based mandatory health insurance

*SCIENTIFIC MISCONDUCT

- recommend this subject be addressed through regulatory approach currently being developed by the Department of Health and Human Resources
- resist efforts for specific involvement of the Office of the Inspector General

*HEALTH RESEARCH FACILITIES

- support efforts to reestablish an NIH and ADAMHA program for the construction and modernization of health research facilities

*PROTECTION OF ORIGINAL IDEAS

- support amendment of Freedom of Information Act to prevent disclosure of original ideas contained in research grant applications and progress reports submitted by investigators

*TAXES

- ~~✓~~ -restore full tax exemption for scholarships and fellowships
- ~~*~~ -support deduction of interest on loans used for educational expenses from income subject to federal tax
- support charitable deduction for gifts at appreciated value of property donated
- support extension of tax credit for businesses to fund the conduct of basic research in higher education institutions
- oppose further erosion of tax exempt bond authority

- oppose taxation of endowment income
- monitor closely developments with respect to the Unrelated Business Income Tax

*USE OF ANIMALS IN RESEARCH

- resist initiatives which will result in decreased availability for responsible use of animals in research and education

*FETAL RESEARCH

- follow progress of Congressional Biomedical Ethic's Advisory Committee's study of the waiver mechanism
- support use of aborted fetal tissue in research

*DEFERMENTS ON STUDENT LOANS

- ~~-achieve at least three year deferments on all GSL loans~~

*STUDENT LOAN DEFAULTS

- ~~-advocate policies which allow institutions with higher than average student loan defaults to continue participation in the HEAL and GSL programs as long as they have addressed any institutional problems that may be exacerbating defaults~~

*MINORITY FACULTY RECRUITMENT

- support loan repayment and other mechanisms to increase minority participation in research and faculty positions

*TRAUMA CARE

- support efforts to develop PHS administered block grants to support regional trauma care networks

*IMMIGRATION

- support creation of a limited "special immigrant" classification for foreign nationals who have been offered faculty positions provided no equally-qualified citizens or permanent residents are available

*MEDICAL AND HAZARDOUS WASTE

-assist in the development of rational policy regarding the tracking and handling of medical waste.

-monitor legislation and regulations regarding the generation, handling, transportation, storage, and treatment of medical and hazardous waste.

ENVIRONMENTAL ASSUMPTIONS

To provide a framework for strategic planning, there must be agreement on a set of environmental assumptions which can guide our thinking about the future. Three broad assumptions provide a framework for reviewing all other aspects of the environment:

- o The Federal deficit will be a driving force behind many national health policy decisions.
- o Major pressure will be placed on the Medicare budget to achieve expenditure savings. The research budget will be treated somewhat more generously, but not at the level of increases in the early 1980's.
- o An empirical basis from which to defend policy positions will become more important than ever.

Following are a basic set of additional assumptions adopted by the AAMC staff in reviewing our plan for the future:

HOSPITAL AND PHYSICIAN SERVICES

- o The number of Medicare eligible individuals in the population will grow faster than the growth of the population.
- o The aging "baby boomers" will increase the demand for health services substantially.
- o The population eligible for medical services provided by the Veterans Administration will grow substantially.
- o Rural populations will have increasing difficulty attracting physicians, nurses, and other health professionals.
- o Minorities will increase as a percentage of the total population.
- o More health and medical services will be provided in ambulatory settings.
- o Hospitals will be largely intensive care, trauma and surgical centers. Reconstruction, replacement and transplant technology will be increasingly common.
- o Academic medical centers will compete with aggressive community hospitals which will have reconfigured their services in the new environment.
- o The number of hospital closures will increase in the short-term.

October 6, 1988

- o Increasing hospital consolidation will result in fewer COTH members.
- o At home medical testing will grow rapidly, and self-referring patients may increase demand for subspecialty care.
- o The growth of managed care of all types (HMO, IPA and other alternative delivery system modalities) will accelerate. Competition will continue to be the health policy in the next 3-5 years.
- o The quality of physician and hospital services will become an issue of increasing public concern.
- o Proposals to change the form and substance of payment to physicians for professional services will be intensively debated. The balance between high and low earning specialties will be marginally addressed.
- o Physician recertification will increasingly be required; the role of state and federal governments in this issue will be intensively debated. Relicensure will be considered by many states.
- o Unable to reduce spending for health services substantially, government and private business will impose various forms of regulation while the "competitive" model continues to be pursued.
- o Price competition will lead to many proposals for a "formal" means of financing graduate medical education.
- o Specific proposals to provide financial sponsorship for citizens without health insurance will receive serious discussion.
- o Medicaid will remain a shared Federal/State responsibility.
- o Long-term care, particularly for senior citizens, will become a major issue.
- o AIDS will continue to provide major challenges to the service, research and educational community.
- o Alcohol and drug abuse will become higher priorities in the future.
- o The attack on the tax exempt status of hospitals will continue.
- o The shortage of nurses and selected allied health personnel will continue.

MEDICAL EDUCATION

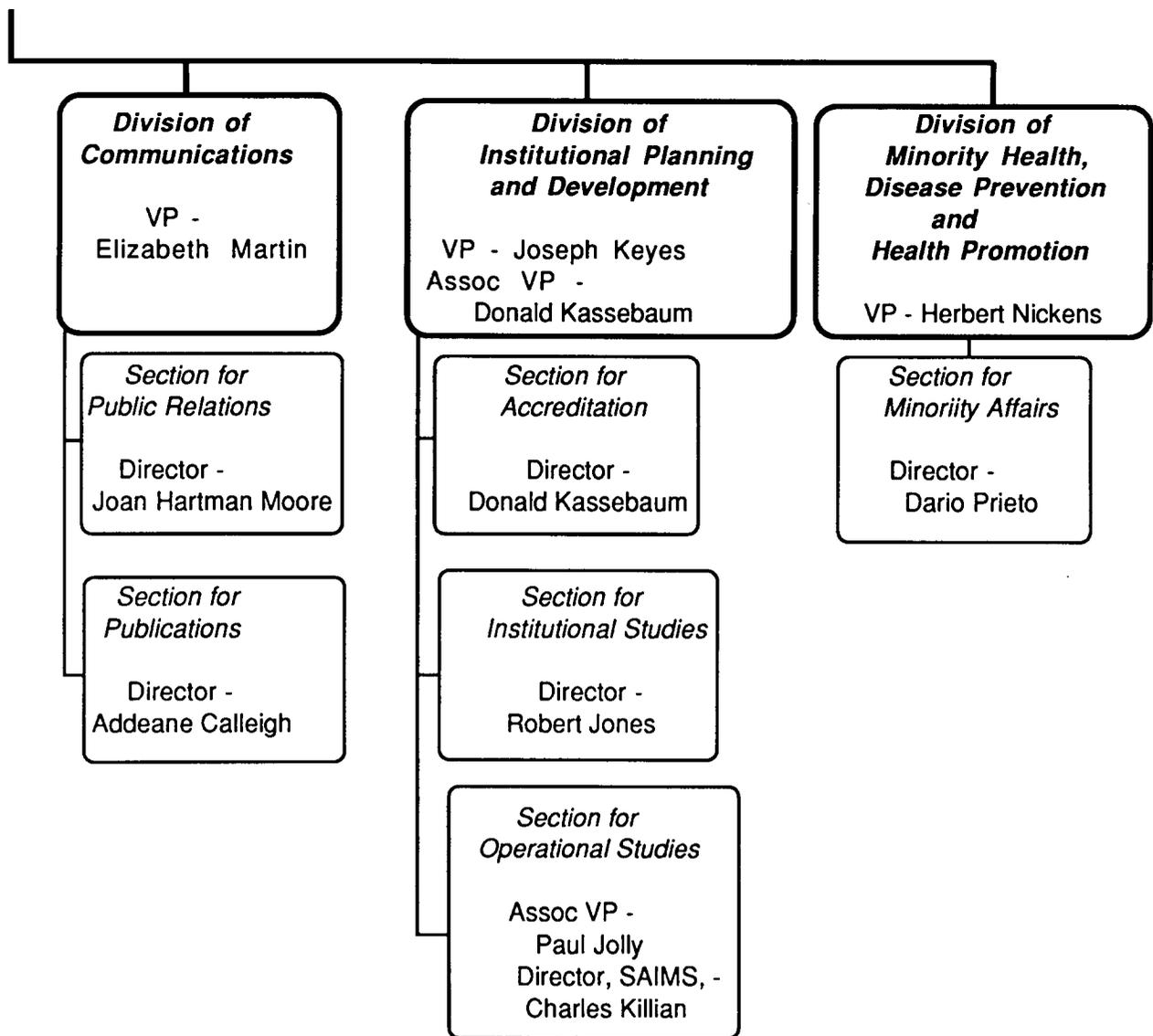
- o The debate over whether there is a physician surplus will not reach a consensus.

- o Minority participation in medical education will not grow at a rate significantly higher than the recent past without intervention.
- o The medical school applicant to acceptance ratio will level off at its current low level, and continue to be an issue which needs attention.
- o The ratio between available residency positions and the number of U.S. medical graduates will progressively increase, due to a slow but steady decline in enrollment.
- o The interest of U.S. medical school graduates in careers in primary care specialties will decline further.
- o The number of U.S. citizens studying medicine abroad will decline, but the role of foreign medical graduates in the U.S. will be debated with no consensus.
- o The nature of the medical education curriculum and the extent to which it follows changes in the health care delivery environment will not satisfy many thoughtful observers and critics.
- o The role of U.S. medical schools in international medical education will require greater attention.
- o Critics of standardized testing will continue to challenge the MCAT.
- o Medical student debt will continue to grow. Student default on loans will increase, and medical school tuition levels will become a major issue.

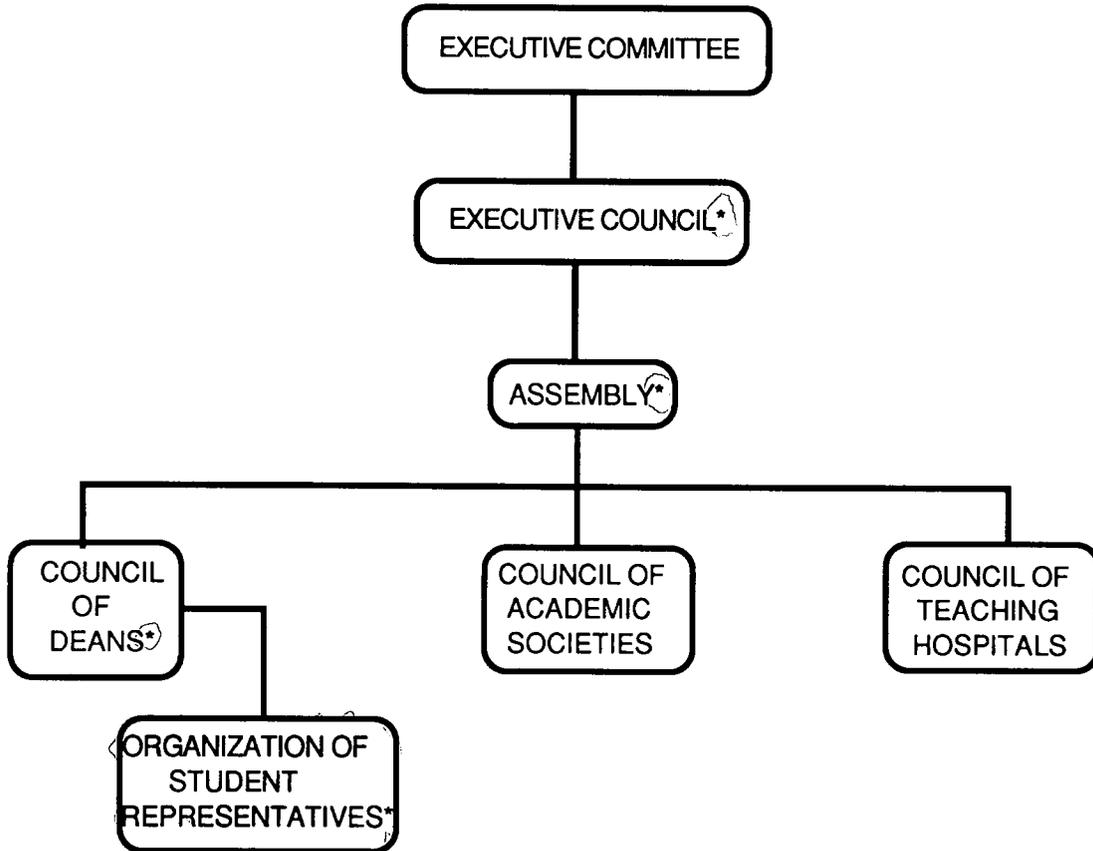
RESEARCH

- o Scientific opportunities in biomedical and behavioral research will escalate, requiring renewed efforts in assuring adequate levels of support.
- o The nation's research manpower pool will not keep pace with an expanding research agenda.
- o The need for adequate research facilities and space will become issues of primary concern as research potentials proliferate.
- o The use of animals in research and education will be a major public issue, with tension between the research community and animal rights activists.
- o Reflecting general societal concerns, the issue of fraud in research will continue to occupy the attention of research institutions, and increasingly public attention will put these institutions on the defensive.

- o Fetal research and the use of fetal tissue in research will offer new treatment modalities but the moral debate surrounding these areas of research will be divisive.
- o Federal and state agencies will further define their roles in the review and regulation of biotechnology and its applications, especially in the field of genetic engineering.
- o Significant advances will continue in developing new technologies, requiring rapid assessment and transfer to the provider community.
- o Relationships between the university and industry will grow and pose new challenges for the academic research centers.
- o Public attention to the issue of laboratory and hospital waste disposal will increase.



Association of American Medical Colleges Governing Structure



* Areas of student participation

Evaluation and Expansion of OSR Administrative Activities

I. Ongoing Activities

- A. Annual Meeting
- B. "Progress Notes"
- C. Resource Manual
- D. OSR Newsletter
- E. Regional Meetings
- F. Regional Newsletters
- G. Ad Board Meetings
- H. Phone Tree
- I. Consortium of Medical Student Organizations
- J. COD/ Executive Council Agenda
- K LCME
- L ORR
- M. Increase GQ response rate - use Progress Notes to promote
- N. COMMITTEES

II. Proposed New Activities

- A. Student Interest Groups → IDENTIFY EXISTING NETWORKS
- B. Student articles in Academic Medicine worth it?
- C. Communication via electronic bulletin boards Low Priority
- work w/ Caroline D. Communicate with schools that have not had active members
- E. Develop list of AAMC contacts at local institutions (Clay - pending)
- F. National Visibility
- G. POSITION PAPERS (AAMC's stand on 'X' issue)
call it: Student Perspective Papers → done by us, at times

OSR Newsletter

OSR Administrative Board Meets

The Ad Board met here in Washington on June 14 in conjunction with the AAMC Executive Council meeting. Minutes for that meeting are enclosed. Please call Wendy with any questions.

Matriculating Student Questionnaire(MSQ)

A summary of results of the 1988 MSQ is enclosed for your information. This survey is administered to all first year medical students, usually during orientation. Results are compared with those from the Pre-Medical Questionnaire on the MCAT and the Graduation Questionnaire. These questionnaires help the AAMC to track specialty preferences, student attitudes, student indebtedness, and demographics.

Housing Exchange Network

You recently received instructions and the form to be completed for the 1989-90 Housing Exchange Network. Deadline for receipt of your school's entry is August 15. This will allow sufficient time for us to reproduce the lists and return them to you by early September for use by fourth year students during interviewing season.

Career Decision-Making Opportunities

I have compiled a listing of various programs and resources medical schools provide to assist students in the career decision-making process. While not intended to describe the "perfect" career counseling program, it does include many excellent ideas that you might want to work to have implemented at your school. If you are interested in receiving a copy, just call me.

The listing will become a chapter in the OSR resource manual as well. If you have a program at your school that you feel is very helpful or unique, please send the description to me for inclusion.

OSR Certification Form

Last week letters were sent to the student affairs officers at all schools where the term of the OSR representative expires in May or June 1989. Certification forms were included for completion by the dean. Once these are returned to the AAMC an updated version of the OSR roster will be sent to all OSR representatives.

Airline Discounts for Interviewing Seniors

Be on the look out for the announcement of this year's airline discount package for senior medical students interviewing with residency programs. Information will be sent to the schools in the next two weeks...

LCME Workshop

A major discussion item at the June Ad Board meeting was the role of the student in the accreditation of U.S. medical schools. One conclusion of the discussion was that OSR reps can really be essential in coordinating the student portion of the LCME self-study and survey team visit.

The Ad Board is developing a packet to assist students who have upcoming visits. This packet will include examples of excellent student reports from the University of Wisconsin-Madison and Duke.

In addition, the Ad Board will hold a workshop each year at the Annual Meeting for all OSR reps at schools with upcoming site visits. This year that workshop will be held from 11:30 a.m. - 1:30 p.m. on Saturday, October 28.

1989 Annual Meeting Plans

The Annual Meeting is scheduled from October 27-29 in Washington, DC. Preliminary programs will be sent by early August. It is important that you return the room reservation form as early as possible. The OSR sessions will be held at the Washington Hilton and Towers.

The meeting will begin with regional meetings at 3:30 p.m. on Friday afternoon. The OSR meeting ends at the conclusion of the Business Meeting at 4:30 p.m. on Sunday. However, the AAMC Plenary and General Sessions are held on Sunday and Monday. You are encouraged to stay until Monday evening if at all possible.

As a reminder, the discussion group and workshop topics currently planned are:

- History of Medicine
- Evaluation of Clinical Competence
- The Physician's Role as an Educator
- Learning Styles
- Indigent Care
- Career Development in Academic Medicine
- International Medical Education
- Alternative Uses of the M.D.
- How to Lobby/Federal Update
- Teaching Residents to Teach
- Medicine and the Media
- Coping in Medical School

If you are interested in helping out at the Annual Meeting, just give me a call or drop me a note. We need all the help we can get!!

Pre-Meeting Lobbying

Next week you will receive a letter from Lawrence Tsen, OSR Representative-at-Large, inviting you to take advantage of the Annual Meeting being in Washington by coming to town early. Friday morning, October 27, he and Sarah Carr, Legislative Analyst, AAMC Office of Governmental Relations, will be holding a workshop to brief attendees on current issues on the Hill and what the AAMC's stands are on them. Appointments will be made with representatives on the Hill for those students who wish to spend some time sharing their concerns with people who can make real changes. I encourage you to respond to this invitation. It really is a great opportunity.

Questions?

Call Wendy Pechacek, OSR Staff Director, 202/828-0682. Address: Section for Student and Educational Programs, Association of American Medical Colleges, One Dupont Circle, N.W., Suite 200, Washington, DC 20036.

June 27, 1989

EVALUATION OF PROPOSED INITIATIVES

- I. Legislative Activities
 - A. 3 year debt deferment for federally funded loan programs
 - B. Tax deductible status for federally funded loan programs
 - C. National Service Corps
 - D. Use of animals in research

- II. Medical Education
 - A. National Boards
 1. Appropriate use of scores
 2. Pass/ Fail reporting of scores
 - B. Increase awareness of Problem-based learning teaching methods
 - C. Define the educational product
 - D. Support teaching faculty
 - E. Increase exposure to delivery of medicine in alternative settings
 - F. Develop international exchange programs
 - G. Develop guidelines for Medical Ethics Courses

- III. Recruiting
 - A. Attract minorities into medicine
 - B. Increase financial aid
 - C. Increase the attractiveness of the profession
 - D. Promote programs like MEDLOANS

- IV. Student Services
 - A. Universal application for residency
 - B. Enforce Match rules and regulations
 - C. Standardized Dean's letters
 - D. Early matriculation in some residency programs
 - E. Develop a position paper on the student role in assisting impaired colleagues
 - F. Decrease student participation in audition electives
 - G. Peer advising and counseling
 - H. Honor council information
 - I. Improve counseling services for career and marital problems
 - J. Survey library hours

- K. Survey grading systems and student perceptions
 - L. Investigate mistreatment of medical students
 - M. Develop guidelines for chemically impaired students
 - N. Find funding for 4th year travel
 - O. Establish AAMC career development programs
 - P. Evaluate Health Care Services summary
 - Q. Develop policy statement concerning Hep B Vaccine for students
 - R. Increase HIV education
 - S. Increase emphasis on development of women as leaders in academic medicine
 - T. Develop nationwide parental leave policy
- V. Community Outreach/Social Awareness
- A. Increase student awareness of needs of medically uninsured
 - B. Encourage AAMC to adopt policy to support student clinics
 - C. Encourage medical schools to include opportunities to serve in indigent or rural areas for academic credit

We think too small. Like the frog at the bottom of the well. He thinks the sky is only as big as the top of the well. If he surfaced, he would have an entirely different view.

Mao Tse Tung

Strategic Planning Checklist

***A vision without a task is a dream;
A task without a dream is drudgery;
A vision and a task is the hope of the world***

For each proposed initiative we need to consider the resources which are available to us and decide which ones could be most effective. The following checklist can serve as a reminder of our many possible avenues of action. Maybe you can think of some more items that I may have omitted.

- Annual Meeting Workshop
- Regional Meeting Workshop
- Progress Notes ————— FOR ALL ISSUES
- "OSR Newsletter" — to update (briefly)
- Position Paper
- COD/Executive Council Agenda
- Consortium of Medical Student Organizations
- AAMC Committee
- Resource Manual
- Academic Medicine
- Joint Administrative Board Meetings
- Student Interest Group
- Phone Tree
- Other Associational Activities

once clear
on which get
more attention
when limited by
space, time, etc.

TASK IDENTIFICATION LIST

There is no man living who isn't capable of doing more than he thinks he can do.

Henry Ford

Activity

Deadline

SUMMARY OF GSA SURVEY OF STUDENT AFFAIRS OFFICERS RE: NBME PASS-FAIL ISSUE
N = 94 Respondents

I. INFLUENCE OF NBME SCORES

Please indicate your degree of concurrence with each of the following statements. For those statements concerning institutional practice, please answer according to the current practice of your institution. For statements regarding NBME score reporting, please answer according to the current NBME score reporting system.

1	2	3	4	5	
	Average				
	2.88				A. The content of NBME examinations unduly influences the content of the curriculum.
	2.41				B. The institutional expectation of "good" departmental performance results in an overemphasis in the time allotted for student preparation for the examination.
	2.35				C. NBME discipline group performance (means) should be used to evaluate a department's effectiveness in the curriculum.
	3.89				D. The present format of the NBME examination results in inappropriate emphasis on memorization and recall of fact.
	3.67				E. Students' NBME Part I and II scores are being requested by the majority of the residency programs to which our students apply.

II. EFFECT OF PASS-FAIL

To complete this section, you are requested to answer the question in italics for each of the statements noted below. In developing your response, you are to assume that only pass-fail scores are available for the NBME Part I and II examinations.

"Would the reporting of only pass/fail scores require your institution to supplement or modify information (procedures) related to..."

YES	NO	
19.0%	81.0%	...the academic performance of students (for internal student promotion decisions only)?"
41.5%	58.5%	...the analysis of the strengths and weaknesses of the curriculum efforts of basic and clinical science departments (for internal diagnostic use)?"
26.1%	73.9%	...the provision of student performance information to residency program directors?"
43.6%	56.4%	...the overall evaluation of the undergraduate medical education program (for purposes of internal program evaluation)?"
32.6%	67.4%	...the evaluation of the effectiveness of the undergraduate medical education program for use in the LCME accreditation process?"

III. NBME SCORE REPORTING FORMAT

You are requested to assess the effect of two different score reporting formats for the NBME Part I and Part II examinations. For each of the statements in Sections A and B, please indicate the degree of usefulness on a scale of 1 (not useful) to 3 (very useful). The first scoring format (A) represents the current system of reporting scaled scores. For Section B, you are to assume the reporting of only pass-fail scores.

A. Scaled Scores (presently in use)

Please assess the usefulness of the presently available NBME scaled scores for evaluating each of the following:

1	2	3	
	Average		
1.66	1.	student academic performance (for internal student promotion decisions only)	
1.79	2.	strengths and weaknesses of curriculum efforts of basic and clinical science departments (for internal diagnostic use only)	
1.67	3.	student performance provided to residency program directors	
1.69	4.	the undergraduate medical education curriculum (for purposes of internal overall program evaluation)	
1.54	5.	the effectiveness of the undergraduate medical education curriculum for use in the LCME accreditation process	

B. Pass-Fail (proposed)

You are now requested to assess the usefulness of NBME pass-fail scores for evaluating each of the following:

1	2	3	
	Average		
1.78	1.	student academic performance (for internal student promotion decisions only)	
1.31	2.	strengths and weaknesses of curriculum efforts of basic and clinical science departments (for internal diagnostic use only)	
1.42	3.	student performance provided to residency program directors	
1.39	4.	the undergraduate medical education curriculum (for purposes of internal overall program evaluation)	
1.45	5.	the effectiveness of the undergraduate medical education curriculum for use in the LCME accreditation process	

IV. Please check the one statement with which you concur:

- 21 A. I support the reporting of only pass-fail scores to students, schools and programs with the provision that individual discipline scores for students also be reported to a single institutional official at each medical school to be used for counseling or the evaluation of coursework.
- 19 B. I support the reporting of only pass-fail scores to students, schools and programs.
- 29 C. I support the proposal of the NBME study committee to report pass-fail scores and an individual overall scaled score to students. Additionally, pass-fail scores, individual overall scaled scores and group (class) performance data by discipline would be available to schools.
- 4 D. I do not believe the AAMC should take a position on the issue of the NBME score reporting.
- 17 E. I do not concur with any of the statements above and propose the following alternative or recommendation:

Of the 17 responses, 10 suggested keeping the current system.

YES NO

- 59 10 If you checked statements A, B or C, do you favor changing the score reporting format on the current version of NBME Parts I and II (prior to implementation of the new comprehensive examination)?

Southern Regional Meeting of OSR

Phillip Noel

The Southern Regional meeting, as always, served primarily as a forum for the exchange of ideas. On the afternoon of October 27th, a list of topics of interest to representatives was solicited. Over 31 different topics for discussion were brought up on a variety of subjects from novel approaches to the 3rd year surgery clerkship to programs to cover the cost of the Hepatitis B vaccine. At the meeting on October 29th about a dozen of the aforementioned topics were discussed and the names and addresses of those with information to share on the subjects were taken by the chairman to publish in the Regional Newsletter. In this way, those in need of information on how to implement a program discussed will have a resource to turn to for information and advice. Also discussed at the Southern Regional meeting were ideas for new sections in the revised Resource Manual, plans for the Regional meeting in the Spring, and future plans for changing Progress Notes to make this a more useful tool. Plans were also made with the leadership of the Southern Region of the GEA to invite student representatives from the OSR Southern Region to take part in the Regional meeting of that body in Chapel Hill, NC. The GEA is very enthusiastic about having student input at the meeting and it is hoped that a lasting alliance will be forged between the Southern Region of the OSR, and that of the GEA.

Central Region of the OSR

Amy Davis

We had a very successful project exchange modeled after the northeast region. On Friday's meeting I passed around a sheet of paper for people to write down ideas or projects they were looking for, and on Sunday AM, we took the list and spent over an hour going through the topics. With each topic we listed the names and schools of people responding with ideas to be distributed along with an updated mailing list so that they could be contacted. I also requested that each member present write up at least one project because there was obvious interest. I might add that I asked if anyone was unwilling to do this and no one was. We intend to put these projects together for a regional resource book and to submit them for the national resource book. I also emphasized that since many of them were already going to be writing a project up for the person requesting information, that they could go ahead and write it up for their own sakes for future organization within their own school, a semblance of continuity, and for the rest of the region to potentially benefit from. The response to this was excellent. I realize that they will need to be reminded and intend to incorporate this into the phone tree.

We discussed communication at length. I emphasized the importance of setting up a meeting when they return home with their GSA and GME people. For some this will be difficult, if not impossible, but at least there will be an attempt made. People requested a listing of who these people are so that they know who to contact. The group seemed to be very pleased with our interest in communication and willingness to include them in the input into the Ad Board. Representatives, in general, have not felt that they really were a part of the national input and frankly I tend to agree with them. The group also seemed to be pleased with the fact that we expect certain things from them in the future, other than attendance at meetings, "a free trip" so to speak. I really feel many of the reps felt that it was about time that we try to improve communication and they did not resent the idea that we would be following up on assignments with phone calls from the Ad Board. Perhaps for the first time the people in my region really felt like they were a part of this national organization.

Regional Meeting in Chicago, April 1990. I was able to get volunteers to organize workshops entirely on their own. I tried to

emphasize that this is not my meeting but rather our meeting, and OUR responsibility to put on. I was able to get 3 local Chicago volunteers to act as on-site coordinators. I also met with these people while in Washington. I met with the GME and GSA people while in Washington as well. Believe me, if I did not initiate meetings with them I would never know what is going on. Originally our OSR was not intending to meet with GME this year but, consistent with the attitude of the national GME, they are requesting that we overlap so that students may participate in the small group discussions which in general deal with curriculum and evaluation. Obviously these are exciting areas for student input so I have subsequently rearranged our meeting schedule to coordinate with both groups.

Housing Network - Explained what it was and encouraged those schools who did not participate this year to consider it for next year. We discussed ways to get people to volunteer at the respective schools.

Northeast OSR Summary: National Meeting 1989

During our regional meeting several issues came up. By far the most significant was the effect that the Boards Part I was having on the basic science curriculum. It seems that while Part I has always had an influence on the first two years of medical school, the large number of failures of two years ago has caused some schools to react in a way in which their solution has only aggravated the problem. SUNY Syracuse students have complained that the faculty has already added more material to an already overloaded curriculum in an attempt to boost Board scores. The students feel that this has only added to the problem since they now have less time to go over the material well. While the failure rate at some schools have gone down this past year, several have experienced a second year of increased failures. To make matters worse many of these schools require passing of Part I to advance to the clinical years. Hopefully, Dr. Volle's attempts for change will help solve these problems.

Another problem brought up, especially by the Washington D.C. schools was the rising debt level. For the schools in D.C., where tuition alone has risen over \$20,000, the interest on loans is significant (approximately \$12,000 for one year alone given a debt of \$150,000). While students are given two years deferment after graduation, most university affiliated residency programs have effectively extended this grace period by classifying their residents as students thus allowing them to retain their deferment. New legislation, however, will prohibit this leaving all residents with only two years of deferment regardless of how long their training is. For students coming out of the D.C. and other high end private schools, the additional interest will add yet another barrier to their medical training. Many fear that this will effectively shut out the poorer college students from considering medicine as a career. This loss of deferment is made only worse by the rising cost of tuition, thus financially squeezing the student from both ends.

OSR WESTERN REGION REPORT

Ashleigh Head, UW
November 1989

During our individual region meetings in DC this October, western reps discussed topics brought up at the seminars that were of enough interest that we wanted to pursue them further at our regional meeting this spring. Our purpose at the meetings was to raise the issues and choose questions to focus on, rather than to find answers or form resolutions at that time. The more concrete work will be done at regional. The following list describes the "burning issues" we will be exploring.

Healthcare financing. In light of the recent repeal of catastrophic healthcare coverage, we were curious what the options would be for financing and providing "health for all". Also of interest was how this can and will be addressed in the educational process. Jeff Moses, USC will be coordinating this session.

Legislative strategies. This topic was selected for two reasons. First, the seminar given by Lawrence Tsen and Sarah Carr on lobbying for national issues was so inspirational we wanted to put on something like it regionally where we will reach more reps than were able to attend in DC. Second, we have started a tradition of Fireside Chats with students and deans that generate specific goals to be taken back to individual schools. It seemed that similar "legislative strategies" might enhance our political and bureaucratic savvy, thus helping us be more efficient and successful at achieving the chosen goals at the local level. Coordinator is Zen Meservy, Nevada.

Serving the underserved. In keeping with OSR's ongoing interest in indigent care, we will be running two sessions on training medical students in and for underserved areas. The first will be training for rural medicine coordinated by Dave McClain, Oregon and the second will be training for urban medicine coordinated by Mike Collister, Utah.

Our remaining sessions in the spring will focus on issues that we have generated at the regional level.

Defining the "product". This was one of the problems/goals generated at our Fireside Chat last year. The question specifically was, how does one go about changing curricula in a responsible manner when no one is quite sure what the student completing any curriculum should know/feel/be able to do. Thus a clear definition of the ideal finished product, while elusive, is essential to effective curriculum design or reform. We will have one session focusing on what the community believes the product should be set up by Sherrita Cotton, UCSD. Our second session on the product will actually be our second annual fireside chat with deans, facilitated by Scott Christensen UCD, where we will hopefully be able to start forming a consensus definition.

Exchange programs. Based on UCLA's success with their Soviet Sister School program, we were interested in a how-to workshop. Elaine Pico and Vicki Hendrick from UCLA will lead this.

**DRAFT SCHEDULE
WESTERN REGION OSR MEETING APR 22-25 1990**

Sunday 4/22

- | | | |
|----|----------------|---|
| | 3:00 - 6:00 pm | Registration |
| | 4:00 - 5:00 | Business meeting/ intro to OSR for new reps |
| ** | 5:00 - 6:00 | Sister med schools/ exchange programs
Vicki Hendrick, UCLA |
| | 6:00 - 7:00 | dinner |
| | 7:30 - 9:30 | Monterrey Aquarium ("the fish thing") Tour
with dessert |
| | 10:00----- | Stress Reduction Techniques
Cindy Knudson, CO |

Monday 4/23

- | | | |
|----|----------------|---|
| | 7:30 - 9:00 am | breakfast/sleeping through alarms etc |
| | 9:00 - 10:30 | Keynote Address by Dr Faith Fitzgerald
"History: Are We Doomed To Repeat It" (our theme) |
| | 10:30- 11:00 | break |
| ** | 11:00- 12:00 | Healthcare Financing (providing care for all)
Jeff Moses, USC
this is one of four sessions at this time, the other topics will be
(vaguely): AIDS, AAMC Report, ACME (assessing change
in med ed) |
| | 12:00- 1:00 pm | lunch |
| | 1:30 - 2:30 | Plenary I (all groups attend these) |
| | 2:30 - 3:00 | break |
| ** | 3:00 - 4:00 | "How to lobby" and legislative strategies
Zen Meservy, NV
(other groups holding separate sessions here) |
| ** | 4:15 - 5:15 | Community Definition of "the Product"
Sherrita Cotton, UCSD |
| | 5:15 - 6:00 | free time |
| | 6:00 - 7:00 | dinner |

Monday 4/23 cont

- *** 7:00 - 10:00pm Second Annual World Famous
FIRESIDE CHAT
"Defining the Product"
Scott Christensen, UCD
- 10:15- 10:20 extremely brief business meeting for nominations, etc
- 10:30----- Hogsbreath (an OSR tradition) or reviewing material learned at stress workshop, etc

Tuesday 4/24

- 7:30 - 9:00 am breakfast
- 9:00 - 10:30 Plenary II
- 10:30- 11:00 break
- ** 11:00- 12:00 **business meeting** (discussing the results of your efforts achieving one of our five themes from last year at your school....so if there are no results at this time, please plan on having some by April!!) NOVEMBER
- 12:00- 1:30 pm **Lunch with Deans**- this year the deans have suggested a box-lunch session where they meet with students from other schools as well as their own....we need a volunteer to coordinate this- anyone interested please let me know
- 1:00 - 6:00 concurrent activities....tide pool tours, nature walks, etc
- 4:00 - 6:00 **OSR Volleyball Challenge**- us against the deans (or possibly against everyone...)
- 6:00 - 7:00 special dinner (BBQ- pray for nice weather)
- ** 7:00 - 8:00 **Training for Rural Medicine**
Dave McClain, OR
- ** 8:00 - 9:00 **Training for Urban Medicine**
Mike Collister, UT
- 9:00 ----- free time: back to Monterrey or Carmel or party in the lodge (anyone with specific suggestions for this time is welcome to offer them.....)

Wednesday 4/25

- 7:30 - 9:00. you guessed it, breakfast
- ** 9:00 - 10:30 **business meeting**- election of chairperson for the coming year, further discussion of goals to be achieved at schools for report in 1991

4871 Coldstream Drive
Doraville, GA 30360
November 5, 1989

Ms. Wendy H. Pechacek
OSR Staff Director
Association of American Medical Colleges
One Dupont Circle, NW
Washington, D.C. 20036

Dear Wendy:

As you requested, I am writing to report to the OSR Administrative Board the activities of the GSA Committee on Student Affairs. We met on Saturday, October 28, 1989 at the AAMC Annual Meeting.

Item I. Review of Recommendations Regarding Health Care Services and Insurance for Medical Students

Based on the results of a Health Care Survey distributed by the GSA/COSA in 1988, the committee developed a list of recommendations to be sent on to the GSA Steering Committee. A summary of these recommendations, based only on my notes from the meeting, is attached to this letter.

Recommendation #11 suggests that the Committee on Student Affairs work with the Organization of Student Representatives to develop a position paper on the subject of student responsibility to assist impaired student colleagues. I have discussed this idea with Caroline Reich and Henry Siedel, M.D. (new COSA Chair); they are both in favor of having the OSR take the lead on this position paper. Dr. Siedel suggested that I bring a draft to the next COSA meeting early next year. Mary Jo Miller (outgoing COSA member) is interested in assisting with this project. With members of the OSR, I would be very interested in developing this position paper. Please contact me when the OSR Administrative Board decides if they would like to move forward with this project.

Item II. Update on Status of Guidelines for Development of Chemical Impairment Policies

The GSA/COSA has been working on adapting "Guidelines for the Development of Chemical Impairment Policies for Colleges of Pharmacy" developed by the American Association of Colleges of Pharmacy for medical schools. The guidelines have been drafted and reviewed by committee members; comments and suggestions for revisions were discussed at this meeting. Hershel P. Wall, M.D. offered to present the guidelines in their present form at a conference which he will be sponsoring in November. Representatives from nearly twenty medical schools with strong chemical impairment programs will be attending this conference in Memphis. Dr. Wall believes that these leaders in chemical dependency programs will be able to offer excellent suggestions for developing our own guidelines. Comments and suggestions from this November meeting will be circulated to the committee by mail in order to send a finalized set of guidelines to the next GSA Steering Committee meeting (January/February).

Item III. Discussion of AMA Survey Regarding Mistreatment of Medical Students

The AMA distributed a questionnaire to medical students regarding mistreatment in medical school. The survey had a poor response and showed high rates of mistreatment. This committee felt the questions used were

extremely leading. With poor response and leading questions, this survey most likely is not statistically valid. There is some concern, however, that the results may be picked up by the popular media.

The committee feels that mistreatment of medical students should be explored. COSA recommends that questions regarding mistreatment be developed to be included in next year's AAMC Graduation Questionnaire. Areas that might be explored include sexual harrassment, racial discrimination, and physical and verbal abuse.

Item IV. Future Directions for the Committee on Student Affairs

The possibility of providing funds for fourth year students to travel to residency interviews as part of their financial aid packages was discussed. This idea will be presented to the Committee on Financial Aid.

The committee in the future might explore standardizing residency interview time by specialty so that students could better organize their trips and cut costs.

Concerns were raised regarding the military residency match. The committee would prefer the military match occur on the same schedule as the regular match.

After the meeting, some students presented me with issues that they would like to have addressed by the COSA. Sheila Rege asked that I pursue the national distribution of the Career Development Programs which she developed with you last year. Another student questioned whether any medical school honor councils have jurisdiction over faculty and staff. I certainly will bring these issued before the committee at the next meeting.

If there are any other issues that the OSR would like brought before the COSA, please contact me before the next meeting to be held sometime between January and March. I really enjoyed the COSA meeting and the AAMC Annual Meeting, and I am looking forward to working with the OSR and the COSA during this academic year.

Sincerely,

Melissa

Melissa A. Conte
Student Representative to the GSA
Committee on Student Affairs

Attachment

Recommendations Regarding Health Care Services
and Insurance for Medical Students

1. For the benefit of students, all schools should have written policies regarding provisions for out-patient care, mental health services and hospitalization and these policies should be reviewed with students on a regular basis.
2. Efforts should be taken to insure that students are aware that the cost of hospitalization is their responsibility. If insurance is required, provisions for hospitalization should be clearly delineated and gaps identified. If insurance is not required, students should be counseled regarding the danger of being uninsured.
3. Since most schools do not provide health care for visiting students, there should be clear written policy giving advance notice to visitors regarding the need to provide for their own coverage.
4. AAMC might investigate the possibility of authoring an explanation of health insurance questions and answers that could be available to all enrolled medical students, to inform them about critical insurance issues and the risks of being uninsured or underinsured. A study group could draft a definition of essential and optional benefits. Perhaps a AAMC task force could be established to provide necessary guidance concerning life, health, and disability insurance to students and administrators.
5. Request that the LCME inquire about the amount of any required student health fee and the amount of any required annual student insurance fee to determine financial impact on students.
6. Consider adding a question to AAMC Graduation Questionnaire to determine how many medical students have no insurance coverage of any kind (not covered by family, student or institutional self-insurance).
7. Encourage all medical schools to have clear policies regarding the confidentiality of mental health service records for medical students, making any necessary distinction between confidentiality when evaluation and/or treatment is administratively required. Recommend that schools have guidelines regarding the utilization of mental health professionals and/or records of assessment and treatment by mental health professionals in proceedings regarding student advancement and dismissal.
8. Recommend that all schools publish and regularly update for their students a list of available mental health assessment and counseling services, means of access and cost to the student.
9. All medical schools should establish written policies regarding institutional response to known or suspected chemical dependency in students.
10. The Student Affairs Committee should undertake further study of critical issues relating to chemical dependency, including (1) funding options for treatment, (2) mandatory testing, (3) significance of appropriate follow-up for the recovering student, (4) institutional reporting of known chemical dependency.

11. The Student Affairs Committee might consider drafting (perhaps in conjunction with the OSR) a position paper on the subject of student responsibility to assist impaired student colleagues.
12. The AAMC should adopt the Guidelines for Development of Policies regarding Chemical Impairment as modified from the AACP guidelines (see Item II).
13. Medical schools should be encouraged to have written policies about availability and guidelines for leave of absence for medical students. Those guidelines should convey the institutional attitude toward such leaves, which seems to be quite positive.
14. An appropriate committee(s) should study (1) implications of leave of absence for financial aid as student demographics change, (2) implication of increasing requests for leaves of absence, (3) follow-up students granted leaves for reasons of physical or mental health, and (4) effect of leaves of absence on graduation rate. The committee is interested in learning the long-range outcome for students granted leaves of absence during medical school.
15. The Student Affairs Committee should conduct further study of problems in provision of adequate health insurance for medical students and their dependents, identifying problems where resolution might be within the scope of the AAMC.
16. All medical schools should have written guidelines (technical standards) regarding eligibility for admission of individuals with major health impairments, such as blindness, deafness, chronic disabling disease, etc.
17. Before matriculation, all students should have a complete history and physical examination. At this examination, students at high risk for treatable diseases would be identified for further follow-up. In addition, students should have appropriate regular screening for illnesses for which they are at risk (for example, tuberculosis).
18. Recommend that students be required to provide proof of immunity to measles/mumps/rubella, diphtheria/pertussis/tetanus, and polio consistent with Centers for Disease Control guidelines.
19. Recommend that students should receive Hepatitis B vaccination. Schools should be encouraged to provide the vaccination to students at the lowest possible cost.
20. Recommend that medical schools establish a centralized monitoring system to insure that students receive and document all required vaccinations, screenings, and histories and physical examinations.
21. All medical schools should establish written policies regarding HIV-infected personnel.
22. Students should receive regular instruction on Universal Precautions and infection control measures. Perhaps a videotape could be developed on these subjects which could be distributed to all medical schools.
23. Policies and requirements for visiting students should be identical to those for regular students.

WOMEN IN MEDICINE COORDINATING COMMITTEE REPORT
from the AAMC National Meeting, Oct. 29-Oct. 31, 1989
by Lisa D. Staber, 3rd-year medical student, Univ. of South Dakota

Attendance at the Women In Medicine sessions at AAMC's 100th Annual Meeting was better than in any previous year and I was very pleased to see fellow OSR representatives, male and female, at most of the plenaries and the Tuesday luncheon. I stress the importance of the male attendance at these sessions because I feel the topics discussed (parental leave policies, options available for men and women in medicine when plans for starting a family are being made, methods of achieving leadership roles in medicine, etc.) are as pertinent to male medical students and residents as they are to us female medical students and residents. *Sim, Oct. 29,*

The first WIM plenary session on "Managing Maternity Leave" included a panel of four speakers: a hospital administrator, a pediatrics department administrator, a residency training program director, and a female resident with three children under the age of six. Ralph W. Muller, president, U. of Chicago Hospitals, expressed the view that parental leave policies are relatively inexpensive and that the time has come to institute better policies across the board. He also stressed the need for day care facilities in hospitals. Eleanor Wallace, M.D., chief of general internal medicine, Long Island Jewish Hospital, noted that losing a resident for any length of time places great stress on the patient care system. In her view internship/residency is the worst time during medical training to have children. She urged women to consider these realities in their planning. The general consensus of the participants of the discussion that followed the panelist's presentations was that formal, written maternity/paternity leave policies are necessary in all medical schools and residency programs. Background information about maternity leave policies can be gained by reading Janet Bickel's article, "Maternity Leave Policies for Residents: An Overview of Issues and Problems," *ACADEMIC MEDICINE, Sept., 1989.*

~~The~~ ^{on} ~~that~~ evening at the Women Liaison Officers Caucus the AMA's Department of Women in Medicine presented their study of maternity leave policies and procedures and AMWA representatives talked about their project on day care. Much discussion was made about the choice of a woman speaker for a AAMC plenary session next year. One woman mentioned was Toni Novello, a candidate for appointment to the Surgeon General position.

The theme of the WIM and Academic Chairs Breakfast, Mon., Oct. 30, was "Building a Stronger Women in Medicine Program at Your Institution." The ideas generated at this meeting will be used to construct a handbook to aid medical schools in building stronger WIM programs.

Wendy Levinson, M.D., was the keynote speaker at the plenary session about "Work and Love: Career Dynamics of Women in Academic Medicine." She presented a study conducted of women physicians at or under the age of 50 teaching in depts. of medicine who were asked about issues such as marriage, child-rearing, academic pressures, parental leave policies, etc. Coping strategies that were most

popular for these women included: changing structural aspects of life by hiring help, increasing efficiency, limiting personal expectations, systems support, and giving up control of the home, spouse and children. Potential changes the women surveyed wanted made were increased flexibility, modification of time-to-tenure, counseling and encouragement of junior faculty, commitment of senior administration to promotion of junior female faculty to positions of leadership, and on-site child care. Respondents to Dr. Levinson's presentation talked about the husband's point-of-view and the perspective of a single woman in academic medicine. A discussion of the options available to women who want to combine a medical career and child-bearing included these options: 1) Getting married, having children, then starting med. school; 2) Taking a year off from residency of med. school; 3) Waiting to have children when training is over.

The session that was my personal favorite of the WIM program was the luncheon on Tues., Oct. 31, because I especially liked the speaker, Bernadine Healy, M.D., and because I sat at a table with Caroline Reich and was able to discuss some WIM issues with her that I would like to see OSR address (I will mention these at the end of my report). The part of Dr. Healy's speech that I felt was most interesting was that she emphasized that women who want to become leaders in the world of medicine must go into academic medicine rather than clinical practice. Women are becoming a major force in the medical profession; now ~~we~~ women leaders in the medical profession are needed, and academic medicine careers are the path to follow in order to achieve leadership roles for those female medical students who are so inclined.

The next meeting of the Women in Medicine Coordinating Committee will be March 2, 1990, in Washington, D.C. We will be planning the topics and speakers for next year's WIM session at the National AAMC Meeting in San Francisco. I welcome any suggestions from the OSR Ad. Board that I can share with my fellow WIM Committee members.

Topics I would like to see addressed this year by the Ad. Board include: 1) a nation-wide medical school and residency program ^{parental} → ~~paternal~~ leave policy; 2) a nation-wide medical school and residency program on-site child care program; 3) careers in academic medicine and residency programs such as one at the U. of Minnesota tailored toward academic medicine training; 4) promotion of a study of medical student and resident indebtedness by Congress and a three-year deferment for federally-funded loan programs, such as the Stafford Loan Program, as part of the Higher Education Act to be revised by Congress next year. (I realize that my last topic doesn't deal directly with a WIM issue; it's one of my personal interests!).

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NRMP - National Resident Match Program

The Board of the NRMP last met during the AAMC National meeting in Washington, DC. The reason for that meeting was to hold an open session (Friday evening) where the directors of the medical specialties are requested to attend and anybody can address concerns/suggestions regarding the match. The board will meet again after the upcoming match to follow up.

The board is interested in input regarding the specialty matches that do not participate in the NRMP match: Ophthalmology

Otolaryngology

Neurosurgery

Neurology

Urology

Radiation Oncology (just joined a non NRMP-match).

These program directors don't perceive problems in their matches. They have asked the residents in their programs and no one expressed dissatisfaction. I see problems with this in that those potential residents who would have been dissatisfied either didn't apply or didn't get in. Also, who would complain to their program director? THESE MATCHES DON'T HANDLE COUPLES, either. The NRMP also hoped to unite the military residency matches (although the Navy held their assignment session early).

If students pressed for a uniform match this could be a strong incentive to effect change in this system

22,198 positions were offered through 3,509 programs as well as 1,552 PG2 positions. The NRMP accommodates independent applicants (ie. not sponsored by a US/Canadian medical school) as well as osteopathic and fifth pathway candidates.

Dermatology is a unique specialty in that their match is a PG2 match run in the "off season" (November, I think) - this raised questions about potential disruptions to senior medical students and interns schedules, as well as whether candidates matching in dermatology should be allowed to leave their 3 year internal medicine matches. (Ideally, they matched into preliminary year internal medicine matches).

Other concerns include applicants, and equally importantly, program directors who are misinformed about how the match actually works. The NRMP distributed book has been condensed and carefully reviewed to try to make it as useful and direct as possible. It is in the student's best interest to rank programs in order of his/her preference (rank lists are confidential) - ie. the program you match with will never know you had ranked them last. There are other areas where misinformation abounds (ie. supplemental vs. categorical rankings, couples matches, etc.)

Another concern - for those who don't match and "scramble" for positions the medical school deans are supposed to notify nonmatchers 24 hours before match announcement day. Some have jumped the gun giving those notified a distinct advantage regarding finding available positions.

Another concern - candidates or programs that don't fulfill their match agreement and refuse to attend or offer the position in question. The NRMP

match is a legal document and the match could enforce/punish/admonish those who don't comply. If the program and the candidate are both willing not fulfill the match agreement there is no problem, but if someone is disgruntled they could pursue legal action - this has not yet happened to our knowledge.

Another thought that has been getting quite a bit of attention is a uniform residency application (much like AMCAS). The thought is to minimize the amount of supplemental information programs would require. This would significantly reduce the burden of filling out several different residency applications - which can take a tremendous amount of time in a medical students already busy schedule.

The AMA prints up the GREEN book listing the accredited residency programs and distributes it to all 3/4th year US medical students. They will no longer distribute the book free (it will cost \$40-) and instead are promoting the AMA - FREIDA system. This system charges residency programs to list them in a computer's database that can then be accessed with regard to many different criteria. Although I'm pleased that the system is becoming computerized, I wish the book wouldn't be abandoned. Also, if you computer search only programs that, say, have only once-a-week on-call, you will not see the programs that allow call from home. In other words, the computerized data can be deceiving and alter the list of programs receiving applications. Please don't hesitate to contact me regarding these or any other concerns with the NRMP match. Together, we can make this service as useful and timely as possible for all medical students.

Sincerely,

Jeffrey W. Honeycutt MD
1002 Langley Rd. Apt #4
Norfolk, Virginia 23507
(804) 624-9358

The University of Texas
Health Science Center at Houston



GRADUATE SCHOOL
OF BIOMEDICAL SCIENCES
Genetics Centers

P.O. Box 20334
Houston, Texas 77225
(713) 792-4680

Dear Ad-Baord,

It is with some sadness that I write this because this is the first time in six years that I have not been among you. Ah well, I know you will do an outstanding job as this is this is one of the best Ad-Boards I have seen. Good luck!!!

The purpose of this brief communication is to report on the current status of the Task Force on Physician Supply.

We thought that we had completed our task in September. When the draft report was presented at the Executive Council Meeting in September, there was stark disagreement from all Councils with the content and recommendations of the report. Therefore, at the Annual Meeting, the Steering Committee met with representatives from the various Councils. In addition to myself, Clay represented us. The discussions at that time were much friendlier than at the September meeting. However, there was very little substantive feedback from the Councils as to what specific recommendations to make.

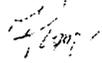
Regardless, at the present time, Dr. Tosteson, Chair of the Task Force, is currently re-writing the entire report. It will then be processed through the four committees and then communicated to the Executive Council for final comment.

Enclosed is a copy of the goals of the committee and the current recommendations.

I am hopeful of a final report soon.

Again good luck on your year in the upcoming year as you go about Oranganizing Students Responsibly.

Cheers,


Kim Dunn

PREFACE

The Task Force on Physician Supply was established by the Executive Council of the Association of American Medical Colleges (AAMC) in January of 1987 because of rising concern among the member institutions about several complex and interrelated questions.

- o What will be the consequences of current behavior for the relation between the numbers of various kinds of physicians emerging from training programs and the demand for physician services in the health care system?
- o What are the origins of the recent fall in the number of applicants to medical school and how will this trend affect the relation between supply of and demand for physicians?
- o What is the prospect for increasing the numbers of persons from under-represented minorities practicing medicine?
- o How will the continuing entry into the U.S. of a substantial number of physicians educated abroad influence the balance between supply and demand?
- o What will be the balance between the supply and demand for medical scientists?
- o In light of the answers to these questions, what changes in current policies and practices should be adopted by institutions belonging to the AAMC?

The Steering Committee of the Task Force considered these and other related questions and decided that it could best carry out its mission by creating working committees; The Committee on Implications of Physician Supply Issues for Undergraduate Medical Education, Chaired by Saul J. Farber, with Paul Jolly as Senior Staff Person; The Committee on the Implications of Physician Supply Issues for Residents and Fellow Education, Chaired by Mitchell T. Rabkin with James Bentley as Senior Staff Person; The Committee on Foreign Medical Graduates, Chaired by Richard Moy with August Swanson as Senior Staff Person; and the Committee on The Implications of Physicians Supply Programs for the Education of Biomedical Scientists, Chaired by David Korn with Joseph Keyes as Senior Staff Person.

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Task Force Recommendations

(Abridged)

1. In view of the projected ample supply of physicians, medical schools should not expand class sizes, nor should new medical schools be started during the remainder of this century.
2. The AAMC should advocate that the number of first year residency positions be reduced to equal the number of graduates from LCME accredited medical schools.
3. The decline in the number of students applying to medical school should be addressed by the AAMC. A campaign should be developed to attract the most able students to the study of medicine and the biomedical sciences.
4. The primary responsibility of medical schools is to assure the quality of their graduates. ~~A strategy to accept high risk students to achieve important social or institutional objectives is appropriate if the school has not only the commitment and resources to provide the requisite personal and academic support but also the determination to ensure the qualification of its graduates. However,~~ If too few qualified students are available, schools should reduce the size of their entering classes rather than compromise the competence of their graduates.
5. The AAMC should assist member institutions in developing criteria for quality of applicants and graduates that are consistent with their social and professional objectives.

6. Increasing the presence of underrepresented minorities in the profession of medicine requires aggressive action. The AAMC should advocate the development of a long term, comprehensive program ranging from steps to foster and preserve affirmative action gains to imaginative and productive efforts directed toward expanding the number of qualified minority applicants. ~~Health sciences should be vigorously promoted in primary and secondary schools.~~

7. Adequate access to health services for all should be identified as a high priority of society made more feasible by a growing supply of physicians. The AAMC should catalyze an effort with other organizations to develop durable solutions to the problem of access to care for the underserved.

8. Health services research should be undertaken to measure and monitor the relationship between impact of an abundance of physicians and matters such as the maintenance of physician skills and physician-induced demand for unnecessary services.

9. The AAMC should investigate why diminishing numbers of U.S. medical school graduates are choosing primary care residencies, and the AAMC should advocate the adoption of educational programs and other measures that will encourage ~~appropriate incentives for~~ graduating physicians to enter primary care specialty practice in greater numbers.

10. All physicians medical school graduates should complete an accredited residency program before entering independent practice. ~~This should apply to both graduates of U.S. medical schools and graduates of foreign medical schools.~~ Graduate medical education program directors and their

sponsoring institutions should take into account data descriptive of national and regional needs as they decide on the character and scope of the training opportunities that they will provide. Whatever training programs are offered should be based primarily on the educational needs of the trainees rather than the service needs of the institution.

11. Stable funding should be secured for graduate medical education programs with patient service revenues continuing to serve as the primary source of residency funding. Special purpose funds should be developed to provide incentives for needed programs which are not economically self-sustaining.

12. Enhanced data resources and analysis should be applied in the decision-making of medical schools, teaching hospitals, residency programs, and policy makers on matters affecting physician supply; the AAMC should continue to develop its capabilities in this area. In particular, it should establish on-going advisory mechanisms to report regularly on estimates of future physician requirements by specialty, geography and other characteristics and on the availability of residency positions and resident preferences.

13. The training of scientists, including physician scientists, in the biological, behavioral and social sciences basic to medicine should be affirmed by the AAMC as being of major importance for academic medical centers, along with their missions of educating practicing physicians and providing exemplary patient care.

14. The eligibility of foreign medical graduates to enter accredited graduate medical education programs as qualified residents should be determined by examinations administered by the Educational Commission on Foreign Medical Graduates.

15. The International Medical Scholars Program deserves continued support by the AAMC and other national organizations concerned.

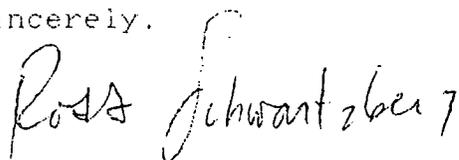
LCME REPRESENTATIVE REPORT TO THE OSF EXECUTIVE COMMITTEE

As you know, my tenure as the AAMC-OSF student appointee to the Liason Committee on Medical Education began in July. This year, Dr. Donald G. Kassebaum, CO-Secretariat of the LCME, arranged for myself and the AMA student appointee for 1989-90 to attend the June 1989 meeting, in order to familiarize us with general procedures, and also to provide an opportunity for interaction with the outgoing student participants.

The October meeting of the LCME in Chicago represented my first chance to actively participate as student representative. My mail box was stuffed for weeks as hundreds of pages of reports, surveys, memos, agendas, etc., serving as preparatory material for the meeting, arrived for my detailed review. Although confidentiality protocol prevents me from discussing specific topics addressed, I can relate that I was extremely impressed by the thoughtfulness and sincerity with which the members of the committee approached the issues at hand. The LCME truly functions as an impetus to improve all aspects of medical education.

Briefly, the mechanism for student input exists at two levels. First and most important, is the role of the individual student at the home school. We must get involved and stay committed to excellence in our education! If your school is scheduled for a site-visit, help to organize a unified student voice. Visit the Dean and read the published AAMC publications on the student's role in the survey process. There is a direct relationship between active, organized student involvement and rapid change for the better. The second mechanism for input is through myself, the student appointee. If you have any specific concerns or questions, contact me and I'll do my best to help.

Sincerely,



Ross Schwartzberg
University of Arizona

COMMITTEE ON STUDENT FINANCIAL AID (COSFA) REPORT TO OSR

There are several areas that COSFA is interested in making legislative and institutional changes. To begin with, congress instituted a new methodology (called congressional methodology) for determining needs analysis, starting with the 88-89 year. Since the guidelines were global, i.e., applicable to all recipients of federal aid, medical financial aid officers (FAO's) had difficulties applying a system designed for undergraduates to med students. This new methodology is inherently biased against certain groups of medical students. These groups include single parents, married students, students who take a year off for any reason and earn money (usually research), and students who worked before their first year of med school. FAO's have found ways around these obstacles through loopholes in the legislation, but COSFA is currently working on ways to legitimize these methods.

A second area of activity within COSFA is the issue of deferment of loans during residency. The AAMC is interested in pursuing a third year of deferment for residents. The rationale is that this will directly impact the rate of default on student loans by residents. There has not been resistance within congress on this issue, but neither has there been action. This could be a good area for OSR to be involved, since it is conceivable that congress may be willing to make this concession, and current med students could benefit from it.

In my last report, I mentioned the congressional mandate to come up with a "simple, free, common form" for financial needs analysis. The issue is that a common form may discriminate against low income applicants, who would need to give more information (and pay to do it) to be eligible for scholarships targeting the lowest income students. No progress on this issue has been made since the two sides cannot agree.

The annual meeting program for COSFA concerned FAO's and admissions personnel relations and a congressional update. I have already outlined most of the congressional activity above. The issue of relations between financial aid and admissions is currently minimal, but with the upcoming changes in the "traffic rules," it will become increasingly important for applicants to know their financial options at each school they are considering. COSFA thought about recommending that schools reveal probable financial aid packages before the April 15 deadline. They decided not to because it might be unfair to higher priced schools, and would create additional stress for already overburdened FAO's.

In summary, things are relatively stable on the financial aid scene. The new congressional methodology is in place and FAO's are working the bugs out. No significant changes appear in the works. My major recommendation to the OSR would be to pursue the issue of an additional year of deferment for residents. I would be willing to work with the adboard on this issue if you decide to target it.

Michael Stuntz, MSIII
University of Arizona

COMMITTEE ON STUDENT FINANCIAL AID REPORT TO OSR

I missed the most recent meeting of the committee, but I was given the minutes and I am constantly getting information to update me on new legislation. There are several areas that COSFA is interested in making legislative changes. To start with, congress instituted a new methodology (called congressional methodology) for determining needs analysis, starting with the 88-89 year. Since the guidelines were global, i.e., applicable to all recipients of federal aid, medical financial aid officers (FAO's) had difficulties applying a system designed for undergrads to med students. This new methodology is inherently biased against certain groups of medical students. These groups include single parents, married students, students who take a year off for any reason and earn money (usually research), and students who worked before their first year of med school. FAO's have found ways around these obstacles through loopholes in the legislation, but COSFA is currently working on ways to legitimize these methods.

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Mike Stutz MSIII
University of Arizona

Leonard E. Lawrence, M.D.
Chairman, GSA - MAS
Associate Dean for Student Affairs
University of Texas Health
Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78284-7790

Kyndal A. Beavers
OSR Liaison to the GSA-MAS
Box 220
Meharry Medical College
Nashville, TN 37208

October 31, 1989

Dear Dr. Lawrence and Members of the MAS Coordinating Committee:

As the Organization of Student Representatives - Minority Affairs Section Liaison, I wanted to take the time to make sure I addressed some of the issues brought out in the letter by Student National Medical Association National President, Victor Freeman to Dr. Robert Beron, Assistant Vice President of the Section for Student and Educational Programs for the American Association of Medical Colleges.

I spoke with Mr. Freeman at length on Sunday, Oct. 29, 1989, following the adjournment of the OSR Business Meeting. As a member of both OSR and SNMA, I was impressed with Mr. Freeman's efforts to draw attention and to promote discussion on minority medical student representation within the OSR and within subcommittees of the AAMC. However, I was disappointed with his admission that he neither contacted any of the under-represented minority members of the OSR, which includes the representative body-at-large, the OSR-MAS Liaison, or the minority members of the OSR Administrative Board, nor did he consult the OSR Orientation Handbook prior to writing his letter. Since a clear understanding of the OSR hierarchy and functions were not demonstrated, I questioned his basis and objectives for writing such a broad based letter focusing on OSR activities. I also inquired as to the meaning of the term "...institutionalize communication links...".

To address some of Mr. Freeman's concerns regarding minority involvement in OSR activities, I informed him of some of the changes which have taken place at this year's OSR National Convention as well as proposed changes and suggestions for the upcoming year. Presented here is a modification of the list presented by the OSR-MAS Liaison at the MAS business meeting on Monday, Oct. 30, 1989:

1. The OSR's Past-Chair, Clayton Ballantine, M.D., recommended at our business meeting that a subcommittee be formed for OSR members interested in minority affairs.

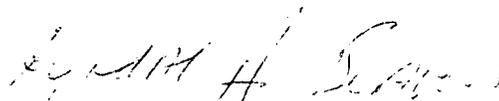
2. Working with Clayton Ballantine, an Open Forum on Minority Medical Student Issues was added to the agenda in order to afford an opportunity for interested students to meet with the OSR-MAS Liaison to discuss the functions and activities of the MAS Coordinating Committee. In addition, a 'Round Robin' discussion was conducted which elucidated many of the important issues and dilemmas faced by minority medical students. This meeting was well attended by the OSR Administrative Board and by minority and majority students of the OSR.
3. The OSR-MAS Liaison recommended that times and places be included in the next OSR National Convention Agenda for both a workshop and a plenary session on minority affairs. This was met with positive assurances from the OSR Chair, Caroline Reich.
4. The OSR Resource Manual, a newly conceived project, will include a chapter on minority medical student issues.
5. The Present Chairperson will also make inquiries regarding the appropriation of funds to send future OSR-MAS Liaisons to the Consortium of Medical Student Associations meetings. This would allow for a broad-based information exchange for all under-represented minority medical students through their respective student association leaders.
6. OSR's interested in minority affairs asked to be allowed to attend the MAS Executive Board Meetings.
7. Dr. Margaret Haynes, Chair of the Northeast Region of the MAS suggested that an OSR regional representative be appointed to each of the MAS regional committees. This would foster and encourage increased student input and representation. I will ask if the OSR Administrative Board would execute this prior to the spring MAS regional meetings.
8. At the conclusion of the OSR elections, a represented minority, Lawrence Tsen, Univ. of Kansas, will serve as Chair Elect. Also, two of the five members of the OSR Administrative Board are under-represented minorities: Anita Jackson, Univ. of Chicago, and Andrea Hayes, Dartmouth Medical College.
9. Most importantly, all OSR members were strongly encouraged, during the OSR-MAS Liaison's annual report, to inform, enlighten and encourage under-represented minorities to become either involved OSR activities or to become an OSR representative and attend the national and regional meetings.

With regard to Mr. Freeman's references to lack of information exchange and wanting us to "...to consider the establishment of seats on the aforementioned committees for student representatives (appointed by the OSR) who will serve as communication links with minority medical student associations." To the best of my knowledge, there are student representatives to all of the committees referred to in his letter. These persons are accessible, but more importantly they are responsible to the student body they serve, which includes under-represented minorities, to pass on the information and encourage student input regarding the concerns of each committee. Perhaps emphasis on informing the student body and a need for formal written reports exists in order to establish stronger lines of communication.

In conclusion, I believe that all of the above actions and suggestions will culminate in increased representation of under-represented minorities in the OSR, as well as increased discussions and sensitivity to minority concerns. I would like to add, that my experiences working with OSR have been both positive and productive and I anticipate that this environment will continue under OSR's new leadership.

I appreciate your time, input and attention regarding this matter.

Sincerely,



Kyndal A. Beavers

cc: Victor Freeman
Robert Beron, M.D.
OSR Administrative Board
Bruce Ballard, M.D., MAS Chair

AMWA American Medical Women's Association Inc.

801 NORTH FAIRFAX STREET • SUITE 400 • ALEXANDRIA, VA 22314 • TELEPHONE (703) 838-0500
REPRESENTING WOMEN IN MEDICINE SINCE 1915

LILA A. WALLIS, MD, *President*
EILEEN McGRATH, JD, *Executive Director*

Minutes from The Consortium of Medical Student Organizations October 29, 1989 The Washington Hilton Host: AAMC-OSR

Present:

Jim Slayton, AMSA (Chair)
Judy Linger, AMA-MSS
Clayton Ballantine, AAMC-OSR
Caroline Reich, AAMC-OSR
Charlene Avery, ANAMS
Katherine Schneider, AMWA (Minutes)
Elliott Bennett-Guerrero, BHO
Mark Bair, AAFP
Virginia San Miguel, TAMAMS
Linda Narvaez, CMSA
Victor Freeman, SNMA
Anita Jackson, OSR, AMSA

Guests:

Jim Davis, The Upjohn Company

Kyndal Beavers, AAMC-OSR
Liaison to Group on Student Affairs, Minority Affairs Section
Box 220, Meherry Medical College, Nashville, TN 37208
(615) 269-3898
Interested in input from all minority student groups.

Claire H. Kohrman, PhD, Research Associate
Center for Health Administration Studies
The University of Chicago
1101 East 58th St., Chicago, IL 60637
(312) 702-7104

Researching med students' specialty interests, writing a book on training in internal med.

1. Note from Judy Linger: Dipali Apte added to mailing list due to Federal appointment to Council on Graduate Medical Education.
2. Corrections/Additions to previous minutes: from SNMA, delete sentence "...and have been promoting....". Minutes approved.
3. Additions to agenda:
 - a. Minority self-identification on AMCAS
 - b. Addition to conference call report
 - c. NRMP report

- d. Recruitment issues
- e. Communications improvements

4. Reports:

AMA

Interim meeting first weekend in December, Honolulu. Consortium members invited to speak at the assembly. Issues: ET's appear to be scrapped, with endorsement of the AMA's reimbursement proposal. Note that AAFP is in favor of Bush's ET proposal. Coming up at next meeting: Resident's hours debate. **Reminder, delegates from consortium to the AMA-MSS (many of whom require a constitutional change to do this) need to submit requests for delegate seats 90 days in advance.** Or try to work things out with Judy. Annual mtg: June 21-24.

AAMC-OSR

In midst of annual meeting. Highlights: LCME with student reps from upcoming accreditation sites, addressing need to educate students about the process, and involve students more. Materials available. Met with curriculum committee representatives to promote interactions between students and faculty, especially, orchestrating a push for P/F on the National Boards; first need to reach a consensus on this issue. Internal affairs: "How-to" resource manual in development for local branches, will solicit information from Consortium members. **Will bring outline to next Consortium mtg and get input.** Also in dev't is a phone tree of OSR reps. Lobbying efforts: Protection of student loan deferment system (**letter-writing campaign materials will be distributed to consortium**). AAMC is constructing a new building, Organization of Resident Representatives is ensuing. Next annual meeting: San Francisco, October 19 - 21. Regional mtgs coming up. Note: Wendy Pechasek is leaving, will be replaced soon. **Planning retreat is coming up in early December, contact OSR if you have input or issues to raise.** Note: **Airline discount for seniors interviewing is in effect again - further info is in Student Affairs offices; AAMC/OSR has openings on a number of committees - see Progress Notes or contact Caroline if interested (open to all students because all students are automatically members of OSR).**

ANAMS

Council has been expanded; will carry on expanded version of Health Careers Awareness Workshop, fund-raising efforts (will bring t-shirt order form to next meeting), clean up the constitution, expand communications with other health-science students. Financial status is quite stable. ANAMS will form their own permanent chapter of the American Indian Science and Engineering Society; this will be the Society's largest chapter. Has been working on recommendations to AAMC on Native American identification on AMCAS application; suggesting rider stating, "Documentation must be provided on request." Also providing suggestions on other application/interview processes, e.g. "heritage sheets" for applicants to fill out, followed up by phone call to parents. (Note: Stanford does this, and reports that it's not uncommon for parents to have no clue about the child's reported status). Trying to eliminate prejudicial question about whether applicant plans to return to practice in their native area. Next mtg: July/Aug, somewhere on the West Coast.

AMWA

Just returned from Annual Meeting, "The Cycling Woman". Successful student-oriented workshops included Anti-Smoking training workshop for school programs, "How to Fulfill Educational Loans and Plan for the Future" (**contact KS if you are interested in replicating this**), "Choosing A Residency," "Gender Equity". New national

officers: President, Susan Stewart MD, President-Elect Roselyn Epps (will be first black president of AMWA), National Student Coordinators Karen Parko (student at USUHS) and KS reelected. Resolutions: (Male membership got tabled along with international membership) Strongly reaffirmed pro-choice stance, with some very specific resolutions targeted to issues brought up at the Supreme Court; called for FDA to establish tobacco as a regulatable drug; condemned imprisonment of pregnant, drug-abusing women for the sole purpose of preventing drug use during pregnancy. Interim meeting: Washington DC, June 16-18 (will include lobbying day). 75th Anniversary Annual Meeting, Philadelphia Oct 31-Nov 4, focus on leadership.

B H O

Boricua: Name originated from Indian word for Puerto Rico. BHO is a national organization, but primarily concentrated in Northeast; will be incorporating physicians as members to increase the membership base, with student chapters paying \$100 dues rather than having individual student dues. Next mtg will be in NYC, April 6-7, on "AIDS and the Latino Community". Next year's convention will be in Boston. Will continue to hold pre-med workshops to encourage medical school applications. Have set up a collection for Hurricane Hugo victims in P.R.

A A F P

Issues from last national meeting: Condemned mandatory substitution of generic drugs with more patient info on generics; support 100% barring of smoking in hospitals; award to Northwest Airlines for smoking ban; Surgeon General's recommendations on alcohol approved; vague discussion of residents' hours; push for requirement of ambulatory care rotation in med school; bill supporting licensure following PGY-1 (coming from the student section) was shot down by one vote.

T A M A M S

Represents 8 medical schools in Texas. Membership is open to everyone, at some schools represents all minority students. Activities: AIDS education project in public schools; annual community health fairs with basic screening test; retention and recruitment; encouragement of young minority students. Note: Goals and policy statement is attached to these minutes. Annual Mtg: April 29, Galveston. 10th Anniversary. Close association with the state physician's group.

C M S A

Planned activities: Work with parent organization CMAC; poster describing CMSA for applicants to the 9 medical schools in CA; video on getting into health professions; Supernet program targeting undergrads to help minority applicants. Also concerned about sensitivity to Chicano community from interviewers. Linda expressed concern about Hispanics that do not fall into the AMCAS categories, for example Central American, that don't get considered fairly in admissions. Clay read graduate statistics (self-reported): 1.2% Mexican-American, 0.6% Mainland Puerto Rican, 1.4% Commonwealth PR, 1.7% Other Hispanic. **Clay discussed this further after the meeting with representatives from the Hispanic groups.** Winter mtg: Davis, Feb 3; Annual at UCSF (pending) April 21, "Challenges Facing Health Care Delivery to Latino Community"; April 28, Coalition for the Future of Public Health (co-sponsor).

S N M A

Victor expressed his joy at living through an earthquake in an elevator. SNMA's programmatic agenda for 1989-90: Health professions recruitment, undergrad in particular, but working draft is being put together on high school recruitment as well. Has met with frustration in getting funded. **There was a great deal of interest in**

getting copies of these materials; again, this topic was postponed for New Business, and we ran out of time. SNMA is trying to document what is going on at local chapters. Such information-gathering is a major project this year so as to avoid re-inventing the wheel. Also interested in refining AAMC questionnaires on minority experience during medical school. In community affairs, refining AIDS program protocols. Legislative affairs: Working with AAMC. 25th Annual meeting in Atlanta (Westin Plaza), April 13-14 (Easter weekend).

AMSA

Celebrating 40th anniversary; will co-sponsor plenary conference on Community Health (March 21st and 22nd) before the national meeting (handed out materials describing this conference, also you should have received mailings by now). Each session will have a discussion group facilitated by students along with experts - Jim is seeking help from Consortium members for this - **please notify him immediately if you or any members of your organization are interested in serving as facilitators.** There will be a poster session on Community Health projects: **Deadline Jan 1.** The regular meeting will include a legislative lobbying day (Fri March 23), theme will be "Medical Education and Community Practice: Heeding the Call for Change." Other recent activities by AMSA: Completed 32 min. video, "How to select a residency: Making sense of the match process," available through the AMSA Resource Center. Also, pilot project for Washington Health Policy fellowship will be offered again next summer. AMSA's full-time legislative affairs director publishes newsletter, "Straight from the Hill," and legislative alerts based on issues pending on the Hill. **Update: student loan interest deduction was killed in committee, and will be brought up again.**

5. Old Business

Minority Self-identification on the AMCAS: (presented by Victor Freeman) Upon finding that changes to the AMCAS were due in the next month, Victor prepared a list of suggested changes and asked the Consortium to endorse the general sentiment of the suggestions. Discussion ensued, first about the process, then the content. Clay suggested that the first step is to submit a laundry list of our concerns and issues, and worry about the language later (the AAMC will totally revise the language anyway). These would be for the AMCAS for the entering class in 1991. One key issue was the inclusion of students in minority status due to a background of financial disadvantage (independent of financial aid); currently this is somewhat vague and Victor suggested a clarification in the instructions. Confusion ensued about the purpose of minority self-identification, i.e. is it for purely affirmative action purposes based on race/ethnicity, or is it to promote consideration of strength of cultural identification/community involvement as a criterion for affirmative action. We could not resolve this question. One point is that students who check the box for consideration as minority status should be prepared to not only document it, but discuss it in interviews, etc. Victor pointed out that there are many materials used to guide admissions committees in minority interviewing. Judy suggested that a **cover sheet of concerns be drawn up by Katherine, Charlene and Virginia.** Victor asked that these be submitted to him as soon as possible. There was a consensus that the changes in the "financial" section should be seriously considered, and that the section on minority self-identification be used as a starting point for discussion, and that a list of concerns would be added to the suggestions to clarify their purpose.

6. New business:

Organizational issues within the consortium: Minutes from a conference call were distributed. **Be prepared for a formal discussion of these issues and arrival at some resolution at the next meeting.** "Log" of previous Consortium issues was also handed out as culled from Katherine's limited collection of minutes; **please look through your old inherited minutes and add to this list of actions taken.** Caroline noted that the Consortium does not get complimentary registration for AAMC meeting (but you'll get the information anyway and are welcome to attend sessions).

Suggestion from Anita Jackson: Consortium-sponsored focus group on "Disadvantaged Minority Health Recruitment Bill" to be held at the AMSA meeting, to look retrospectively at what has worked in promoting minority medical education, a bit on the history of the National Health Service Corps, and to educate funding sources on possible programs for improvement of minority medical education. Suggestions would be sent back to Congress, educational institutions, etc. Consortium participants would invite speakers, and have a 3-4 hour structured discussion based on a few carefully delineated questions. **Requests: Support, participation, development of a joint invitation for speakers, submission of a list of suggested outside participants, particular list of issues, and publicity within your organization.** Discussion ensued about the appropriate format. Jim will take it back to AMSA, and will send Consortium members a list of possible issues and further description of format; **please give feedback.** Probable schedule: Focus group Friday night, Consortium meeting and Upjohn panel on Saturday.

Motion from Elliott, carried unanimously: **Organizational reports will be limited to 3 minutes, and written reports are strongly encouraged.**

Request from Clay: Please assemble materials on what your student/parent organizations are doing vis-a-vis medical school RECRUITMENT. **Bring all recruitment materials as a focus for the next meeting.** A lot of duplication of efforts is taking place.

NRMP report: (Victor Freeman standing in for Gerrie Gardner) Main issue: Simplification of the match (try to establish only one match date), establishment of a universal residency application. Two particular requests for **student input by March 26th** (send to Gerrie): 1. (This got cut off the tape, please correct at the next meeting) Suggestions about the universal residency application process???? 2. Guidelines for Dean's letter preparation being compiled by AAMC; AMA-FRIEDA will be brought up for discussion at the next Consortium meeting. Victor has suggested that better communication be established between the NRMP and the student organizations

Next meeting: Saturday March 24th, 9am-1pm. Chair: Judy Linger, Secretary: Caroline Reich. (Upjohn will tentatively meet 1-5pm).

Meeting adjourned.

Minority Self-Identification on the AMCAS

There is a need to develop language that will deter individuals from checking the "Ethnic" box who want to be considered under affirmative action but who have shown no previous participation in or identification with the ethnic community that they have specified. The language is needed because the present form of self-identification does not discourage such student abuse of the principles of affirmative action. The abuse results in an overestimation of minority student numbers and the effect of affirmative action in the recruitment of minority students. In addition, it may result in resources being diverted to students who are merely exploiting the lack of refinement in how being a "minority" is defined.

Proposed Changes

Instruction Booklet

Page 7 "Minority Programs"

2nd Paragraph - Insert After 1st Sentence

"...Refer to Page 18 (Question 14) Instructions..."

Page 18 "Question 14"

Insert After 1st Sentence

"...Students who check the box for "Ethnic" may be expected by the medical schools to which they apply to demonstrate [residence in or] active participation in a community of that particular ethnic group. Such participation may be demonstrated by pursuit of educational, political, religious, social, cultural or other community activities.

Applicants who have checked the "American Indian/Alaskan Native" box in Question 13 and the "Ethnic" box in Question 14 may be expected to provide official documentation/certification of active affiliation with a recognized tribe or reservation community...."

Designation Form

Question 14 ADD

"...(SEE Instructions)..."

There is also a need to develop language that will deter individuals from checking the "Financial" box who want to be considered under affirmative action but who have not experienced the hardship or loss of educational opportunities associated with growing up in a low income community.

Page 18 "Question 14"

Insert After 2nd Sentence

"...Students who check the box for "Financial" may be expected by the medical schools to which they apply to demonstrate that from an early age they resided in a low income community or experienced an enduring family financial hardship that severely compromised their educational opportunities..."

This language does not fully address the problems in self-reporting, but should act as a deterrent without forcing AMCAS into a policing role.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

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WASHINGTON, DC 20036
TELEPHONE: (202) 898-0400

The Association of American Medical Colleges' project, funded by the Charles E. Culpeper Foundation, "Assessing Change in Medical Education: The Road to Implementation" - (ACME-TRI), is well on its way to accomplishing its goals. This letter is in response to the many inquiries on the project's status and the expressions of encouragement and interest received by project staff.

The project is examining the response of American medical education to previously published recommendations concerning the preparation of physicians. The state of implementation of these recommendations by medical educators, the identification of facilitators and inhibitors of change, the development of strategies for change and the provision of technical assistance for change are among the project's objectives.

The data collection is focused upon appraising the utility of each recommendation and identifying conditions which must be present to assimilate them. From this background the staff, with the aid of an Advisory Group, will develop strategies individual medical schools and regional and national groups may use to facilitate the integration or maintenance of the individual recommendations.

At this halfway point in the first year of the three year project, a variety of activities have been completed. These include the selection of identifiers which define implementation of the chosen recommendations. Data collection from individual medical schools will begin in early fall. This phase includes developing survey instruments to be distributed through the Dean's office. Three major groups will be requested to respond: administrators, faculty and students. Additionally, mission statements, program descriptions, curricula and various other school specific data will be obtained to disclose the extent of change. Current data from the field will be analyzed with the AAMC and LCME data bases on medical education collected over the past ten years. There appears to be encouraging developments in the reduction of required scheduled hours in the preclinical curriculum. Preliminary analysis shows that total scheduled hours since 1983/84 have been reduced an average of 79 hours in year one.

The next phase of the project, beginning early Spring 1990, will identify the features of medical education that merit detailed studying and the factors that influence their implementation. Schools where implementation was successful, where implementation was unsuccessful and the schools where no change occurred will be identified. Through data analysis, the core research questions and specific hypothesis that address the incorporation and implementation of the recommendations will be tested.

ASSESSING CHANGE IN MEDICAL EDUCATION:

The Road To Implementation



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

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TELEPHONE: (202) 898-0400

Two bibliographies projected for completion by Spring 1990 are being assembled. These include references of reported curricular innovations in medical schools, and reported facilitators and inhibitors to change in medical education.

Beginning January 1991, the Advisory Group and project staff will select schools for further study and site visit, will develop institutional specific protocols and will collect additional data. This phase will include the development of a self-assessment instrument for schools to use in order to implement desired change. Additionally, the Advisory Group and staff will prepare a final report on the findings of the state of medical education and the factors that influence change. The project will also identify faculty and deans from schools where successful change occurred who may be used as workshop leaders.

The final phase of the project focuses upon disseminating information through regional and national workshops. This phase is scheduled to start in the Spring of 1991 with completion scheduled for December 1991.

Enthusiasm for the project is high. The need for a description of the nature of change in medical education, of the current practices in medical education, and assistance to those medical schools desiring to innovate is clear.

If you have any suggestions, would like additional information or would like to register your opinion, please do not hesitate to contact Louis J. Kettel, M.D., Vice President, Division of Academic Affairs and Principal Investigator, ACME-TRI Study.

ASSESSING CHANGE IN MEDICAL EDUCATION:

The Road To Implementation



**ASSOCIATION OF
NATIVE AMERICAN
MEDICAL STUDENTS**

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Oklahoma City, Oklahoma 73159
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HUN
DIVISION OF MINORITY HEALTH
DISEASE PREVENTION AND
PROMOTION

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October 14, 1989

Mr. Dario Prieto
Association of American Medical Colleges
One Dupont Circle
Washington, D.C. 20036

Dear Mr. Prieto:

On behalf of the Association of Native American Medical Students (ANAMS), we would like to express our sincere appreciation to you for meeting with us at the ANAMS Annual Meeting held August 7-11, 1989. We also hope that you enjoyed participating in the Association of American Indian Physicians' (AAIP) annual conference on "Healthy Indian Youth: Pathways to the Future" held concurrently with the ANAMS meeting. Both meetings were very well attended and we feel fortunate to have been able to accomplish so much in Oklahoma City.

As you are aware, ANAMS has been discussing the issue of Native American admissions before the Consortium of Medical Student Organizations for the past several years. In this way, the topic has been brought to the attention of AAMC through Bob Beran, Ph.D. and OSR National Chairman Clayton Ballantine, M.D. To reiterate, the issues surrounding this matter have been outlined as follows:

ANAMS became increasingly concerned about an apparent discrepancy between the number of Native American students which medical schools reported as being enrolled at their schools, and the actual number of Native Americans which ANAMS knew to be enrolled at the particular schools in which we had members. This concern was heightened upon receipt of an article in JAMA (1987) in which it was reported that there were 242 Native American medical students nationwide. Again, ANAMS immediately recognized that these figures were likely inflated based on knowledge that ANAMS had from their membership.

ANAMS estimates that there continues to be fewer than 200 Native Americans represented among more than 50,000 medical students nationwide. Given these small numbers, the implications of such over-reporting on future Native American recruitment efforts are grave if admissions committees are to infer

from these figures that their recruitment programs are succeeding in the area of Native American admissions.

It is well known that Native American representation in the health professions is far below that of all other ethnic/racial groups in America. In fact, in addition to the approximately 350 Native American physicians there are currently, it is estimated that 3,000 more Native American physicians would be needed in order for there to be as many Native American physicians per number of Native Americans as there are non-Indian physicians per number of non-Indians. With such gross underrepresentation, there cannot be any laxity in efforts to recruit Native American health professions students.

With these concerns in mind, ANAMS initiated an informal survey of their own to document, at least to some degree, the actual number of Native American medical students. This survey asked our members to identify for us the following:

- 1) The number of Native American medical students their admissions office reported as being enrolled at their school;
- 2) The number of Native American medical students that the student knew to be enrolled at their school, based on the fact that, generally, Native American students know who their fellow Native American students are.

This survey revealed an approximate 30% discrepancy from the figures reported by JAMA, i.e. that there were 177 Native American medical students and not 242.

As we see it, this situation has evolved primarily because medical school applicants who identify themselves as "Native American/Alaskan Native" are not required to provide any evidence of this claim. To illustrate, many ANAMS members have active, participating roles on the admissions committees at their respective schools. From these members, as well as from our collective experiences, ANAMS is aware that many non-Indian applicants have indicated on their medical school applications that they were Native American for the oft-quoted reason that they were "born in America" and, therefore, felt entitled to check the Native American box on their applications. This practice continues despite the fact that there is a Caucasian box that might be a more accurate choice, and that the Native American box specifies, "Native American/Alaskan Native." ANAMS is frankly bewildered at the naivete of post-graduate students who could be so mistaken in identifying their racial/ethnic backgrounds thusly, and consequently, it is difficult for us not to speculate as to what the genuine motives of such applicants might be.

Nonetheless, the result of such actions is the falsely-inflated number of Native American medical students that admissions committees report as being enrolled at their schools. This over-reporting is a detriment to true Native American students who might otherwise receive more thorough consideration of their applications; it also lessens the perceived need for more concerted and effective recruitment efforts, which in turn jeopardizes the struggle to achieve parity with the rest of the country in the area of Native American representation in the health sciences.

For these reasons, ANAMS has suggested that a "rider" be added to the box marked "Native American/Alaskan Native" stating: "Documentation must be provided upon request." We feel that the addition of this stipulation alone would greatly discourage applicants who might otherwise inappropriately check this box. We would also like to suggest the addition of a clarifying paragraph in the instruction booklet to help those students unsure of their application status. Such clarification may include a definition of Native American, and suggested forms of documentation, i.e. Certificate of Indian Blood, genealogical evidence, tribal membership card, or other evidence.

Finally, we would like to suggest the alternate specification of "American Indian" rather than Native American because the former term is perhaps more easily recognized and provides no opportunity for non-Indians to mistakenly identify themselves as Native American simply because they were born in America.

In either case, we would like to stress the need for a "rider" to act as a deterrent to those applicants who might otherwise inaccurately identify themselves as Native American. We are confident that the dissuasion induced by this stipulation alone will significantly help to remedy this particular situation. Ideally, were admissions committees to follow up on this rider by requesting documentation, more careful screening of prospective Native American medical students would be achieved.

In keeping with this greater goal, at your request ANAMS is proposing several recommendations for inclusion in the AAMC guidelines for admissions committees, particularly for those guidelines that pertain to minority admissions. These suggestions are discussed below and ANAMS welcomes your input in order that we may strengthen these recommendations for more likely implementation at some future time.

Firstly, it is crucial to Native American admissions practices to have a working definition of "Native American," satisfactory to prospective Native American students as well as being capable of easy incorporation into admissions screening procedures. Such a definition may be found in the Indian Health Services scholarship program packet. This definition is identical to that used by the Bureau of Indian Affairs and the U.S. Department of Education, Indian Education Program. Further, this definition does not specify a minimum blood quantum and helps to avoid numerous other issues, not the least of which are great reluctance and difficulty on the part of any agency to establish a minimum blood quantum in view of such factors as reservation affiliation, knowledge of and fluency in one's tribal language, cultural practices, community involvement, differing tribal identification methods, etc. However, ANAMS would like to emphasize that without a minimum blood quantum, it then becomes necessary for admissions committees to obtain either documentation of tribal affiliation or have in effect procedures to adequately establish one's tribal identity.

Several means by which to achieve this verification of tribal affiliation already exist in the form of commonly-used supplemental medical school application forms which could be easily modified or addended, and "minority recruitment offices," "dean's minority committees," "minority affairs offices," and "minority review committees" which operate as subcommittees under the admissions committee itself, and other similar structures within or cooperative with medical school admissions offices. Indeed, ANAMS proposes that Native American medical students at the various schools be allowed to assist with the verification process.

Regarding specific verification procedures, ANAMS has learned of a model for effectively verifying one's identification as Native American that is currently used by Stanford University. This procedure includes distribution of a "heritage sheet" that requests the self-identified Native American applicant to provide additional information concerning their tribal affiliation such as specific tribe, blood quantum if known, Indian community involvement, reservation description, specific tribal activities, tribal language, and other cultural information.

This heritage sheet is then reviewed and followed by a phone call to the applicant's household for more in-depth discussion of various items mentioned on the heritage sheet. For each of these steps, we have been told that not uncommonly, the heritage sheet is returned with a statement from the appli-

cant that a "mistake" has been made in their designation as a Native American; or an applicant's parents, when telephoned, are puzzled or surprised that their son or daughter was designated Native American when, in fact, they are not. In this way, applicants are readily determined to be properly identified as Native American.

Although implementing such a heritage sheet would undeniably carry with it the fact that more work would be required of admissions committees, ANAMS proposes that this burden could easily be carried by Native American medical students enrolled at the various schools. A panel of Native American medical students to assist in the screening and advocacy of Native American applicants would doubly serve the purpose of promoting Native American admissions. Of course, while the optimal situation would be a panel with voting privileges, even a non-voting panel would serve the more important role of acting as advocates for prospective Native American applicants.

ANAMS would also strongly urge that any requests for documentation be made prior to the interview process. ANAMS requests this in view of the fact that by the time an applicant obtains an interview, several levels of screening have occurred. ANAMS can envision a scenario wherein true Native American applicants, with impressive backgrounds in the face of undue hardships nonetheless may have accompanying grades that are respectable though less outstanding than their majority counterparts; such an applicant may be eliminated early in the process in favor of those non-Indian applicants who had identified themselves as "Native American" and were then being mistakenly considered as a Native American applicant. One can easily see the impact on admissions of requesting documentation earlier or later in the admissions process. ANAMS would even suggest that interviews be made contingent upon proof of Native American status.

In addition, Native American and other minority medical students have reported a recurrent question that is often asked by admissions committees that we feel should be eliminated from application forms and interviews. This question is, "Do you plan to return home to practice medicine among your people?" ANAMS believes this question to be highly prejudicial in the assumption that a Native American or other minority physician can only be effective by returning to their home communities. This assumption neglects the fact that great advances are and could be made by Native Americans and other minorities working in such fields as research, academia, health care policy, etc., not to mention the impact that minority professionals working in these capacities have as role models to their younger minority students. Again, ANAMS would urge that

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this question be eliminated from the screening, essay, interview or other process in which the applicant may be requested to respond to this or a similar question.

In closing, ANAMS would like to express their appreciation to you and AAMC for your interest and support in our joint effort to improve Native American admissions. We look forward to meeting with you and AAMC later this month to discuss this matter more fully. In the meantime, if you have any questions please feel free to contact me at 1721 W. Glendale, Apt. 2061, Phoenix, Arizona 85021 (602) 249-9062.

Thank you.

Sincerely,

Charlene Avery

Charlene Avery
Consortium Representative
ANAMS Executive Council

Jeffrey A. Henderson, M.D.

Jeffrey A. Henderson, M.D.
ANAMS Immediate Past-President
Consortium Representative 1987-89

cc: ANAMS Executive Council
Association of American Indian Physicians
Clayton Ballantine, M.D.