

AGENDA

FOR

ORGANIZATION OF STUDENT REPRESENTATIVES

BUSINESS MEETING

THURSDAY, NOVEMBER 2, 1972

8:00 - 10:00 P.M.

VOLTAIRE ROOM

FONTAINBLEAU HOTEL

MIAMI BEACH, FLORIDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D.C.

Association of American Medical Colleges
ORGANIZATION OF STUDENT REPRESENTATIVES

Business Meeting
Thursday, November 2, 1972
8:00 - 10:00 p.m.
Voltaire Room, Fontainebleau Hotel
Miami Beach, Florida

AGENDA

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ORGANIZATION OF STUDENT REPRESENTATIVES
OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES

BUSINESS MEETING

February 3-4, 1972
Palmer House
Chicago, Illinois

I. Call to Order

The meeting was called to order by the Chairman, Mr. Larry Holly,
at 1:30 p.m.

II. Roll Call

Mr. Holly declared the presence of a quorum.

III. Minutes of the Previous Meeting

The minutes were approved without change.

IV. Chairman's Report

Mr. Holly presented a report on the history of the OSR and his activities
since the November meeting. He asked that the OSR pay particular atten-
tion to defining its policies for the coming year.

V. Finance Committee Report

Mr. Richard O'Conner, Chairman of the ad hoc Finance Committee, stated
that attempts to secure moneys solely for the purpose of travel was not
possible and that his committee would attempt to define projects which
the OSR could accomplish and which could provide some operating capital
for our organization.

VI. Consideration of the Priorities of the OSR

Mr. Holly then directed the Representatives to break into the eight
groups to which they were assigned by random numbers. The groups were
instructed to discuss what the priorities of our Organization should
be over the next year. They were asked to record the results of their
discussions and present them to the Chairman-elect, Mr. Kevin Soden,
who will compile them into a working document.

VII. Relationship of the AAMC to Related Health Organizations

Mr. Holly presented the background material organized by Mr. Joe Keyes
of the AAMC staff in response to our concern with the representation of
osteopathic physicians and other health professionals in the AAMC.

ACTION: On motion, seconded and carried, the OSR adopted the following motion:
That the OSR extend an invitation to a representative of each of the American schools of osteopathic medicine and to a representative of the student organization of each of the members of the Federation of Associations of Schools of the Health Professions to attend the annual meeting of the OSR in Miami and participate in our discussions.

VIII. Reevaluation of the OSR Committee Structure

Mr. Steven Ketchel clarified the status of OSR committees. He stated that all committees are ad hoc in status and they will be reviewed prior to the next annual meeting by the Administrative Board to decide which should become standing committees and which should be disbanded. Mr. Ketchel reminded committee chairmen that theirs was an information-gathering role and that the only spokesman for the OSR was the Administrative Board of the OSR. He also announced that a new name would be sought for the political action committee to better describe its purpose.

IX. Review of the Year in Washington

Mr. Holly commended to the Representatives' reading the review of the year in Washington written by Dr. John A. D. Cooper, President of the Association, in his AAMC Memorandum #72-1.

X. Faculty Representation in the AAMC

In discussion the OSR reaffirmed its belief in institutional representation of medical school faculties in the AAMC. The major concern with the present proposals was the possibility that the representatives of the faculty would be the same as those represented in the CAS. No action was taken.

XI. Clinical Clerkships for Americans from Foreign Medical Schools

The OSR discussed the medical clerkship (Fifth Pathway) concept but took no action. They did support the COTRANS concept.

ACTION: On motion, seconded and carried, the OSR adopted the following motion:
That the Organization of Student Representatives recommends that the AAMC adopt the following policy statement: All United States medical schools are urged to pay increased attention to American students in foreign medical schools by being receptive to applicants to transfer on advanced standing via COTRANS, which uses Part I, National Board of Medical Examiners, as a qualifying screen.

XII. Regional Meetings of the GSA

Mr. Holly urged that each Representative make every effort to attend his GSA regional meeting in the Spring and to take along his Representative-elect if at all possible. These regional meetings provide excellent means for exchange of information between members of the OSR.

XIII. Additional Representatives for Schools Whose Representatives are Officers or Regional Representatives

The OSR rejected this idea without discussion.

XIV. Student Members of GSA Committees

Mr. Holly noted the names of student members of GSA committees who were appointed through the recommendation of the OSR.

XV. November Meeting

Mr. Holly reminded the Representatives of the November meeting in Miami and asked them to participate in the planning of the OSR sessions.

XVI. Temporary Adjournment

The meeting was adjourned and called to order the next day at 1:30 p.m. by the Chairman, Mr. Holly.

XVII. Committee Reports

Miss Barbara Costin, Chairwoman of the ad hoc Senior Electives Committee, reported that she plans to send out questionnaires to each school. Examples of the questionnaire were shown to the Representatives.

Mr. Vernon Daly, Chairman of the ad hoc Minority Affairs Committee, reported that his committee has not been satisfied with the action taken by the Association with regard to minority students and that his committee will make suggestions for positive action.

Mr. Sol Edelstein distributed material on the physician draft and promised to forward additional information as it appeared.

XVIII. Minority Affairs

Mr. Dario Prieto of the AAMC Office of Minority Affairs spoke regarding the involvement of the Association in this area and offered the services of his office to any Representative interested in improving the programs for minority students at his school.

XIX. Election of Representative-at-Large

Mr. James Pendleton of Dartmouth Medical School was elected to the position of Representative-at-Large by a majority vote of the Representatives to fill the vacant seat.

XX. Minority Affairs at the Annual Meeting

The OSR discussed how to best involve the Association in minority affairs.

ACTION: On motion, seconded and carried, the OSR adopted the following motion:
Be it resolved that the Organization of Student Representatives of the Association of American Medical Colleges strongly urges the Executive Council to consider the relationship between minority groups and academic medical centers as its major theme during an annual convention and consider this issue as a primary priority during the coming years. (Areas that would be included in such coverage would be minority students including women, in medicine, recruitment, retention, and special programs; out-patient and ward care of minorities, consumer input, cultural problems, and financing; medical center-related clinics, pre-paid groups, experiments in delivery, and free clinics; governmental roles in training and treating the medically indigent, etc. For present priorities, see weekly report #59.)

XXI. National Boards Examination

The addition of an additional testing date for Part I was discussed.

ACTION: On motion, seconded and carried, the OSR adopted the following motion:
The OSR instructs its Action Committee to investigate the feasibility of having Part I of the National Boards Examination offered a third time annually. Their report and recommendations should be forwarded to the Chairman of the OSR by August 1, 1972, for consideration at the annual meeting in November 1972.

XXII. Matching Program for Financial Aid from Communities

The OSR discussed means by which a student in need of financial aid could be matched with a community in need of a physician that could give the student financial aid in exchange for his promise of serving the medical needs of that community for a specified time.

ACTION: On motion, seconded and carried, the OSR adopted the following motion:
That the OSR form an ad hoc committee to investigate the establishment of a central information center and matching program

whereby students seeking financial aid coupled to a service commitment might be placed with appropriate communities, counties, regional planning commissions, etc., willing to provide financial assistance for their medical education. Their report and recommendations with supporting material should be forwarded to the Chairman of the OSR by August 1, 1972.

XXIII. MECO Project

Representatives from SAMA's MECO project presented their program to the OSR and asked for the OSR's recommendation that academic credit be given for MECO experiences. The OSR will take this under advisement.

XXIV. Council for Health Interdisciplinary Participation (CHIP)

Representatives from CHIP distributed information regarding their programs at the University of Minnesota Health Sciences Center and offered to discuss with the Representatives their experience in setting up a community participation program for medical students.

XXV. Communication

Mr. Ketchel urged each Representative to respond quickly to each communication he received from the OSR, especially the questions sent as part of the Question-Exchange Program of the OSR.

XXVI. Meeting with the Council of Deans

Mr. Holly reminded the Representatives of the meeting with the Council of Deans after the conclusion of our business meeting and urged full attendance.

XXVII. Adjournment

The Organization of Student Representatives Business Meeting was adjourned at 3:45 p.m.

Steven J. Ketchel
Secretary

Attachment: Schools Represented at OSR Meetings, February 3-4, 1972.

W#8268 R/2

SCHOOLS REPRESENTED AT OSR MEETINGS
FEBRUARY 3-4, 1972
(58 Schools)

U. of Alabama	U. of Louisville
Albert Einstein	Loyola University
U. of Arizona	U. of Maryland
U. of Arkansas	U. of Massachusetts
Boston University	Medical College of Ohio
Bowman Gray	Medical College of Pennsylvania
UC Davis	Medical College of Wisconsin
UCLA	Michigan State University
UCSF	U. of Michigan
Case Western Reserve	U. of Minnesota
Chicago Medical School	U. of Missouri, Columbia
U. of Colorado	U. of Nebraska
U. of Connecticut	New York University
Creighton University	U. of North Dakota
Dartmouth	Northwestern University
Duke University	U. of Oklahoma
Emory University	U. of Oregon
U. of Florida	U. of Pittsburgh
George Washington University	Temple University
Georgetown	U. of Texas, San Antonio
Howard University	U. of Texas, Southwestern
U. of Illinois	Tufts University
Indiana University	U. of Utah
Jefferson	U. of Virginia
Johns Hopkins	U. of Washington
Kansas University	Wayne State University
Loma Linda University	West Virginia University
LSU	U. of Wisconsin
LSU Medical Center at Shreveport	Yale University

REPORT OF THE SOCIAL CONCERN COMMITTEE

It was decided that the best way for the Social Concern Committee to function would be to prepare fact sheets on various issues of interest to OSR. The original thought of researching specific legislation was dropped - due to impracticality. It was felt that informing the membership of the real facts and both sides of social issues important to us and letting these issues be discussed and possibly resolutions passed, was the best method. The members of the Committee were asked to pick topics of interest such as the draft, National Health Plans, quality of health care, abortion, etc. About five responded and picked topics. But as of September 24th, I've only received one finished paper, which is enclosed. It is the work of Steve Helgerson and is well worth your inspection.

Unfortunately, due to clinical commitments I won't be able to make the Convention. However, I hope that this paper will be of interest and of value.

Respectfully submitted,

Barry C. Sussman

Barry C. Sussman
Class of 1973

New York University School of Medicine

Note: The report of the Social Concern Committee also includes a paper entitled, "Health Care as a Right," by Steve Bazeley, which was submitted just prior to the agenda book deadline. -- SPD

National Health Insurance Proposals - 1972

The types of coverage and methods of payment used by health insurance programs both public and private, are prime examples of the fragmentation and inefficiency of health care delivery in the United States. For example, while 81 percent of all individuals under 65 years of age and essentially everyone over 65 years of age¹ are covered by some type of health insurance, still 30 percent of private hospital expenses, 57 percent of physician expenses, and 95 percent of other health care costs² were not paid by insurance payments but rather paid for directly by the persons involved.³ By paying "usual and prevailing" rates, health insurance encourages providers to charge as much as they can get.⁴ National Health Insurance proposals are attempts to provide public planning and control for this system. Each proposal calls for a financing mechanism to cover the cost of privately provided services. None would make government a direct provider of medical services.

Space will not permit a discussion of the historical background of National Health Insurance movements.⁵ Instead the major proposals currently being considered will be compared with respect to a number of crucial variables. Anyone interested in more details should start by reading the references given and by obtaining copies of the bills for careful perusal.

Almost all national health insurance proponents are seeking "a program that assures universal access to comprehensive and continuous health services of high quality, delivered under circumstances that are convenient, comfortable, and dignified and in a manner that is efficient and economical."⁶ Numerous authors have compared current bills with respect to certain relevant variables.⁷ This discussion follows most closely the method of Berki.⁸

More than a dozen national health insurance bills have been introduced in the 92nd Congress.⁹ The major bills are: the Kennedy-Griffiths bill (S.3, H.R. 2162), the AMA's Medcredit (S.987, H.R. 4960), and the Administration's bill (S. 1623, H.R. 7741).¹⁰

ISSUES

Population: Whereas the Kennedy plan would be compulsory and cover all U.S. residents, both the Nixon and AMA plans would be voluntary with certain exclusions. The Nixon plan excludes (1) poor families without children, (2) federal, state, local, and city government employees and employees of religious organizations, and (3) persons qualified under Medicare. The AMA's plan also excludes the latter.¹¹

Coverage: The Nixon and AMA plans both have deductibles and co-payments, while the Kennedy proposal has neither.¹² Kennedy's legislation would provide for all services (physician and hospital ambulatory, in-patient, and home services, as well as social work) with some limits on psychiatric, nursing home, dental, optometric, and pharmaceutical services.¹³ Coverage under the Nixon proposal would consist of two distinct plans. Employed persons (National Health Insurance Standards Act) would be covered for all in- and out-patient services, except

psychiatric, dental, optometric, and pharmaceutical services, up to a limit of \$50,000/year per family member. On the other hand, low income families with children (Family Health Insurance Plan or FHIP) would be limited to 30 days of in-patient or 90 days of extended facility care, 8 physician office visits per year, maternity care, and some additional services for children under 12.¹⁴ The AMA plan would cover all ambulatory and in-patient services (with the exception of cosmetic, optometric, and pharmaceutical services), but limit hospitalization to 60 days/year or 120 days/year in an extended facility.¹⁵

Utilization: Both the Kennedy and Nixon plans encourage continuity and comprehensiveness of care by advocating group practice systems.¹⁶ The AMA proposal would create a Health Insurance Advisory Board to develop standards, but the exact methods are not specified.¹⁷

Quality Control: The Nixon plan implies standards to be maintained by group practices (Health Maintenance Organizations), but not necessarily by individual practitioners.¹⁸ Professional Standards Review Organizations can be utilized "to the same extent as they apply to payments under title XVIII or under State plans approved under title XIX."¹⁹ The AMA's proposal would establish a Board to implement yet unspecified standards. The Kennedy proposal is more specific about continuing education, record keeping, and other factors thought to influence quality of care. A Health Security Board would enforce these controls, primarily through economic sanctions.²⁰

Payment of Providers: By relying on classical market competition and paying "usual and customary" charges, the AMA's plan would leave the present payment structure unchanged. The Nixon proposal also relies on market competition. Payments for care would be subject to Medicare limits on reasonable costs and charges for institutions and professionals respectively. Group practice systems could be paid on a capitation basis.²¹ The Kennedy plan is very complex. If enacted, it would pay hospital and group practices according to an approved prospective budget. Group practices could receive additional incentive payments for increased productivity. Funds would be allocated first with regard to geographic region, and then by type of service and type of organization within that region.²²

Financing: The Nixon employer-employee plan would have employers helping to purchase health insurance for their employees. The employer share would initially be 65% of the premium cost, rising to 75% in three years. The Family Health Insurance Plan would be financed through Federal general revenues plus contributions from the beneficiary, varying with family size and income. "Medicredit" would pay 100% of the insurance premium for catastrophic coverage. For basic coverage, however, a smaller percentage of one's premium would be credited against one's income tax liability. Half of the funding for the Kennedy plan would come from Federal general revenues, the remainder through payroll taxes. Employers would pay 3.5% and employees 1.0% of wages and salaries up to \$15,000. Self-employment and nonwage incomes would be taxed at 2.5% and 1.0% respectively.²³

Administration: The Nixon employer-employee plan as well as "Medicredit" would be administered by private insurance carriers. The FHIP would be administered by the Federal government utilizing private carriers and intermediaries.²⁴ The Kennedy plan replaces private carriers with

the Health Security Board under HEW. Actual administration would be accomplished by regional and health service area offices, assisted by Health Advisory Councils with a majority of consumer representatives.²⁵

Organizational Impact: The AMA proposal would not change the present system of health care delivery. It affects only the financing mechanism. The Administration's plan emphasizes cost and utilization controls, and incorporates the Medicaid program. It encourages the use of Health Maintenance Organizations, rather broadly defined prepaid group practice plans, but also emphasizes the need to maintain a pluralistic health care delivery system. The Administration's plan would put new emphasis on the delivery of care by group practices, but would not radically change the present system. The Kennedy plan would not only promote group practice, but penalize fee-for-service delivery of care; not only establish guidelines for the delivery of quality care, but enforce these guidelines by linking quality control to reimbursement; and not only incorporate Medicaid, Medicare, and the Federal Employees' Plan, but also emphasize planning for the health care delivery of the future. If enacted, this plan would generally restructure the health care delivery system.²⁶

Footnotes

1. In addition 50 percent of those covered by Medicare also have some form of supplemental private health care insurance.
2. Costs such as dental, optometric, prescription, and nursing home services are referred to here.
3. For these and more thorough statistics see:
Mueller, Marjorie Smith, "Private Health Insurance in 1969: A Review," Soc. Sec. Bull., 34:2, 3-18, Feb. 1971.
4. Arrow, Kenneth J., "Uncertainty and the Welfare Economics of Medical Care," Am. Econ. Review, LIII:5, 941-973, Dec. 1963.
5. An excellent historical account of the movements for the enactment of national health insurance can be found in:
Anderson, Odin W., The Uneasy Equilibrium--Private and Public Financing of Health Services in the United States, 1875-1965,
Hew Haven, Conn.: College and University Press, 1968.

Other books of interest include:

Harris, Richard, A Sacred Trust, Baltimore: Penguin Books, Inc., 1966.
Stevens, Rosemary, American Medicine and the Public Interest, New Haven, Conn.: Yale University Press, 1971.

6. Burns, Eveline, "A Critical Review of National Health Insurance Proposals," HSMHA Health Reports, 86:2, 111-120, Feb. 1971, p. 111.
7. See, for example:

Blue Cross Association, "Comparison of Major National Health Insurance Proposals for 1971," Chicago: Research and Development Division of Blue Cross Association, 1971.

Falk, I. S., "National Health Insurance: A Review of Policies and Proposals," Law and Contemporary Problems, XXXV:4, 669-696, Autumn 1970.

Somers, Anne, Health Care in Transition: Directions for the Future, Chicago: Hospital Research and Educational Trust, 1971.

Somers, H. M. and A. R. Somers, "Major Issues in National Health Insurance," Milbank Memorial Fund Quarterly, 50:171-210, April 1972.

8. Berki, Sylvester E., "National Health Insurance: An Idea Whose Time Has Come?", The Annals of the American Academy of Political and Social Science, 399:125-144, Jan. 1972.

9. For a list of the bills see:

Ibid., pp. 143-144.

If Senator Kennedy and Representative Mills present a joint bill as they discussed on June 17 in St. Louis (Washington Post, June 18, 1972), it will obviously become a major proposal also.

10. For a brief discussion of Senator Long's S.1376, Senator Javits' S.836, the AHA's "Ameriplan," and others see:

Falk, op. cit., pp. 679-690.

11. See:

S.1623, Sec. 602a, b, and Sec. 625.

H.R. 4960, Sec. 2002.

H. R. 2162, Sec. 11, and Sec. 12.

12. See:

S.1623, Sec. 603b, and Sec. 626b.

H.R. 4960, Sec. 2010.

13. Experimental, cosmetic, and custodial services are excluded. See:

H.R: 2162, Sec. 22 through Sec. 28.

14. See: S.1623, Sec. 603a, c, and Sec. 626a, d.

15. See: H.R. 2162, Sec. 2009a.

16. See:

S.1623, Sec. 603 h.

H.R. 4960, Sec. 47, and Sec. 87.

17. See: H.R. 4960, Sec. 2020, and Sec. 2021.

18. See: S.1623, Sec. 604 c, g, and Sec. 628 a,2(B).
19. See: S.1623, Sec. 626g.
20. See:
H.R. 4960, Sec. 2020, and Sec. 2021.
H.R. 2162, Sec. 41 through 51, and Sec. 121, 122, 125.
21. See:
S.1623, Sec. 603f 2, 3, 4, and Sec. 628a.
H.R. 4960, Sec. 2009.
22. See: H.R. 2162, Sec. 61 through 89.
23. See:
S.1623, Sec. 602 a, and Sec 605a.
H.R. 4960, Sec. 2004, and Sec. 2005.
H.R. 2162, Sec. 61 through 67, and Sec. 201 through 214.
24. Just as Medicare is currently organized.
25. See:
S.1623, Sec. 606, and Sec. 626 f.
H.R. 4960, Sec. 2001.
H.R. 2162, Sec. 61 through 67, and Sec. 121 through 128.
26. Anne Somers has cautioned Kennedy supporters that:
"This effort to manipulate both providers and consumers into a form of health care which, regardless of its appeal to the experts, is still distinctly a minority pattern is as unacceptable in a democracy as the AMA's traditional effort to straitjacket everyone into the fee-for-service system." (in Anne Somers, op. cit., p. 143.)

Steve Helgerson
University of Washington School of Medicine

Health Care as a Right

"It is the right of every citizen to have access to adequate medical care, but it is the responsibility of the citizen or of society to seek it."
(Statement, AMA, June 1971)

We live in the midst of a real crisis in health care delivery for the U.S., and something must be done.

--Under our present system, those privileged people with knowledge and money can get pretty good medical care, while those not so blessed must take what they can get, if anything.

--Mental illness still suffers from a nasty social stigma, and its coverage is curiously absent or deficient in most contemporary "health packets."

--The lack of provision for dental care bespeaks a thorough lack of medical knowledge.

--The proliferation of nursing homes reinforces society's belief that he who does not contribute must be pushed to the side.

--Considering the struggle over sex education, what's to become of family planning, genetic counseling, prenatal instruction--and who will pay for it?

--The dispensation of rehabilitation--and its availability--are too far and few between considering the needless, senseless agony such deficiencies spawn.

--Bringing medical care via home visits seems beyond the scope of present charities, volunteers, and public health groups.

--The "poor" react all too humanly to the impersonal, abrasive treatment of hospital emergency rooms. They don't go at all, or wait much too long before going. The little things like eye checks, Pap smears, etc., go undone due to a lack of information.

--Who takes care of the high-risk patient refused by health insurance groups?

--Quite inequitably, the "consumers" have little (if any) role in policymaking in the health field--for their own health!

--There can hardly be "equal rights for all" in this country where the doctor must unfortunately take into consideration a patient's financial status before prescribing certain diagnostic tests and therapy.

--If there truly is a shortage of doctors in America, then we must train more doctors. And if the general population wants more doctors, they must be willing to sacrifice the sanctity of their

one-to-one doctor-patient relationship so that medical students can learn from them how to become doctors. It really isn't fair that the "poor" alone must bear the brunt of doctor training and medical innovation.

--Medical students must become aware of their responsibility to go where help is needed, and not to be overwhelmed by the glories of rugged individualism.

--Rural areas perhaps suffer more than anywhere else because they lack the "bright city lights" to attract young doctors (and their wives or husbands) and may not have the wherewithal to offer the advantages of group practice.

And so, where do we go from here? The problem is bigger than stopgap measures can handle, so perhaps National Health Insurance is the answer. The problem is most acute for the poor and indigent for whom tax credits mean nothing and "handouts" would go to essentials; the problem lies in their totally understandable lack of understanding of when and why to seek medical care. Only when the financial barriers are down on both sides can we hope to solve this problem.

It is interesting to note the similarities between the present discussion on public-for-all health care and the past debate over public education. Is not health as vital as education--should it not also be guaranteed to every man, woman, and child? What good is a sound mind in a diseased body?

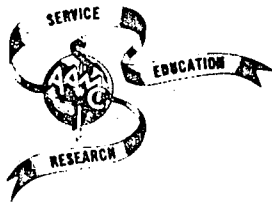
But what about "encroaching federalism?" How will we stop the government once it gets its foot in the door? There is no easy answer to this question. However, we have a bad system now, and need a change. All of us are deeply concerned with health care, and our politicians, whom we elect, are also very concerned about their constituents. Can we not trust (excuse use of old-fashioned word) in each other and in our ability to make ourselves heard? Can we afford to sit back and do nothing while the tragedies go on, all because we're afraid of what might happen? We as medical students must quickly realize the magnitude of health care problems, so that we may have a share in their solution.

Steve Bazeley
Medical College of Ohio

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

On May 19, 1972, the Executive Council approved a statement previously adopted by the Council of Deans in May 1971 stating:

Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

DIVISION OF STUDENT AFFAIRS

MEMORANDUM

May 31, 1972

TO: Administrative Board, Organization of Student Representatives

FROM: Roy K. Jarecky, Ed.D., Associate Director
Division of Student Affairs

SUBJECT: Current Status of the National Intern and Resident Matching Program

Since 1951 when the matching plan was first made operational, its procedures have proved highly effective in enabling medical students to apply for places in first-year graduate programs through fair and "controlled" competition with other students who might also want to enter the same program.

With the shortening of medical school curricula and gradual elimination of internship programs as such, there has been a tendency for some specialty programs to try to recruit students outside of the NIRMP. Bypassing the plan is grossly unfair to those students, hospitals and programs who continue to play by the rules and, therefore, has the overall effect of seriously impairing the NIRMP.

Because of the importance of the issue, the OSR may wish to take a definite stand on the maintenance of the NIRMP. If the program is to continue, all hospitals with approved graduate programs must recruit within the NIRMP framework. Individual recruiting outside the program will inevitably result in a chaotic condition in which both students and graduate programs will suffer.

The attached NIRMP policy statement provides a more detailed overview of the situation and reflects the problems that are developing.

RKJ/sg

Enclosure

STATEMENT OF NIRMP POLICY 1971-72

Introduction

The position of the isolated, free-standing internship in the continuum of graduate medical education has been a matter of concern and study for the past twenty years. Throughout this period, an intern matching program for medical students and hospitals has operated satisfactorily, even though there have been progressive changes in the nature of the internship. In more recent years, the position of the internship has come under concentrated study, based in part on the report of the Commission on Graduate Medical Education (Millis Commission), but also based on the expressed social needs for increase in medical manpower. This has been reflected by the mutual proposals of medical students and medical educators to accelerate the process of graduate medical education while achieving economies in time and effort.

The changes responsible for much of the present concern are largely the result of the efforts of large numbers of medical schools to shorten their curriculums plus the determination of a significant number of medical specialty boards to eliminate the internship as a specific requirement leading toward certification. These changes have met with varying degrees of acceptance throughout the United States because of the individual licensure requirements of the fifty states.

Hopeful of stimulating some degree of coordination among these disparate forces, the House of Delegates of the American Medical Association approved a series of ten recommendations made by the Council on Medical Education in December of 1970 of significance to medical schools, medical specialty boards, state boards of licensure, hospitals, and directors of programs of graduate medical education in all specialties. One of these recommendations was "that the principle of a voluntary matching program be preserved, and that the only point at which this can be preserved is at the time of obtaining the M.D. degree". Support of the concept of a matching program was further reaffirmed by the following groups:

Motion of the Council of Deans - May 20, 1971

"Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, the first hospital-based graduate training appointment after the awarding of the M.D. degree should be through the National Intern and Resident Matching Program."

Position of the Council of Teaching Hospitals - February 12, 1971

Some of the problems resulting from the transitional status of the internship and subsequent policy changes in the functioning of the NIRMP were discussed by the Administrative Board of the Council of Teaching Hospitals. There was general concensus that the teaching hospitals should continue to support NIRMP.

Resolution of the Council of Academic Societies - April 9, 1971

"The Administrative Board unanimously supports the continuation of the Matching Program for graduating medical students for all disciplines."

The Central Regional Group on Student Affairs - May, 1971

"Every medical student deserves all of the advantages inherent in the National Intern and Resident Matching Program. In order to assure them this advantage, every hospital-based post-graduate training program should be a full-fledged participant in the National Intern and Resident Matching Program."

The West Coast Group on Student Affairs - May, 1971

"The group unanimously affirmed the importance and value of NIRMP at this interface and noted the significant advantage of the 'matching plan' to both student and hospital."

Resolution of the Student American Medical Association - May 5, 1971

"SAMA endorses the NIRMP as a valuable service to participating students in hospitals and encourages every medical student and hospital offering post-graduate education to participate in the NIRMP and that this Association condemns as unethical the violation of the contract by either participating students or hospitals."

Within the past two years, a variety of questionnaire studies have been conducted on the acceptance of a matching program by the various groups concerned. Separate questionnaire studies of interns and of residents have displayed convincing testimony of the worth of a matching program at the first graduate year level, and they recommended that it be continued. Questionnaire replies from the deans of medical schools in the fall of 1970 confirmed the fact that medical students desire a matching program at the first graduate year level.

Response to March 4, 1971 Questionnaire Study

This study of the NIRMP evoked an overwhelming preponderance of responses from hospitals and program directors in both university and non-university hospitals, recommending maintenance of a matching program for medical students.

The additional responses to that questionnaire are summarized as follows:

1. Many hospitals and program directors intend to continue offering positions to medical students at the internship level and are reluctant to include such students in the established pattern of resident recruitment at this time.
2. It was recommended that NIRMP maintain, and not suspend, a matching program for this coming year despite the requests of program directors in some specialties. It was recommended that the nine categories of rotating internships continue to be listed in the Directory as before, along with the same five categories of straight internships as before.

3. There was general understanding and agreement with the proposal that it is optional with a program director whether or not he participates in the plan, and that his actions were not binding on other program directors of specialty programs in the same institution. (Please see further qualification of this policy in paragraph 4 below as well as paragraph 3 under Principles of the 1971-72 Matching Program.)
4. It was clearly understood and generally agreed by program directors in both university and non-university hospitals that non-participation of a program in the NIRMP means that positions in that program at the first-year level would not be offered to medical students.

Subsequent to the issuance of the March 4 memorandum and questionnaire, the AMA Council on Medical Education issued a memorandum dated March 18, 1971 entitled "Implications of Recent Actions to Integrate Internship and Residency Programs".

Principles of the 1971-72 Matching Program

The tentative proposals included in the March 4 memorandum will be the basis for NIRMP policy for 1971-72.

1. The program is available to all medical students who are eligible for first-year appointments in graduate medical education. The decision as to eligibility is to be made locally. It is not the role or responsibility of the Matching Program to decide on the legality as to whether or not students are eligible to serve first-year appointments in graduate medical education.
2. The Matching Program is available to all hospitals having approved programs in graduate medical education, and such institutions are required to participate in the NIRMP as corporate entities. Since some specialty boards will have deleted the internship requirement, medical students may be eligible for appointment directly to first-year programs in those specialties, at the option of the program directors.
3. Participation by a hospital in graduate medical education is a corporate responsibility. If a hospital decides to participate in NIRMP, that hospital may not offer any first-year appointments to medical students outside the program.
4. Program directors in a few specialties have recommended that their members be given special exemption from the Matching Program and be permitted to recruit freely from medical students at any time. The NIRMP Board of Directors is of the opinion that to make an exception in the case of even one specialty, no matter how large or small, would cause undue pressure on students and would violate the basic principle of equality upon which the plan was founded.
5. Special purpose hospitals such as those limited to psychiatry, orthopedic surgery, obstetrics-gynecology, or pediatrics may have approval

for residencies in those fields, but may never have been approved for internships in the past. Programs in those hospitals will receive NIRMP code numbers, and if they wish to offer appointments to medical students, they will be expected to observe the same NIRMP procedures as apply to all other hospitals.

6. The first year of graduate medical education may be listed as a rotating or straight internship, as in the past, or it may be listed as a residency in those specialties in which the corresponding specialty boards have deleted the internship requirement.
7. The assignment of an NIRMP code number to each program listed in the Directory of Approved Internships and Residencies implies its use only for appointments of medical students to the first year of those programs. Note the statement in The Essentials of Approved Residencies: "Contracts for one year, renewable by mutual consent, are preferable."
8. The assignment of an NIRMP code number to a residency program does not commit the director of that program to offer first-year appointments to any medical students unless he wishes to. He may restrict such appointments, as in the past, to physician candidates currently serving internships, serving residencies in other specialties, serving in the armed forces, or in practice, but he must signify by December 1, 1971, his desire to participate or not in the matching program for medical students.
9. To participate in the plan for matching medical students to first-year positions in a residency program, the director is not required to list all such first-year positions, but he must include at least one such position. He may make other first-year appointments to candidates as enumerated in Point 8 above.
10. Participating medical students may apply for appointments to any program participating in the plan, complete the rank order lists and observe the specified dates, as in the past. They are honor-bound to reject efforts of non-participating program directors to induce them to accept contracts for appointment prematurely, not in keeping with the agreements they have previously signed. The determination of medical students to present a united front and to be deliberate in their choice of graduate appointments is the key to success of the plan.

June 28, 1971

POLICY STATEMENT ON THE PHYSICIAN DRAFT

On May 19, 1972, the Executive Council approved the following policy statement:

1. The "doctor draft" should terminate on July 1, 1973, the same date on which draft legislation expires. The termination of the doctor draft should apply to all individuals in college, medical school, or postgraduate medical training, regardless of age, selective service status or previous deferment. However, firm commitments previously made to specific services and programs by individuals should be honored.
 - (a) Subsequent to this termination date, military physician manpower requirements should be met entirely by volunteers. Current programs which include scholarships for medical students planning military service, higher pay scales for service physicians, the increased use of health professionals other than physicians, and the continuing critical review of the numbers of military physicians should be further developed and expanded. Retention of physicians in the service should be improved by changing current assignment requirements for those in higher rank, and by generally improving pay scales, working conditions, and opportunities for professional advancement.
2. If a physician draft call is necessary prior to the July 1, 1973, termination date, the vulnerability to military conscription should be determined by a random sequence number drawn by Selective Service specifically for this purpose. This proposed lottery system should be administered nationally rather than by local or state draft quotas. If a national administration is not possible, a national ceiling number should be set beyond which no physician could be called by any local board.
 - (a) Draft liability under the existing law should be limited to one year, with the individual to be vulnerable no earlier than two years after receipt of the M.D. degree.

RESOLUTION ON THE INTERACTION OF BASIC AND CLINICAL SCIENCES

On May 19, 1972, the Executive Council approved in principle the resolution stated below, and agreed that it would be considered by the Administrative Boards (other than CAS which initiated the resolution) and would be transmitted to the Liaison Committee on Medical Education.

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

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

The Association of American Medical Colleges should vigorously pursue this principle in developing criteria for the accreditation of medical schools.

POLICY STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL
COLLEGES ON ELIMINATING THE FREESTANDING INTERNSHIP*

The policy statement which appears below was first recommended by an Ad Hoc Committee of the AAMC in September 1971. This was after the AMA House of Delegates approved the concept that the freestanding internship should be eliminated. It was also felt that a statement on this matter would be consistent with the AAMC's position on the responsibility of academic medical centers for graduate medical education.

This issue was considered by the Executive Council previously and referred to the three Councils for deliberation. In February, all three Councils approved some form of the statement.

The Council of Deans and the Council of Teaching Hospitals approved the full text of the statement which reads:

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

The Council of Academic Societies, meeting on the same day, approved an abbreviated version of the statement, ending after the words "well-planned graduate medical education." **

*The freestanding internship is herein defined as an internship program in a hospital which has no residency training programs.

**The policy statement, as approved by COD and COTH, was also approved by Executive Council, May 19, 1972.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

POLICY STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON THE ESTABLISHMENT OF A CABINET-LEVEL DEPARTMENT OF HEALTH*

The issues confronting this nation in providing a higher level of health and well being to its citizenry are among the most vital and urgent of existing domestic problems. The prospect of some form of universal health insurance coverage will press to the absolute limits our resources and ingenuity to provide health services based on need rather than on arbitrary economic determinants.

Since its establishment in 1953, the Department of Health, Education and Welfare has grown into a bureaucracy of 102,000 employees with an overall budget of nearly \$79 billion, one-third of the entire federal budget. More than 250 categorical grant programs are operated by the Department, including 40 separate health-grant programs.

The present framework within the Department of Health, Education and Welfare subordinates and submerges the health function in a manner which derogates the critical significance of these vitally important issues. There needs to be a single, authoritative point of responsibility for health policy within the federal structure. There needs to be a vigorous national leadership for the evolution of sound federal programs in the health field. The President's current Executive reorganization proposal to create a Cabinet-level Department of Human Resources would only further obscure the process of policy formulation in health.

THEREFORE BE IT RESOLVED that the Association of American Medical Colleges wholeheartedly supports the establishment of a Cabinet-level Department of Health to serve as the single point of responsibility for defining health policy, administering federal health programs and evaluating the state of the nation's health. The Department should be administered by a Secretary of Health appointed by the President with the advice and consent of the Senate. The Secretary should be responsible for all health programs now administered by the Secretary of Health, Education and Welfare including Medicare and Medicaid and any new program of national health insurance. In connection with establishment of a new Department of Health, an independent panel of experts should conduct a study to develop a thoughtful and coordinated national health policy and a detailed national health program for meeting current and future health needs for the United States.

*Final paragraph of policy statement (beginning "Be it resolved . . .") approved by Executive Council, May 19, 1972.

POLICY STATEMENT ON THE PROTECTION OF HUMAN SUBJECTS

There have been a number of widely publicized incidents recently concerning major health research projects (the Tuskegee Syphilis Experiment, for example) which have raised serious questions about the ethics of certain kinds of research and the adequacy of government supervision of Federally-supported research. This is not a new issue but recent newspaper articles have created new interest in it. This interest is being reflected in an increasing number of Congressional proposals to study the ethics of biomedical research and to extend tighter Federal control over the kinds of research receiving Federal support. Bills have been introduced to establish study commissions on the ethics of research, to ear-mark a percentage of Federal research funds to the study of the implications of the research, to prohibit Federal research support unless the human subjects of the research are fully informed of the implications and dangers of the project, and most recently Mr. Javits has introduced a bill to amend the Public Health Service Act by inserting a new section concerned with the protection of human subjects.

On September 15, 1972, the Executive Council approved a policy statement of the AAMC on the Protection of Human Subjects as modified by the COD and CAS. The statement reads as follows:

The Association of American Medical Colleges asserts that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the DHEW Guidelines for the Protection of Human Subjects as amended December 1, 1971. Those faculty members charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity is integral to the educational responsibility of the institutions and their faculties.

FUNCTIONS AND STRUCTURE OF A SCHOOL OF THE BASIC MEDICAL SCIENCES

On May 19, 1972, the Executive Council approved in principle two policy statements (listed below) of the LCME to assist in developing the final version of the "Functions and Structure of a School of the Basic Medical Sciences." It was agreed that the previously considered "Resolution on the Interaction of Basic and Clinical Sciences" would be transmitted to the LCME along with these statements.

- I. The Liaison Committee has categorized the types of basic medical science programs that it will consider for accreditation as follows:
 - (1) Existing two-year programs accredited or provisionally accredited
 - (2) New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium,
and
 - (3) New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case the program will be accredited as a component of the M.D. degree-granting institution or institutions.
- II. It is the policy of the Liaison Committee to discourage the establishment of programs in the basic medical sciences that do not have a clearly defined pathway leading to the M.D. degree.

FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL*

The document which follows is a re-working of the version approved by the AAMC Executive Council on February 5, 1972. Since that date, the AMA Council on Medical Education (meeting on March 10-12) made several minor word changes which are indicated by the heavy black underlining.

The Liaison Committee on Medical Education (meeting on April 26) added the paragraph shown in italics on the final page of the document.

RECOMMENDATION

It is recommended that the Executive Council approve this version of the Functions and Structure of a Medical School and refer this to the Assembly for consideration.

*Approved by Executive Council, May 19, 1972.

FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

1 I. Introduction

2 This is a statement of the Liaison Committee on Medical Education,
3 of the Association of American Medical Colleges, and of the Council on
4 Medical Education of the American Medical Association.* It is intended
5 that this material be used to assist in attainment of standards of education
6 that can provide assurance to society and to the medical profession that
7 graduates are competent to meet society's expectations; to students that
8 they will receive a useful and valid educational experience; and to
9 institutions that their efforts and expenditures are suitably allocated.

10 The concepts expressed here will serve as general but not specific
11 criteria in the medical school accreditation process. However, it is
12 urged that this document not be interpreted as an obstacle to soundly
13 conceived experimentation in medical education.

14 For two-year schools, see Functions and Structure of a School of Basic
15 Medical Sciences.

16 * Adopted by the House of Delegates of the American Medical Association
17 on _____, and the Assembly of the Association of American
18 Medical Colleges on _____.

1 II. Definition and Mission

2 A medical school is an aggregation of resources that have been organized
3 as a definable academic unit to provide the full spectrum of instruction
4 in the art and science of medicine in not less than 32 months, culminating
5 with the award of the M.D. degree. The educational program must be
6 sponsored by an academic institution that is appropriately charged within
7 the public trust to offer the M.D. degree.

8 As an institution of higher education, a medical school has four
9 inherent responsibilities which embody the concept of a continuum of
10 education throughout professional life. These are:

11 I. A principal responsibility of the school is to provide its
12 undergraduate medical students with the opportunity to acquire a sound,
13 basic education in medicine and also to foster the development of
14 lifelong habits of scholarship.

15 II. A medical school is responsible for the advancement of knowledge
16 through research. In addition to biologically oriented studies, the
17 research carried on in a medical school will ordinarily include studies
18 related to cultural and behavioral aspects of medicine, methods for
19 the delivery of health care, and in the medical education process.

20 III. Each school is responsible for development of graduate education,
21 both to provide models for better care of patients through clinical residency
22 programs and to contribute to the development of teachers and investigators
23 through advanced degree programs in the basic medical sciences.

24 IV. Continuing education is another important role for the medical
25 school because it improves the competence of physicians engaged in caring
26 for patients in the years following completion of formal graduate education.

27 In addition, the resources that characterize the modern academic medical
28 center constitute a unique instrument for meeting selected community health

1 needs. As a central intellectual force within its community, the medical
2 school should identify those of its community needs that it might meet and
3 create programs to meet those needs. These efforts can serve as models for
4 students.

5 Participation by medical schools may contribute to the educational
6 programs of other professions in the health field, such as dentistry,
7 nursing, pharmacy, and the allied health professions.

8 A medical school should develop a clear definition of its total
9 objectives, appropriate to the needs of the community it is designed to
10 serve and the resources at its disposal. When objectives are clearly
11 defined, they should be made familiar to faculty and students alike, so that
12 efforts of all will be directed toward their achievement. Schools should
13 be cautious about overextending themselves in the field of research or
14 service to the detriment of their primary educational mission.

15 III. Educational Program

16 The undergraduate period of medical education leading to the M.D.
17 degree is no longer sufficient to prepare a student for independent medical practice
18 without supplementation by a graduate training period which will vary in
19 length depending upon the type of practice the student selects. Further,
20 there is no single curriculum that can be prescribed for the undergraduate
21 period of medical education. Each student should acquire a foundation of
22 knowledge in the basic sciences that will permit the pursuit of any of the
23 several careers that medicine offers. The student should be comfortably
24 familiar with the methods and skills utilized in the practice of clinical
25 medicine. Instruction should be sufficiently comprehensive so as to include
26 the study of both mental and physical disease in patients who are hospitalized
27 as well as ambulatory. At the same time, it should foster and encourage the
28 development of the specific and unique interests of each student by tailoring
29 the program in accordance with the student's preparation, competence, and

1 interests by providing elective time whenever it can be included in the
2 curriculum for this purpose.

3 Attention should also be given to preventive medicine and public
4 health, and to the social and economic aspects of the systems for
5 delivering medical services. Instruction should stress the physician's
6 concern with the total health and circumstance of patients and not just
7 their diseases. Throughout, the student should be encouraged to develop
8 those basic intellectual attitudes, ethical and moral principles that are
9 essential if the physician is to gain and maintain the trust of patients
10 and colleagues, and the support of the community in which the physician
11 lives.

12 IV. Administration and Governance

13 A medical school should be incorporated as a nonprofit institution.
14 Whenever possible it should be a part of a university since a university
15 can so well provide the milieu and support required by a medical school.
16 If not a component of a university, a medical school should have a board
17 of trustees composed of public spirited men and women having no financial
18 interest in the operation of the school or its associated hospitals.
19 Trustees should serve for sufficiently long and overlapping terms to
20 permit them to gain an adequate understanding of the programs of the
21 institution and to function in the development of policy in the interest
22 of the institution and the public with continuity and as free of personal
23 and political predilections as possible.

24 Officers and members of the medical school faculty should be appointed
25 by, or on the authority of, the Board of Trustees of the medical school
26 or its parent university. The chief official of the medical school, who
27 is ordinarily the dean, should have ready access to the university
28 president and such other university officials as are pertinent to the
29 responsibilities of his office. He should have the assistance of a capable

business officer and such associate or assistant deans as may
2 be necessary for such areas as student affairs, academic affairs, graduate
3 education, continuing education, hospital matters and research affairs.

4 In universities with multiple responsibilities in the health fields
5 in addition to the school of medicine as, for example, schools of dentistry,
6 pharmacy or nursing, it may be useful to have a vice-president for health
7 affairs, or a similarly designated official, who
8 is responsible for the entire program of health-related education at the
9 university. Ordinarily, the deans of the individual health-related
10 schools would report to this individual.

11 The medical school should be organized so as to facilitate its
12 ability to accomplish its objectives. Ordinarily, this is best effected
13 through the development of a committee structure that is representative
14 of such concerns as admissions, promotions, curriculum, library, and animal
15 care. Names and functions of the committees established should be subject
16 to local determination and needs. Consideration of student representation on
17 committees is both desirable and useful.

18 The manner in which the institution is organized, including the
19 responsibilities and privileges of administrative officers, faculty and
20 students, should be clearly set out in either medical school or university
21 bylaws.

22 V. Faculty

23 The faculty must consist of a sufficient number of identifiable
24 representatives from the biological, behavioral and clinical sciences
25 to implement the objectives that each medical school adopts for itself.
26 The specific fields represented do not have to be reflected in any set
27 pattern of departmental or divisional organization although the faculty
28 should have an interest in research and teaching in the fields in which

1 instruction is to be provided. Inasmuch as individual faculty members
2 will vary in the degree of competence and interest they bring to the
3 primary functions of the medical school, assignment of responsibility
4 should be made with regard to these variations.

5 The extent to which the school's educational program may depend on
6 the contributions of physicians who are practicing in the community will
7 vary with many factors, including the size of the community and the
8 availability of qualified teachers in the several medical specialties.
9 The advantage to the student of instruction by such physicians, as well
10 as by those in full-time academic service, should be kept in mind.

11 Nominations for faculty appointment ordinarily involve participation
12 of both the faculty and the dean, the role of each customarily varying
13 somewhat with the rank of the appointee and the degree to which administrative
14 responsibilities may be involved. Reasonable security and possibility
15 for advancement in salary and rank should be provided.

16 A small committee of the faculty should work with the dean in setting
17 medical school policy. While such committees have typically consisted
18 of the heads of the major departments, they may be organized in any way that
19 would bring reasonable and appropriate faculty and student influence into
20 the governance of the school. The faculty should meet often enough to
21 provide an opportunity for all to discuss, establish, or otherwise become
22 acquainted with medical school policies and practices.

23 VI. Students

24 The number of students that can be supported by the education program
25 of the medical school and its resources, as well as the determination of the
26 qualifications that a student should have to study medicine, are proper
27 responsibilities of the institution. Inasmuch as all medical schools con-
28 stitute a national resource, and all operate in the public interest, it
29 is desirable for the student body to reflect a wide spectrum of social and

1 economic backgrounds. Decisions regarding admission to medical school should
2 be based not only on satisfactory prior scholastic accomplishments but also
3 on such factors as personal and emotional characteristics, motivation, industry,
4 resourcefulness, and personal health. Information about these factors can
5 be developed through personal interviews, college records of academic and
6 nonacademic activities, admission tests and letters of recommendation. There
7 should be no discrimination on the basis of sex, creed, race, or national
8 origin.

9 Ordinarily, at least three years of undergraduate education are required
10 for entrance into medical school although a number of medical schools have
11 developed programs in which the time spent in college prior to entering
12 medical school has been reduced even further. The medical school should
13 restrict its specified premedical course requirements to courses that are
14 considered essential to enable the student to cope with the medical school
15 curriculum. A student preparing for the study of medicine should have the
16 opportunity to acquire either a broad, liberal education, or if he chooses,
17 study a specific field in depth, according to his personal interest and
18 ability.

19 Advanced standing may be granted to students for work done prior to
20 admission. The increasing diversity in medical school curricula and the
21 greater integration of the total curriculum, require that transfers between
22 medical schools be individually considered so that both school and student
23 will be assured that the course previously pursued by the student is
24 compatible with the program he will enter. Otherwise, supplementation
25 of the student's program may be necessary after he has transferred.

26 There should be a system for keeping student records that summarizes
27 admissions, credentials, grades, and other records of performance in
28 medical school and where possible, information regarding the performance

1 of the student during the first year of graduate training. These records
2 should reflect accurately each student's work and qualifications by
3 including a qualitative evaluation of each student by his instructors.

4 It is very important that there be available an adequate system of
5 student counselling. Such counselling is especially critical for those
6 students who may require remedial work. Academic programs allowing
7 students to progress at their own pace are desirable.

8 There should be a program for student health care that provides for
9 periodic medical examination and adequate clinical care for the students.

10 VII. Finances

11 The school of medicine should seek basic operating support from
12 diverse sources. The support should be sufficient for the school
13 to conduct its programs in a satisfactory manner and it should reflect,
14 as accurately as possible, the educational, research, and service programs
15 of the school.

16 Special attention must be paid to providing financial aid for students
17 since it is desirable that economic hardship not hinder the acquisition
18 of an education in medicine.

19 Arrangements whereby professional fees earned by the faculty are used
20 to support salaries or other medical school activities should be clearly
21 understood and agreed to by all concerned.

22 VIII. Facilities

23 A medical school should have, or enjoy the assured use of buildings
24 and equipment that are quantitatively and qualitatively adequate to provide
25 an environment that will be conducive to maximum productivity of faculty
26 and students in fulfilling the objectives of the school. Geographic
27 proximity between the preclinical and clinical facilities is desirable,
28 whenever possible. The facilities should include faculty offices and
29 research laboratories, student classrooms and laboratories, a hospital of

2 sufficient capacity for the educational programs, ambulatory care facilities
3 and a library.

4 The relationship of the medical school to its primary or affiliated
5 hospitals should be such that the medical school has the unquestioned
6 right to appoint, as faculty, that portion of the hospital's attending
7 staff that will participate in the school's teaching program. Hospitals
8 with which the school's association is less intimate may be utilized in the
9 teaching program in a subsidiary way but all arrangements should insure
10 that instruction is conducted under the supervision of the medical school
11 faculty.

12 A well-maintained and catalogued library, sufficient in size
13 and breadth to support the educational programs that are operated by the
14 institution, is essential to a medical school. The library should
15 receive the leading medical periodicals, the current numbers of which
16 should be readily accessible. The library or other learning resource
17 should also be equipped to allow students to gain experience with newer
18 methods of receiving information as well as with self-instructional
19 devices. A professional library staff should supervise the development
20 and operation of the library.

21 IX. Accreditation

22 The American Medical Association through its Council on Medical Education
23 and the Association of American Medical Colleges serve as the recognized
24 accrediting agencies for medical schools. Though retaining their individual
25 identities, both groups work very closely in this activity through the
26 Liaison Committee on Medical Education. To be accredited, a medical school
27 must be approved by the Liaison Committee on Medical Education, by the Council
28 on Medical Education and be offered membership in the Association of American
29 Medical Colleges. This is granted on the finding of a sound educational
program as a result of a survey conducted by the Liaison Committee on

1 Medical Education. The Liaison Committee representing the voluntary pro-
2 fessional sector includes a representative from the government and the public,
3 and is recognized by the National Commission on Accrediting, the United
4 States Commissioner of Education, the NIH Bureau of Health Manpower Education
5 and various state licensure boards as providing the official accreditation
6 for medical education.

7 It is the intent that newly developing medical schools should be surveyed
8 several times during the initial years of active existence. Provisional
9 accreditation is granted, when the program warrants, for the first two years
10 of the curriculum and definitive action is taken during the implementation
11 of the last year of the curriculum.

12 *Existing medical schools are surveyed at regular intervals. Decisions*
13 *regarding accreditation require assessment of the school's constellation*
14 *of resources in relation to the total student enrollment. Any significant*
15 *change in either should be brought to the attention of the Liaison Committee*
16 *and may occasion review of the accreditation. Every attempt is made to fulfill*
17 *requests for interim surveys as a service to the medical school. **

18 Further information about accreditation can be obtained from the
19 Secretary, Council on Medical Education, American Medical Association,
20 535 North Dearborn Street, Chicago, Illinois 60610, or from the Director,
21 Department of Institutional Development, Association of American Medical
22 Colleges, One Dupont Circle, N.W., Washington, D. C. 20036

23 * Adopted by the LCME, April 26, 1972

ESSENTIALS FOR EDUCATION OF THE PHYSICIAN'S ASSISTANT

The document which follows has been received by the Liaison Committee on Medical Education from its Subcommittee on Physician's Assistants, July 12, 1972.

The document has not been approved by the LCME but has been forwarded by it to the parent councils for their consideration and comment. The LCME will consider any suggested amendments proposed by the AAMC Executive Council and the CME prior to full LCME Action. *

*Document approved in principle by Executive Council, September 15, 1972.

ESSENTIALS FOR EDUCATION OF THE PHYSICIAN'S ASSISTANT

I. Introduction

This is a statement of the Liaison Committee on Medical Education, of the Association of American Medical Colleges, and of the Council on Medical Education of the American Medical Association.*

It is intended that these Essentials for Education of Physician's Assistants be used as the basis for development of educational programs that can provide assurance to the medical profession and to society that the graduates are competent to receive nation-wide public recognition and acceptance as members of the expanding team of health care occupations and professions.

II. Sponsorship

The nature of the Physician's Assistant's role, his/her clearly defined and close working relationship with the physician, the distinctions between functions performed by the Physician's Assistant and the physician all combine to force the conclusion that there should be a very close relationship between the education of the physician and that of a Physician's Assistant. The consequences of this conclusion are that the Physician's Assistant is to be educated in a medical school-academic medical center, or health science center, in a program under direction of a faculty of physicians and basic medical scientists. A substantial part of the training should be done in a well-developed teaching hospital engaged in house staff training.

* Adopted by the House of Delegates of the American Medical Association on _____, and the Assembly of the Association of American Medical Colleges on _____.

This would not automatically preclude the development of programs at settings other than medical schools but would require a similar concentration of teaching physicians and clinical facilities involved in some phase of physician education.

There must be evidence that the program has education as its primary orientation and objective.

III. Educational Goals

The educational program should be structured so as to prepare the physician's Assistant to function under direct supervision of a responsible physician; but, under special circumstances and legally derived rules, the Physician's Assistant should be prepared to perform defined functions with indirect supervision by the physician via modern methods of communication. To be able to perform at this level, the Physician's Assistant must complete a well-developed educational program in medicine sufficient to permit a degree of interpretation of clinical findings and some degree of independent action.

Thus, the educational program must prepare the Physician's Assistant to utilize the skills needed to approach the patient, to communicate effectively in the collection of historical and physical data (the data base) and in presentation of them in such a way that the physician can accurately visualize the medical problem and proceed to determine the appropriate sequence of diagnostic and/or therapeutic steps for his/her patient, thereby conserving time for use in verifying findings and extending professional contact with the patients.

The educational program should prepare the Physician's Assistant to perform diagnostic and therapeutic procedures in common use by

physicians. The program should include instruction in quantitative skills sufficient to insure ability to do accurate calculation and analysis of tests and procedures.

The program should prepare the Physician's Assistant to carry out the physician's patient-care plan and/or actively interpret this plan to the patient.

The educational program should train the Physician's Assistant to coordinate the functions of other more technically and less broadly trained assistants to the physician.

IV. Administration

The program should be under the supervision of a qualified director who should be a physician who has available the faculty and resources necessary to develop effective systems of student selection, a suitable curriculum and means of evaluation thereof, methods of academic evaluation of students, and counselling and career guidance of students. The Director should have a clearly defined relationship with authorities of the sponsoring educational institution, and the participating teaching hospitals. There should be appropriate mechanisms for faculty participation in governance and in development of curriculum and education policies.

V. Faculty

The program must have a clearly designated faculty competent to provide the basic science and clinical teaching which comprise the curriculum. The faculty may include instructors other than physicians, but there must be a significant learning experience under the supervision of clinicians so as to insure understanding of patients, their problems, their reactions to these problems, and the customary diagnostic and therapeutic approaches toward solution of these problems.

VI. Facilities

The sponsoring institution must provide adequate space and modern equipment for all necessary teaching functions. A library, containing up-to-date textbooks, scientific and clinical periodicals and reference material pertaining to the broad field of clinical medicine and its supporting disciplines should be readily accessible to students and faculty.

VII. Finances

The program should be based on a stable operating budget adequate to meet the requirements set forth in this document. Financing should be derived from diverse sources. Tuition fees should not be the sole source of income.

VIII. Educational Program

The curriculum must provide adequate instruction in the basic sciences underlying human medicine. These include normal human structure and growth, major organ and specialized tissue function, response of the human organism to injury, including that by infectious agents, the nature of disease processes and the process of development of signs and symptoms. The social and cultural determinants of health should be stressed.

These studies must be combined and illustrated with instruction, observation, and supervised participation in

- A. The development of the data base; i.e.
 - (a) recording of the patient's chief complaint
 - (b) description of the patient's typical daily habits and other pertinent social data.

- (c) definition of the nature of the present illness or illnesses.
- (d) eliciting of past history of illness and prior and current therapy by review of systems according to a uniform series of logically arranged and explicit questions.
- (e) recording of results of a physical examination of defined content.
- (f) administration of or arrangement for laboratory examination and analysis of results.

and

- B. Diagnostic and therapeutic procedures and other responsibilities in patient care usually accepted by the physician.

Emphasis must be placed on instruction in practical communication skills for use with patients and other members of the health care team.

The close professional working relationship between a Physician's Assistant and physicians should be emphasized in the educational program by providing learning experiences which bring together Physician's Assistant students and undergraduate and graduate medical students. Such exercises can be developed in the clinical setting in the context of both ambulatory and hospitalized patient care.

There must be sufficient evaluative procedures to assure adequate evidence of competence to meet the objectives of the educational program and to allow the graduate to perform effectively in this health career.

The basic program must insure that the graduate possesses a broad general understanding of medical practice and therapeutic techniques;

however, the student may supplement his/her basic studies through extra investment in a particular specialty of medicine.

The level of responsibility proposed for the graduate of this program requires an adequate academic as well as a practical basis. The applicant will present two years of college credit or credit obtained through equivalency examination. These credits should include studies in the sciences of biology, chemistry and mathematics, as well as a cluster of liberal arts and social studies, including English composition.

The duration of this program of instruction should be a minimum of 24 months. All courses of instruction should be rated for university academic credit. Effort should be made to include in the curriculum some experience with use of self-instructional learning systems.

The graduates of this program should be granted sufficient credentials to recognize the scope of their achievements.

The graduates would be awarded the baccalaureate degree or its equivalent, based upon the substance of this program as well as its academic prerequisites.

IX. Selection of Students

It is expected that students seeking careers as Physician's Assistants will have significant motivation toward serving in a role which provides close personal, human interaction. The process of selection should be efficient, fair and impartial. There should be no discrimination on the basis of sex, creed, race or national origin. Attention should be given to each applicant's prior academic record, experience in health related occupations, admission test scores, evidence of good character and ethical behavior, mental stability,

maturity, and general fitness for prospective assignment of responsibility in the sensitive field of medical care for humans.

X. Accreditation

The Liaison Committee on Medical Education was established in 1942 out of an administrative union of accreditation efforts beginning before this century by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. The Liaison Committee expects to incorporate the process of accreditation of programs in education of the Physician's Assistant along with its historic and universally recognized exercise of approval over the medical schools of this country.

Procedures:

- (1) Newly established programs will be reviewed initially by a team sent out for that purpose.
- (2) Subsequent reviews will be accomplished as an aspect of a medical school-center institutional accreditation site visit.
- (3) A standing committee of the LCME will be charged with primary supervision over the Physician's Assistant program accreditation, with final approval reserved to the LCME on the recommendation from this committee.
- (4) The director of each program will be required to submit an annual report to the LCME in response to a formal questionnaire.

GUIDELINES FOR SUB-COUNCIL ORGANIZATION *

The following document, Guidelines for Sub-council Organization, was considered by the Executive Council at its February 1972 meeting. While the need for a document of this type was apparent, the Executive Council felt that the Guidelines were not ready for final approval. They were therefore referred to the three Administrative Boards for consideration and recommendations.

AAMC staff has carefully revised the Guidelines since the February meeting. Each of the Administrative Boards will have discussed them prior to this meeting of the Executive Council. Action is therefore recommended at this time.

The revised Guidelines would eliminate the artificial differences which previously existed between Groups and Sections of the AAMC by providing for only one such class of membership. Groups would be established at the initiative of the AAMC President and with the concurrence of the Executive Council. They will have no voice in the governance of the AAMC.

RECOMMENDATION

Pending the approval of these Guidelines by the Administrative Boards and taking into account any recommendations which they may make, it is recommended that the Executive Council approve the attached Guidelines for Sub-council Organization.

*Guidelines approved by Executive Council, May 19, 1972.

GUIDELINES FOR SUB-COUNCIL ORGANIZATION

There shall be the following classes of sub-council entities, organized in accordance with the definitions and specifications listed below:

- A. ORGANIZATION -- an Organization of the AAMC is defined as a membership component, associated specifically with one Council of the Association, and having voting participation in the governance of the AAMC.
1. Its establishment requires a bylaws revision approved by the AAMC Assembly.
 2. The Association shall assume responsibility for staffing and for basic funding required by the Organization.
 3. The Organization shall be governed by rules and regulations approved by the parent Council.
 4. All actions taken and recommendations made by the Organization shall be reported to the parent Council.
- B. GROUPS -- a Group of the AAMC is defined as representatives of a functional component of constituent institutional members. Groups are created to facilitate direct staff interaction with representatives of institutions charged with specific responsibilities and to provide a communication system between institutions in the specific areas of a Group's interest. Group representatives are appointed by and serve at the pleasure of their deans. Groups are not involved in the governance of the Association.
1. Establishment of a Group must be by the President of the Association with the concurrence of the Executive Council.
 2. All Group activities shall be under the general direction of the AAMC President or his designee from the Association staff.
 3. Groups may develop rules and regulations, subject to the approval of the AAMC President. An Association staff member shall serve as Executive Secretary.
 4. Budgetary support for Groups must be authorized by the Executive Council through the normal budgetary process of the AAMC.
 5. The activities of Groups shall be reported periodically to the Executive Council.
- C. COMMITTEES -- a Committee of the AAMC is defined as a standing body reporting directly to one of the official components of the Association (Executive Council, Councils, Organizations, Groups), charged with a specific continuous function.
1. Committees of the Executive Council may be charged with roles related only to governance, program, liaison, and awards.

Guidelines for Sub-Council Organization
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2. Committees of the Councils and Organizations may be charged with roles related only to governance and program.
3. Committees of the Groups may be charged with roles related only to program.

D. COMMISSIONS -- a Commission of the AAMC is defined as a body charged with a specific subject matter function, assigned for a definite term of existence, and reporting directly to one of the official components of the Association. All previous "ad hoc committees" shall become known as Commissions.

1. A Commission may be charged by the AAMC component to which it is to report, or by the Executive Council.
2. No Commission may be charged for a term longer than 2 years, at the end of which it shall be re-charged or dissolved.

4/17/72

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DISCONTINUATION OF THE FEBRUARY MEETING

At its meeting in June 1971, the Executive Council directed the AAMC staff to "explore moving the February meeting to a suitable location in March as soon as possible." An announcement was made at the October meeting of the Assembly that the AAMC would not continue to meet in conjunction with the AMA Congress on Medical Education after our commitment was fulfilled in February 1972.

Several factors precipitated this proposed change. The February date followed too closely after the Annual Meeting (three months), and past history proved that little or no business required Assembly action in February. In addition, members felt that the combined meeting of the AAMC and the AMA Congress required them to be away from their schools for too long a period of time.

The AAMC staff has discussed the possibility of a "March meeting." It was felt that the semi-annual Assembly meeting was not necessary, in view of the lack of business considered and past difficulty in maintaining a quorum. The Association Bylaws only require one Assembly meeting per year, with any additional meetings considered to be "special meetings."

The staff also felt that the individual Councils should not be constrained to meet in a central place. Councils would be free to schedule Spring meetings much in the manner that the COD scheduled its April retreat. Meetings could be arranged and coordinated independently. (Joint meetings could be similarly arranged.)

In addition, it was felt that the Executive Council should continue to meet four times annually, with the intervals between meetings more even in length.

RECOMMENDATION *

1. that the Assembly discontinue its semi-annual meeting, and meet once a year at the Annual Meeting; a special meeting of the Assembly may be called (as specified in the AAMC Bylaws) should the need be determined;
2. that the Councils (and OSR) work with staff in planning Spring meetings at a date and place of their choice;
3. that the Executive Council meet on the following dates during the coming year:

December 15, 1972
March 16, 1973
June 22, 1973
September 14, 1973

*These recommendations adopted by Executive Council, May 19, 1972.

SCHEDULE OF 1973 GSA REGIONAL MEETINGS

<u>Date</u>	<u>Region</u>	<u>Location</u>	<u>Local Host</u>	<u>Chairman</u>
March 18-20	West	Asilomar Pacific Grove California	John Watson U. of Calif. San Francisco	John Watson U. of Calif. San Francisco
April 5-7	South	Williamsburg Virginia	Miles Hench Medical College of Virginia	Robert Simmons Louisiana State U. New Orleans
May 10-12	Central	Starved Rock State Park Illinois	William Rich Loyola University	Jack Colwill U. of Missouri Columbia
June 18-20	Northeast	Bucknell U. Lewisburg, Pa.	Lester Kieft* Bucknell U.	William Fleeson U. of Connecticut
November 4-9	AAMC Annual Meeting	Washington, D.C.	None	Robert L. Tuttle U. of Texas San Antonio

*Chairman of the Northeast Association of Admisors for the Health Professions
which will meet jointly with the GSA during part of this meeting.

Report of the Ad Hoc Committee on the Establishment of a Centralized Information and Matching Program for the Redistribution of Health Manpower

I. Introduction

This committee was formed at the February 1972 meeting of the O.S.R. in order to investigate a proposal presented to the assembled representatives concerning the development of a centralized information center and matching program of financial aid coupled to a service commitment. The proposal was submitted to the Administrative Board of the O.S.R., serving as a Resolutions Committee; the following recommendation was submitted by the Board and passed by the assembly, entitled, "A Semi-Matching Program for Re-distributing Physicians and the Financial Burden of their Educations":

Recommendation: That the O.S.R. form an ad hoc committee to investigate the establishment of a centralized information center and matching program whereby students seeking financial aid coupled to a service commitment might be placed with appropriate communities, counties, regional planning commissions, etc., willing to provide financial assistance for their medical education. Their report and recommendations with supporting material should be forwarded to the chairman of the O.S.R. by August 1, 1972.

The charge of the committee, then, was to evaluate the specifics and the general intent of the proposal and make recommendations for action upon the proposal by the assembled O.S.R.

II. Method

Investigation was made through letters, meetings, phone calls, and publications; however, the great bulk of this was done by the chairman of the committee with minimal feedback from the committee members because of the necessity of written correspondence. This is unfortunate only in that the chairman was also the author of the proposal; thus, his biases in the final report of the committee should be weighed in making any decisions by the assembled O.S.R. The investigation does not pretend to have exhausted the field and found limited cooperation in certain areas, no doubt a product of researching by mail. Some findings are in the appendices.

III. Discussion

Because of the nature of the method, the original intention of the proposal--to initiate debate and discussion around a specific program to facilitate the redistribution of physicians--was not fulfilled. The committee's report will try to provide more information concerning the underlying and pragmatic considerations of the proposal to facilitate the intended debate by the assembly, provide a number of options available to the O.S.R. assembly, and provide the committee's (i.e., the proposal's author) recommendation.

A. The Financial Arrangement

Two problems are immediately apparent in the proposal concerning financial arrangements: 1.) from where would funds be generated for initiation and administration, given O.S.R. implementation? and 2) was the financial

arrangements proposed between student and community realistic and the best design for the purposes stated in the proposal? The latter question is the more significant, as any grant proposals or other fund solicitation would turn on the specifics of the program sought. Significant criticisms have been made on this latter question, including the following:

- 1) medical students' interests change by the experience and socialization process of medical school, as well as in marital status, etc.;
- 2) personal service contracts are not enforceable by law, so a community's only recourse in broken contracts is suing for damages;
- 3) financial aid is a questionable issue around which to develop tentative or total plans for practice;
- 4) such "indentured service" would apply predominantly to the poor;
- 5) only wealthy communities willing to wait for the returns of their investments would participate; and
- 6) similar programs have not worked satisfactorily in the past.

If the intent of the original proposal's contractual relationship is perceived less as a financial relationship than a mutual, on-going relationship brought about by a financial mechanism (among others, these criticisms lose much of their potency. Of course, this relationship must be fostered by other mechanisms (see recommendations below); also, to limit the financial mechanism only to that described would ignore the intent of creating a relationship between a student or house officer and a community prior to settling in the community. Alternative methods of financing and organization and/or centralization of existing programs should be considered and employed where possible and appropriate. Such alternative methods might include the following:

- 1) community funds pooled as a bank so that a student might enter the program in the beginning of his training, drawing support from pooled or foundation funds, and establish community ties late in his training with a community which might just have entered, if there is no waiting list;
- 2) foundation support similar to the defunct Sears plan, but with third party assessment of need and pre-commitment negotiation and planning with student/house officer;
- 3) junior and/or senior year financing (i.e., salary) with post-internship service, similar to PHS early commitment program or Armed Services programs, etc.; and
- 4) financing positions in medical school classes (scholarships, loans, etc.) for which admission is dependent upon willingness to make commitment on matriculation (the nature of which can be determined later in one's training).

The importance of the relationship between student/house officer and community should not be limited by inflexible or inadequately research mechanisms and where possible, should not be limited to a purely financial relationship.

B. Recruiting and Retention

The National Health Service Corps recently began efforts in a little more than 100 communities throughout the country, physicians serving two years which will exempt them from the draft. Alternative service will continue to attract young physicians as long as there is a draft, which will continue as long as the Armed Services cannot attract sufficient health personnel or educate them themselves. Any program established with purposes parallel to the Corps should seek draft exemption for its participants.

The financial and planning arrangement between student/graduate and community should contribute to recruitment on both sides. Suitable methods of advertising and information distribution would be required.

Existing two year service commitment as alternatives to the draft (such as the NHS) have a serious problem in retention as this service is often viewed as "putting in time" and leads to serious breaks in the continuity of care. Extensive expansion of the Corps might provide redistribution of manpower and improve certain areas; however, it would institutionalize and legitimize two unequal health care systems, regardless of national health insurance.

Retention involves many aspects of medical and non-medical socialization. With medical schools almost entirely teaching hospital oriented, few graduates envision a valuable practice far from the teaching center or without admitting privileges to such a hospital, without the aids of extensive laboratory facilities, consultants, and ancillary health workers, without the "interesting" patients seen in their training. Non-medical problems of retention involve family problems (particularly non-physician spouses), educational opportunities in the inner city or rural community, and all the other factors which lead to physicians and others not settling in the inner city or in rural communities. To affect these aspects would either require a transformation of the environment in which the physician practices or the physician *per se*. By altering admissions practices (i.e., seeking the predictors of rural or inner city practice and then seeking such candidates), physician training and socialization, and the nature of rural and inner city practice (through group and team practices, HMO's and R.P.'s), the gradual centralization of medical care in the medical center might be slowed or reversed. To this end programs should be supported that encourage this; specifically, a student advisory committee should be formed both for new schools developing curricula and established schools revising them, as well as legislatures reviewing or establishing these, admissions committees, etc.

C. Research

A great deal of speculation is made concerning what will work and what will not. Research is needed to predict admission candidates who are most likely to fulfill whatever goals a medical school establishes as its own; these goals should be articulated and public. The effects of the socialization process of medical school and innovations (such as HMO, Wisconsin's summer G.P. program, Yale's Navajo program, etc.) should be known. The qualities that create a successful and rewarding rural or inner city practice, from the nature of the community to the personality of individual physicians in a group would help significantly in determining what evolving graduates are likely to be attracted to or committed to. The experience of the National Health Service Corps should be studied as well as HMO officers.

Historical analysis of previous projects along the lines of that proposed, both in financing and in establishing student-community relationships in planning, education, identification for medical school admissions, etc., should be made. Characteristics associated with success could then be identified. This would be the first step in implementation of a funded program.

D. Implementation

The most difficult aspect of this proposal is developing a realistic and workable plan for implementing its goals in concrete mechanisms. This might best occur on several independent but coordinated levels.

- 1) Organization of a student advisory panel to work with developing and established institutions through the Institutional Development office of the AAMC, providing input supporting III-B above.

- 2) Continuation of an OSR committee to monitor and develop the proposal through
 - a) investigation of federal programs
 - b) investigation of planning of National Health Service Corps
 - c) contact with AAFP and AAGP
 - d) communication with programs in family practice, departments of community, social, and family medicine
 - e) communication with admissions/financial aid programs at existing and developing medical schools
 - f) identification of successful student-community projects.
- 3) Initiation of independent and funded study-group through the executive committee of the OSR which would
 - a) develop grant application for such a study-group
 - b) generate information and research areas of 2a-f above
 - c) seek funding for pilot project
 - d) establish pilot project
 - e) provide centralized information on all related agencies and generated information.
- 4) Periodic review by the OSR of actions and efforts of study-group and pilot projects.
- 5) Eventual expansion of pilot projects.

IV. Recommendations

The OSR assembly has a number of alternatives which it should weigh rather than voting merely on the written proposal verbatim. The following are the options available to the assembly with a short summary of consequences:

- A. Defeat or table the proposal.
This action would indicate that this issue, or this method, was not a primary priority of the OSR. It would essentially allow the status quo to persist, even with the AAMC's support of the National Health Service Corps, without intervention or further study
- B. Pass the proposal as stated.
This action would give priority to this issue in the OSR and dictate specific details of the financial mechanism by which the proposal would become instituted. This would be support the written proposal but not necessarily fund it, as the OSR itself does not have this power, thus, not necessarily guaranteeing its inception.
- C. Pass the proposal as stated, as well as committee recommendations.
This action would be similar to "B" above with the addition of such suggestions as:
 - 1) creation of a student advisory panel to work with the Institutional Development department of the AAMC
 - 2) creation of a student liaison committee with the AAMC's committee on national service plan and Selective Service (Dr. John Gaughey)
- D. Defeat the proposal as stated, but support the recommendations (C).
- E. Accept and approve the committee's report through III-D-2.
This action would extend the ad hoc committee's role in research and study towards ultimate action, without such action. This would indicate that the OSR did not feel that sufficient data had been presented for final action.
- F. Accept and approve the committee's report in toto.
This action is similar to "B" above but includes flexibility in development, the additional committee recommendations, continued study and review while attempting to institute active programs.

The committee supports either "F" or "E" (in that order) with its inherent bias.

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Association of American Medical Colleges
Organization of Student Representatives

GOALS AND PRIORITIES

The Organization of Student Representatives (OSR) of the Association of American Medical Colleges (AAMC), related specifically to the Council of Deans and staffed by the Division of Student Affairs, shall have as its general purposes:

1. The creation and maintenance of channels of communication among students of the health professions, to insure that all such students have access to the Organization of Student Representatives and are consequently made aware of the issues confronted by the OSR and the AAMC.
2. The creation within the academic health center of a forum for the exchange of views concerning old issues and the generation and elucidation of new ones. It is primarily the goal of the OSR to affect the content and direction of the issues addressed by the AAMC.
3. To provide a vehicle for the discussion of problems of students of the health professions as they relate directly to the academic center and the educational process.
4. To initiate and sustain comprehensive consideration of the undergraduate, graduate, and continuing education of the health professional as that education relates both to himself and to the society that he serves.

OSR PRIORITIES: NOTES OF GROUP DISCUSSIONS HELD DURING
OSR BUSINESS MEETING, FEBRUARY 3, 1972.

(The following discussion reports are reproduced as submitted by the recorder for each group, without editorial correction.)

- A. We believe that the purpose of the OSR is to be a means of communication between medical schools. Though the OSR should provide input of student ideas to the AAMC, these ideas must reflect our experiences and knowledge, not mere philosophical or political opinions.

We want to avoid having the OSR become a resolution mill, such as SAMA. Though national health issues are of critical importance, these issues are so complex that few students have the time to become as well informed as the AAMC staff. Thus it seems difficult for the OSR to constructively affect the AAMC position on national issues.

On our own schools, curriculum, and problems, however, we are relative experts. It is in these areas that we are able to constructively affect the AAMC and our own schools.

Problem solving within schools and minority affairs were thought to be useful issues.

- B. The interests as individuals and representatives of our student body reflects our concern to the direction of the OSR and our role in the AAMC.

Topics of concern:

1. Expense of traveling to and from national and regional meetings.
2. Strong endorsement to pursue the establishment of the elective information program. Exchange through this experience will be to the benefit of an elective system.
3. Promotions and discrepancies of promotions within the medical schools.
4. Consider the problems of the pass-fail system.
5. National Board Examinations and other licensure exams and their effects over our practicing.
6. Distribution of physicians into the rural area--community recruitment.
7. Problems of the two-year schools, i.e., transfer, clinical experience, curriculum, etc.
8. Course evaluation program.

The OSR should move to facilitate communication among students pertaining to medical education.

- C. 1. Philosophy: Should OSR accept an "advisory" role as planned by the COD? Consensus was that we should not only act on COD proposals but should generate completely new ideas to go to resolutions committee of COD. It was also noted that the OSR is limited in potential power by lack of specific appropriation from AAMC. However, our representatives do have floor privileges in the AAMC assembly to partially offset this lack of power.

Specific ideas:

2. OSR should support projects begun by SAMA--e.g.:
MECO (preceptorship plan for graduating college seniors,
medical students for summer work on medicine)
Health care of migrant workers, etc.
AAMC should work for academic credit for such projects.
 3. Re: Physician Draft. OSR and AAMC need to define and lobby for a
specific solution.
 4. Funding of medical school education: OSR and AAMC should investigate
"any and all ways" of additional funding of students at the individual
medical school level:
e.g. - AAMC establishment of central loan and/or scholarship fund.
e.g. - differential funding for minority applicants to medical
schools--especially in cases where student would contribute
to support of family if not in school.
 5. Community Health Reorientation of Medical Students: How can AAMC
help change the attitude of medical school admissions committees away
from admission of "super-students" and toward that of students with
genuine desire to practice "humanitarian" medicine?
--AAMC may develop a model for evaluating college seniors in
such a way as to predict their performance in clinical years
and after.
--MCAT is not a good test for this--selects out good test-takers.
--A problem-solving MCAT consisting of "think" questions would be
a good first step.
 6. OSR should find out what was said when AAMC testified before Congress
on November 15, 1971, regarding national health insurance. Do we know
the AAMC position on this?
 7. Re: Admission of Americans trained abroad to internship and undergraduate
medical programs in the U.S.
--Each medical school dean should be notified via the AAMC about
this issue--if pressure is applied personally, action may result.
--The AAMC could officially evaluate the foreign medical schools
to which Americans go in such a way that re-entry of these
students to U.S. programs would be made easier.
- D.
1. Russ Keasler knows of many trusts and grants for students which are not
utilized. OSR should form a committee to investigate and correlate
this information, so that these monies may be used more effectively.
Suggest the Finance Committee handle this or form a subcommittee.
 2. Distribution of physicians to rural and city (ghetto) areas. In this
light there should be a committee set up to investigate what is being
done and OSR's role in all this.
 - a. Find which medical schools have family practice emphasis and how
other schools can do the same, and how other students can get involved.
 - b. Also investigate whole area of use of paramedicals and use of heli-
copters, etc., to airlift people (M.D.'s) into areas of need.

3. Need for more M.D.'s in general. Are we sacrificing quality for quantity? Investigate ways of increasing number of M.D.'s (i.e., three year programs, admission of classes in September and January, combined undergrad-medical school of less than 8 years, etc.).
4. Whole issue of military and medicine.
 - a. Increase present payment to medical students in return for military service.
 - b. Possibility of a military medical school.
 - c. Issue of physician draft.
5. OSR should have on hand the present grading systems and basic curriculum set-ups of all medical schools, so that this information can be used when other OSR members need statistics in order to aid arguments in trying to update their own schools.
6. Careful examination of where SAMA and OSR cross lines and where we are doing the same thing. This will limit wasted effort.

E. Short Term Priorities:

1. Exchange elective programs and credit vs. pay.
2. Establishment of communication with allied health professions students on how we can better work together.
3. Establishment of information centers for returning military personnel on how to become involved with the health professions.

Long Term Priorities:

1. Support and promote establishment of social action corps of physicians in domestic service.

- F.
1. Opening and maintaining channels of communication between students.
 2. Examination of national health insurance.
 3. Examination of the doctor draft--should female M.D.'s be included.
 4. National Student Conference on Medical Education?
 5. Focusing on ways to bring changes down to an individual institutional level.
 6. How to influence distribution of M.D.'s--tax incentives?
 7. Role of Community Hospital in teaching.
 8. Definite mechanism for dealing with students' schools that have problems obtaining funds for attending meetings.
 9. If the AAMC adopts positions on certain matters that the OSR is opposed to, should we issue dissenting counter position papers?
 10. Credit for summer programs.
 11. Ad hoc committee on problems of developing three-year programs.
 12. Sharing of information on how schools determine who is admitted.

G. I. Doctor Draft

- A. More equitable system: Why double jeopardy? Age discrimination?
- B. Earlier lottery, to allow students to plan career.
- C. More alternatives to military service.
- D. Elimination (?)

- II. Health Care Delivery
 - A. Endorse a general statement of principles re: National Health Care legislation.
- III. Increased economic aid from federal government to medical education.
 - A. Emphasize increased funding of teaching positions and activities.
- IV. Licensure Procedures
 - A. Evaluation of FMG licensing.
- H.
 - I. We propose that the COD begin to invite/organize House Staff membership in the AAMC before the next national meeting. (N.B. It may be useful to work with the National House Staff Association.)
 - II. We encourage representatives to inform medical students about the AAMC and OSR and encourage the use of both groups as a clearing house for information.
- I. Eliminate the dichotomy between (1) the federal pressure for more doctors and improved medical education and (2) the paucity of funds expended (not appropriated) by the government for building, etc., given that most medical schools don't have the necessary resources to do it themselves.

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A RESOLUTION FOR CONSIDERATION BY THE OSR

Whereas participation by medical schools in the military manpower procurement procedure is neither a legal requisite nor a professional responsibility, and

Whereas the release of information on students to outside agencies without the knowledge or permission of the subjects is a violation of individual liberty,

Therefore, be it resolved that the Organization of Student Representatives of the AAMC strongly recommends to the Council of Deans that all member schools refrain from releasing any information to the Selective Service System except at the specific request of each student involved.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Division of Student Affairs

Submission of Enrollment and Graduation Information
to the Selective Service System by U.S. Medical Schools*

On May 25, 1972, the AAMC Division of Student Affairs distributed to the student affairs officers at 115 U.S. medical schools a questionnaire concerning the submission of information about enrolled and graduating male medical students to state and local Selective Service offices. Seventy-two schools returned completed questionnaires within one month. On June 21 a second request was sent to those schools which had not yet returned the questionnaire, and 34 additional responses were received (94% return).

Of the 108 schools which responded to the questionnaire, two are new schools without students.

A. Submission of SS103 forms (N = 106 schools)

Forty schools submit SS103 forms automatically for all enrolled male students at the beginning of each year. Sixteen of these also submit SS103 forms automatically for all male graduates and two will do so upon written request. Thirteen of these noted, however, that they do not submit these forms for any student who specifically requests that they not be submitted.

Sixty schools submit SS103 forms at the beginning of each academic year only upon request of their male medical students. Twelve of these will do so upon verbal request from a student; the others require written requests. Four of these schools also submit SS103 forms automatically for all male graduates and 14 submit the forms for male graduates only upon request (eleven of these require written requests).

Two schools reported that SS103 forms are sent by the school only for male graduates who request, either verbally or in writing, that this be done.

One school submits SS103 forms automatically at the beginning of each year only for those enrolled students who are classified I-A, II-A, I-S, and II-S.

One school submits SS103 forms for all male students upon acceptance into the first-year class.

Two schools never submit SS103 forms but leave this responsibility to their students.

Of the 108 respondents, 14 are either two-year schools or new schools which have not yet had a graduating class.

B. Submission of lists of male graduates to state Selective Service offices
(N = 94 schools)

Twenty-six schools reported that lists of male graduates are never submitted to state SS offices. One of these noted, however, that names of graduates are usually printed in local papers and would be available to the Selective Service System.

* Prepared by Suzanne P. Dulcan, DOSA Administrative Assistant

Twenty-four schools reported that such lists are sent automatically each year.

Eleven schools send lists of only those graduates who request in writing that this information be provided to state SS offices.

Nine schools routinely provide the graduation program to state SS offices.

Seven schools reported that a list of graduates is sent annually to the state SS office in response to an annual specific request for such a list.

Six schools will provide lists of graduates as requested by state SS offices, but these schools did not indicate whether or how often such requests are received.

Five schools reported that they provide to the state SS office a list of those graduating students who have earlier requested that SS103 forms be submitted for them.

Three schools indicated that they do not provide lists of graduates to their state SS offices but noted that they do provide lists of fourth-year students to the Berry Plan office in DoD in response to annual requests from this office.

One school reported that the state SS office has not requested lists of graduates but that information about graduating students is supplied to their individual local draft boards upon request.

One school reported that it does not provide a list of graduates to its state SS office but does send individual letters to the local draft board of each graduating student to inform the boards of the change in status of these students.

One school reported that it had been advised by its attorney to provide a list of graduating students to the state SS office but that it does not provide students' Selective Service numbers or addresses with this list.

C. "Additional Comments" included the following:

1. "We routinely sent 103's in about May 1 on all accepted incoming students. The registrar then sent one in during the fall and yearly thereafter. After the Central Group GSA meeting in East Lansing we have changed our policy to:
"1) Our acceptance letter states that the student must tell us in writing if he wants us to send a 103 to his board.
"2) The Dean has directed the Registrar to carry out a similar policy.
"3) People in our office in talking to people in some other schools feel that forms are being sent in routinely by admissions and registrars that assistant and associate deans aren't aware of (which was true of me six weeks ago)."
2. "It would certainly save us a lot of time and energy if we could submit SS103 forms for all entering freshman students, and a list of the graduating senior students with their SS Numbers and B.D. with additional forms being sent for any of those students who discontinue their education during the interim, or new students transferring in.

"At the present, we send in SS103 forms for all students at the beginning of each academic year. The information supplied for any individual student does not change during his four years of attendance at this College of Medicine."

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