ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Business Meeting

October 21 and 22, 1978
New Orleans Hilton Hotel
New Orleans, Louisiana

I. Call to Order

The meeting was called to order by Paul Scoles, Chairperson, at 2:30 p.m.

II. Declaration of Quorum

Paul Scoles declared the presence of a quorum of the Organization of Student Representatives.

III. Consideration of Minutes

The minutes of the November 5 and 6, 1977 business meeting were approved without change.

IV. Nominations for Office

The following OSR members were nominated for national office:

Chairperson-Elect:	Dan Miller, University of California, San Diego John Cockerham, University of Virginia
Representatives-at-Large:	Arlene Brown, University of New Mexico Stephen Sheppard, University of Southern Alabama Molly Osborne, University of Colorado Lawrence Galea, University of Cincinnati Tim Kreth, University of Arkansas Douglas Hieronimus, University of Oregon Ernie Hodge, University of Texas, San Antonio Bob Levine, Loyola-Stritch Fred Emmel, George Washington Lola Sutherland, University of Minnesota, Minneapolis Andrew Leuchter, Baylor

V. Remarks from GSA Chairman

Dr. Marilyn Heins reported that the Group on Student Affairs shares many OSR concerns. She pointed out that one of the ways the OSR can communicate their priorities is through membership on GSA committees, especially in the area of financial aid. She also reported that the GSA Ad Hoc Committee on

on Professional Development and Advising recently completed its work; the resulting, forthcoming monograph on professional and career counseling will be of interest to the OSR. One of the activities of the GSA Steering Committee has been working with the ophthalmologists with regard to the Ophthmology Matching Program. Dr. Heins also noted that the GSA would meet following the Annual Meeting to discuss the GSA in the 1980's. She pointed to two problems which have not been adequately addressed: the gap in counselling during residency and the need for change in post-graduate advising as laws change. In her closing thoughts, she stressed the need for working together to achieve improvements.

VI. Welcome from Dr. Cooper

Dr. John A. D. Cooper, President of AAMC, welcomed the OSR to the Annual Meeting with the hope that they would take advantage of this opportunity to participate in the affairs of the Association. He told the OSR that they have been ably represented by their Administrative Board, who have worked diligently in helping to shape and develop the Association's policies and programs. He affirmed the importance and the influence of the OSR in providing input which is melded with the inputs of all the other councils and constituencies that make up the AAMC. He also expressed the hope that OSR members would get a chance to attend other than OSR meetings in order to get a flavor for the overall Association.

Dr. Cooper mentioned four recent projects which he thought would be of particular interest to the OSR. The first of these was the report of the Task Force on Student Financing, the publication of which was followed by a meeting about financing for medical students with Joseph Onek, Deputy Director of the White House Domestic Council. Dr. Cooper said that they would continue to seek new and different ways to support medical students and to maintain socio-economic diversity within medical student bodies. The second project he noted was the report of the Task Force on Minority Student Opportunities in Medicine, which suggests why the goals set forth in 1971 were not met as well as offering a set of new recommendations which will help schools develop better ways to redress imbalances. Thirdly, he reported that at the end of September, the V.A. announced a substantial cutback in the number of residencies available in V.A. hospitals, which are usually a part of the integrated residency program at academic medical centers. This action, which would have been a serious blow because of the increase in the number of graduating medical students and because of the effect of cost containment and new controls on the development of new residency programs, was forestalled by reinstatement of three-quarters of these 400 positions after negotiations with AAMC. He concluded with the comment that the OSR Report has been found very satisfactory and that this publication will continue to be funded.

VII. Report of the Chairperson

Paul Scoles began by expressing the view that this year the Administrative Board of the OSR had set out to consolidate and to improve the position of the OSR within the Association. This is the year, he said, the OSR became integral rather than incidental to the AAMC--a role which should be continued. He noted that students served on all active task forces and groups, including

the Task Force on Graduate Medical Education, the Task Force on Student Financing, the Task Force on Minority Student Opportunities in Medicine, the Task Force on the Support of Medical Education, the Advisory Panel on Technical Standards for Medical School Admissions, the Working Group on Withholding of Physicians Services, Steering Committee of the Group on Student Affairs, and the Editorial Board of the Journal of Medical Education. He also noted the significant step forward in the appointment of two student members to the LCME.

Mr. Scoles lauded the OSR Report, the only publication which is distributed without charge to all medical students in the country, as a successful enterprise in improving communications between the OSR and its constituency, and said he was delighted to hear that Dr. Cooper will continue to support it.

He next addressed the financial aid dilemma which faces medical students. He reported that the OSR had been actively involved with the GSA Committee on Financial Problems of Medical Students and with the Task Force on Student Financing in investigating alternatives and formulating recommendations on this exceedingly complex problem. The era of easy money is over; only aid with either a service commitment or a high interest level will be available in the future. He expressed the fear that this situation will create a two-class society of medical students: the wealthy and the increasingly large number who cannot afford the cost. He expressed the additional fear that the service-required scholarship programs will soon be oversubscribed, forcing individuals to seek lucrative practices in order to repay debts. The new Health Education Assistance Loan (HEAL) program requires those who borrow $8,000 per year for four years (at an interest rate of 12 percent with the deferred interest payment option) to return a total repayment of $148,709. The prospect of such a debt level, combined with the debt acquired in setting up practice, buying a house and starting a family will frighten prospective candidates away from the profession. The task ahead is to convince the persons responsible for the implementation of the HEAL program that it is a punitive and damaging program. However, the prospects for doing so are not promising because the answer is always the question of why medical students should be subsidized by society.

He addressed HR 2222, the bill which would define house staff in non-public hospitals as employees for coverage under the National Labor Relations Act and which was not acted upon by the 95th Congress. He noted that he understood that Representative Thompson, the sponsor of the bill, proposes to reintroduce it and that the OSR would be kept informed of its progress. He reported that the OSR continues to take an active interest in house staff affairs and that a new AAMC working group has been appointed to consider in what ways the AAMC's responsibilities to its constituents could be benefited by housestaff input and to propose mechanisms for achieving such input; Jim Maxwell, OSR Representative-at-Large and first-year resident in Radiology at Vanderbilt, has been appointed to this group.

Next addressed was the related topic of the involvement of the OSR in graduate medical education. Cheryl Gutmann is the housestaff representative on the Task Force on Graduate Medical Education, and Dan Miller, the student member. He reported on the progress achieved in the area of

increasing the amount of information available about graduate medical education, since the passage of a resolution at the 1977 OSR business meeting recommending investigation of the publication of a directory which would contain more information than is currently available in the NRMP Directory or in the AMA "Greenbook." He reported that such an undertaking was discovered to be impractical because of the resources required and that instead the Administrative Board had adopted a three-pronged approach to the expansion of information on graduate training programs: 1) the Spring 1978 edition of the OSR Report on the residency selection process; 2) initiation of on-going discussions with Jack Graettinger, Executive Vice President of NRMP, which have resulted in the inclusion of a grid in the October edition of the Directory and the discovery that working with the new staff at the AMA on the "Greenbook" might prove a more profitable route; and 3) development of a model questionnaire for evaluation of graduate training programs, which will be distributed to student deans and OSR members before the first of the year.

Other issues, he reported, which the Administrative Board has discussed are the large numbers of students and physicians-in-training, threatening a serious danger of creating an oversupply of physicians. He pointed to the recent report of the Association of Professors of Internal Medicine which showed a shift among internists toward subspecialization and noted that this shift away from primary care is seen as detrimental and that the AAMC is recommending that the number of fellowships in internal medicine and pediatrics be decreased. On this topic, he concluded that this will be a hotly debated issue, both inside and outside the AAMC, and urged the membership to keep informed about it, referring them to Dr. Robert Petersdorf's article in the September 21 issue of the New England Journal of Medicine. Another issue he noted is the development of offshore medical schools, whose function is to attract disappointed applicants to American medical schools. He described these proliferating schools as "rip-offs" which the AAMC is trying to keep its constituents informed about.

Mr. Scoles thanked the leaders of other medical student groups, namely, American Medical Student Association, AMA-Student Business Section, Student National Medical Association, Student Osteopathic Medical Association, and American Academy of Family Physicians-Student Affiliate, who with the OSR have succeeded in forging a strong working relationship. He expressed the expectation that this relationship would continue and the feeling that working with these groups had been for him a profitable and worthwhile experience. He thanked Diane Newman and Janet Bickel for their contributions to the OSR and praised Bob Boerner as a continuing source of assistance. Mr. Scoles also commended the Administrative Board for their exceptional cooperation, singling out Jim Maxwell and Cheryl Gutmann who have served for more than a year.

In conclusion, he remarked that if as chairman he had fallen short in his duties, it was in not sufficiently challenging the Association. He maintained that the OSR has the responsibility to keep the Association alert and aware of what is going on in the minds of students. He stressed

that there are some points which it may be necessary for students to make over and over again, that students have a certain responsibility to do the undoable. Finally, he thanked the membership for the opportunity to have served them as chairman.

VIII. Report of the Chairperson-Elect

Peter Shields reported that the past year of serving the OSR had been an interesting and educational one for him and that on behalf of the OSR he had attended the AMSA national convention, two consortium meetings, and meetings of the Task Force on Support of Medical Education and the Liaison Committee on Medical Education (LCME). As background on the Task Force, he gave a brief history of federal support of medical education. He explained that the Task Force is charged with recommending appropriate legislative proposals for Association support on the extension of existing legislative authorities. He next outlined the nine recommendations set forth in the preliminary report of the Task Force. The LCME is recognized by the Office of Education in the Department of Health, Education and elfare as the official accrediting body for all medical schools in the U.S. and its purpose is to assure that the nation's medical schools are providing quality medical education. Last year the Federal Trade Commission brought suit against the LCME, charging it with restraint of trade by one of its parent bodies, the AMA. Although the Office of Education did renew the LCME's accrediting power, it offered suggestions, which might help in the future to preclude such challenges of its impartiality. One of these suggestions, he reported, was the appointment of two non-voting student members, one each to be recommended by the AMA and the AAMC. He explained that the Administrative board of the OSR had conducted an extensive search for his successor to this Committee and that in June the Chairman of the AAMC approved the OSR's nominees, Lee Kaplan from Albert Einstein.

Mr. Shields offered his views on where the OSR might best concentrate its efforts in the future. His first recommendation was that the OSR should push for Congressional adoption of the recommendations of the Task Force on Student Financing, in light of the worsening financial plight of many medical students. Secondly, recognizing the Association's interest in graduate medical education and the fact that currently house officers have no voice in academic medicine, he stated that the OSR should encourage representation of house staff in the AAMC. Next, in order to help reduce the great investment of time, money and energy required in seeking a residency position, Mr. Shields recommended that the search for a uniform application process for graduate medical education be reopened. Lastly, he supported the continuing publication of the OSR Report. In conclusion, he thanked Diane Newman, Janet Bickel and Bob Boerner for their help, guidance and friendship and the members of the Administrative Board for their dedication.

IX. Report of the Student Member on the AAMC Task Force on Graduate Medical Education

Cheryl Gutmann first reported that a significant step had been taken in the appointment of a small working group to study ways in which house staff input to AAMC programs and policies can be achieved. She next

listed the five Working Groups of the Task Force on Graduate Medical Education: Transition from Undergraduate to Graduate Education, Quality, Specialty Distribution, Accreditation, and Financing. She pointed out that the Transition Working Group is the only one to have thus far completed its work and that its report includes the following recommendations: to improve the quality and availability of information about residency programs; to modify the time table for the application process to allow more time for decision-making for both programs and students and to develop a uniform application process. Dr. Gutmann noted that these and the other recommendations addressed concerns both of the OSR and the GSA. She explained that the Working Group on Quality was dealing with the issues of institutional responsibility for providing quality programs and of methods of evaluating residents and programs, all in the context of providing optimal patient care. She concluded by saying that she and Dan Miller would continue to report to the OSR on the progress of the Task Force and to try to reflect OSR concerns to the Task Force and its Working Groups.

X. Report of the Central Region Chairperson

Dennis Schultz described the format of the 1978 spring meeting, at which one day was spent in small group discussions of three separate topics: student stress, admissions and transition from undergraduate to graduate education; he offered to help other regions to plan similar workshops for their spring meetings. He expressed the view that the local level is an effective place to deal with issues and that the GSA is the greatest ally of the OSR.

XI. Report of the Student Member on the Special Advisory Panel on Technical Standards for Medical School Admissions

Molly Osborne explained that this panel was established by the AAMC Executive Council in March, 1978, in response to HEW regulations dealing with the admission of handicapped individuals to programs receiving federal assistance. She noted that a survey of medical schools revealed that although academic standards for admission are generally clearly defined, few schools have developed technical standards. She reported that the panel has agreed that the primary responsibility for student selection and curriculum content rests with each medical school faculty and that the M.D. degree should remain a broad, undifferentiated degree attesting to general knowledge in all fields of medical practice. The panel, she said, is expected to complete its work by the end of this calendar year. She summarized the complexity of the issue of HEW involvement in these matters and how the panel is working to develop a series of technical standards which will hold up in the courts.

XII. Report on the Western Region Electives Project

Dan Miller described this project which was created at the spring meeting in recognition of the difficulty students have in procuring information about taking electives at other medical schools. He explained that the Western schools worked together to develop a uniform format for collecting information on availability of electives, application procedures, housing and all related matters. This information was then collected and shared. He reported that the Western region would be glad to share the format they developed with the other regional chairpersons.

XIII. Report of the Student Delegate to the Board of Trustees of the American Academy of Family Physicians (AAFP)

Marla Tobin reported on the fifth annual meeting of the AAFP which was held in September at their headquarters, Kansas City. She described a number of the projects and concerns of students who are interested in family practice and who attended this meeting. One of these is the Directory of Family Practice Residencies which is coming out in May and which is compiled by students, residents and program directors across the nation. She noted that this will be a very comprehensive directory, which will help students to decide where to interview and what kinds of programs are available, and that it will be free upon request. Another project has been the development of a packet of information on how to start a local family practice club; she noted that the packet also includes information on activities of established clubs, program ideas, and funding suggestions. She reported that another project is working to establish quality family practice clinical experiences at schools which do not offer them. She also told the OSR that the Academy provides a hotline (800-821-2512) during the Match for unmatched students who are looking for family practice residencies and that this line is open all year to answer questions about family practice. Ms. Tobin concluded by indicating that students are an integral part of the Academy and that their programs are available not only to those who have paid dues but to anyone who is interested in learning more about family practice.

XIV. The meeting was recessed at 5:30 p.m.

XV. The meeting was recalled to order by Paul Scoles at 12:30 p.m. on October 22.

XVI. Mr. Scoles declared the presence of a quorum of the OSR membership.

XVII. Elections

In addition to the nominations offered the previous day, Barbara Bergin (Texas Tech) was nominated for the office of Representative-at-Large.

ACTION: On motion, seconded, and carried, the OSR elected the following representatives to national office:

Chairperson-Elect:	Dan Miller
Representatives-at-Large:	Barbara Bergin
	Stephen Sheppard
	Molly Osborne
	John Cockerham

XVIII. Report of Chairperson of AMA Student Business Section

Bartholomew Tortella reported that the group which he represents is looking forward to continued cooperation with the OSR. He remarked that one goal which the two organizations could strive for together is the inclusion of students on LCME site visit teams. He said that an important point to

underscore is that the OSR should have two roles--input and impact, impact by resolutions and by Administrative Board decisions, which should be firm and unfettered by outside influences. He closed by expressing the hope that the OSR would be an effective and vigorous influence to force changes which would benefit the organization and American medical education in general.

XIX. Resolutions

A. Medical Student Stress

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

WHEREAS, the OSR has been concerned with the issue of undue stress in medical school for many years, and

WHEREAS, the housestaff shares similar concerns about undue stress in residency programs, and

WHEREAS, undue stress in both medical school and residency programs may contribute to increased alcoholism, drug addiction, emotional and mental disorders and suicide,

BE IT THEREFORE RESOLVED, that the OSR Administrative Board review the large body of data it has collected on the stress in medical education and, in conjunction with housestaff, seek specific methods to reduce stress (such as more realistic workload, less sleep deprivation, support groups, trained therapist on the staff of residency programs).

B. American Medical Students Studying Abroad

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, there are more qualified applicants than first-year spaces in American medical schools;

WHEREAS, many of these qualified students are studying medicine in foreign countries;

WHEREAS, there are spaces available in American medical schools in the second and third years due to attrition;

BE IT THEREFORE RESOLVED, that the OSR strongly encourage all American medical schools to give the same consideration to American students from foreign schools as they give to any other applicants for openings mentioned above.

C. Federally-supported Loans

ACTION: On motion, seconded, carried, the OSR approved the following resolution.

WHEREAS, in many cases the income in residency years is not adequate to accomodate the debt burden established during the medical school years;

WHEREAS, students shouldering large debt burdens may choose specialty areas on the basis of income in order to facilitate repayment of their debts;

WHEREAS, medical school affiliated residencies in only some cases aid in deferment of the loan throughout residency years;

WHEREAS, residents in non-medical school affiliated hospitals do not have this option;

WHEREAS, past resolutions of this kind have not succeeded in generating a change in repayment policy;

BE IT THEREFORE RESOLVED, that the OSR strongly urge the Administrative Board of the OSR to maximize all efforts to obtain a deferment throughout residency years for repayment of all federally supported loans.

D. Equal Rights Amendment

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, the ERA has not been ratified in accordance with Constitutional law by two-thirds of the states, and

WHEREAS, the OSR supports the passage of the ERA;

BE IT RESOLVED, that the OSR strongly urges that no AAMC sponsored regional or national conventions be scheduled in states that have not ratified the passage of ERA.

E. Course and Curriculum Objectives

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, medical science curricula presents to the students a large amount of facts and concepts;

WHEREAS, a student needs guidelines both for the specific course and for the curriculum in general in order to alleviate academic stress,

THEREFORE, LET IT BE RESOLVED, that the OSR urges the AAMC to encourage medical schools to institute and make available to students specific course objectives and overall curriculum objectives.

F. Planning Families

ACTION: On motion, seconded, and carried, the OSR approved the following two resolutions:

1. WHEREAS, some medical students plan families during medical school and many schools are willing to change schedules to allow their students to continue their educations in a manner acceptable to these students,

BE IT RESOLVED, that the OSR urges the AAMC to support the actions of these medical schools and urges continuing support and flexibility by schools in dealing with these students.

2. WHEREAS, some residents plan families during the course of their residency years and scheduling of these pregnancies has been potentially problematic,

BE IT RESOLVED, that the OSR strongly recommends that the AAMC urge residency programs to extend maximal flexibility and support to these residents.

G. Smoking

ACTION: On motion, seconded, carried, the OSR approved the following resolution.

WHEREAS, smoking has been proven to be detrimental to individual and public health;

WHEREAS, studies support that non-smokers also are affected by smoke in enclosed public areas;

WHEREAS, we as health professionals should provide leadership to improve our own health as well as that of others;

BE IT RESOLVED, that the OSR restrict smoking to designated areas at all meetings and strongly urge the other member organizations of the AAMC to do the same.

H. Government Funding for Abortion Services

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, federal funding under the Medicaid program for abortion services should be reinstated as a matter of social equity and rights to privacy of low-income women, and

WHEREAS, lack of funding availability for abortion services potentially will result in substantially increased health risks to women who will seek out low cost, low quality services or attempt self-induced abortion, and

WHEREAS, the numbers of states opting to provide funding in the absence of federal funding has been decreasing; and

WHEREAS, the Supreme Court of the U.S. has declared that it is a fundamental right of a woman to choose to terminate a pregnancy, and

WHEREAS, teaching hospitals have traditionally provided for the primary care needs of low-income people, including abortion services and therefore have a responsibility to demonstrate support on behalf of the needs of teaching hospital patients;

BE IT THEREFORE RESOLVED, that the OSR urge the AAMC to support all legislative and administrative efforts to reinstate governmental funding for abortions to insure that all women, regardless of their income level, are afforded equitable access and privacy rights with respect to abortion services.

I. Proper Use of the National Board Examinations

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, as medical professionals, we recognize the necessity for the profession to be held accountable for the capabilities of its members and the need for medical schools to evaluate and if necessary modify their educational process; and

WHEREAS, it is our understanding that the National Boards were created solely for the purposes of national licensure, thereby insuring a standard of competence and it has come to our attention that medical schools, perhaps

improperly, have been utilizing the National Boards as a means to evaluate students for promotion and to modify curricula and in addition that teaching hospitals have used the scores as one criterion for selecting residents; and

WHEREAS, we are concerned that their increasing importance may jeopardize the development of diversified curricula,

BE IT THEREFORE RESOLVED, that an OSR study group be established to study the National Board Examinations and literature related to the Boards and propose guidelines for insuring their appropriate use.

J. National Health Service Corps and Armed Forces Scholarships

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, there is a significant and increasing number of medical students participating in the National Health Corps and military scholarships programs,

WHEREAS, information concerning these programs, their obligations, benefits and pitfalls is often vague and misinterpreted and medical students commit themselves to these programs without an adequate understanding of the scope of their obligation,

BE IT RESOLVED, that the OSR and AAMC maximize their efforts in obtaining accurate and much-needed information about these programs and that in all future task forces and publications of the OSR and the AAMC concerning medical student financing that adequate time and effort be spent in diffusing this information to OSR members and financial aid officers.

K. Tuition Contracts

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, in recent years, the cost of medical education has increased substantially, and

WHEREAS, in response to these monetary demands, a medical student must plan well in advance where his fiscal support will originate, and

WHEREAS, tuition changes are rarely predictable from year to year and may constitute significant increases, thus disrupting a student's advance planning, and

WHEREAS, these tuition increases are further complicated by the rapidly diminishing financial aid resources and alternatives,

BE IT THEREFORE RESOLVED, that the OSR strongly urges the Executive Council of the AAMC to encourage in its member schools the development of "tuition contracts" or other agreements by which a medical student, upon admission, may be able to reasonably predict the total cost of his medical education.

L. Due Process

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, for family obligations, financial problems or other reasons, it has occasionally been necessary for medical students to take reduced schedules or extended leaves of absence;

WHEREAS, some schools have inconsistently applied existing guidelines or have failed to establish guidelines for accomodating such individual needs;

WHEREAS, despite the LCME and AAMC policy statements resulting from the Lukacs decision of 1974, recent events have made it apparent that adherence by medical schools to guidelines for due process for students may be highly variable.

BE IT THEREFORE RESOLVED, that the OSR in conjunction with the GSA address the problems arising from individualized programs of medical education and variable application of established guidelines for due process.

M. Grading Systems

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, some schools are now changing from present pass-fail grading systems to ranked grading systems, and

WHEREAS, the OSR Report is a forum for dealing with issues of national student concern,

THEREFORE BE IT RESOLVED, that the OSR requests that a literature search on pass-fail versus ranked grading systems be made and that an OSR Report address itself to the topic of pass-fail versus ranked grading systems and that a bibliography be included.

N. HEAL and FISGL

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, the new federal regulations concerning the HEAL program set the yearly maximum at $10,000, with interest rate of up to 12% plus 2% insurance,

WHEREAS, the yearly maximum for the FISGL has been set at $5,000 with interest rate of 7%,

WHEREAS, the new federal regulations concerning the HEAL program prohibit a borrower from receiving both a HEAL loan and a FISGL loan in the same academic year, and many students have a yearly financial need of greater than $5000,

THEREFORE BE IT RESOLVED, that the OSR urges the AAMC to strongly support new legislation to change the above stated policy which prohibits holding both HEAL and FISGL in the same academic year.

O. Student Representation on AAMC Committees

The OSR considered a resolution on maximizing the number of students active on AAMC/OSR committees and groups; this resolution grew out of a concern expressed by some OSR members that Administrative Board members are often selected to serve on committees. This resolution also included the request that the Administrative Board publish a list of persons holding committee positions so that OSR members would know who to contact with input to these committees. This resolution was accepted as an instruction to the Chair.

P. Internal Medicine Fellowships

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, it is becoming evident that numbers of fellowship positions in internal medicine subspecialties greatly exceeds the number of specialists required, and

WHEREAS, these fellowships currently provide useful manpower for precedure-oriented subspecialities, and

WHEREAS, little factual information is currently available concerning medical student career plans upon entering general internal medicine programs, and

WHEREAS, such information on medical students' interests in fellowship programs and motives for entering such programs would be useful to the OSR in formulating a stand with which to represent medical student opinions to the AAMC,

BE IT THEREFORE RESOLVED, that the OSR attempt to survey a selected population of medical students on this issue and that the OSR, on completion of such a study, make the results known to the appropriate AAMC body.

Q. Research Opportunities for Medical Students

ACTION: On motion, seconded, carried, the OSR approved the following resolution:

WHEREAS, firsthand research experience contributes greatly to the development of scientific thought processes which are of value in all areas of medicine and continuing education;

WHEREAS, medical undergraduates have the opportunity to devote smaller blocks of time to research endeavors than is required for post-graduate commitments;

WHEREAS, many medical students have been unaware of opportunities or have been unable to fully utilize such opportunities because of problems with scheduling, funding, etc.

BE IT THEREFORE RESOLVED, that COD-OSR-CAS form a joint committee to investigate possibilities for improving and encouraging research opportunities, basic as well as clinical, for medical students, with an interest towards funding, scheduling, and student research presentations.

XX. Installation of the Chairperson

Paul Scoles turned over the chair to Peter Shields, the new OSR Chairperson. Mr. Shields said that he looked forward to serving the membership during the coming year.

XXI. The OSR Business Meeting adjourned at 4:45 p.m.

ch Oct. 21-22, 1978 1978
OSR Business Mtg
Agenda Box 3

RESOLUTIONS PASSED by OSR

at the 1978 BUSINESS MEETING

The OSR Administrative Board felt it important to address in writing each of the resolutions passed at the 1978 OSR Meeting. Each is discussed in the following pages. The resolutions dealing with financial aid have been grouped together and additional background information on this important subject has been included. Rather than quoting each resolution in full, we have summarized the intent of each; reference should be made to pages 8 through 15 of the 1979 OSR Agenda book to see the complete versions. The Administrative Board hopes that this addendum to this year's agenda materials will constitute a handy resource for those considering submitting resolutions and that its responses as provided here will be satisfactory and helpful to the membership.

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FINANCIAL AID

Financial aid has long been an issue of highest priority to medical students and this was evidenced this past year by both the number and variety of resolutions passed at the 1978 meeting and by its number one ranking in a survey of OSR membership in January, 1979 on important issues confronting medical students. It is a complex, highly political subject which has received a great deal of attention by state and national legislators around the country.

First, some background information is needed to set the stage. President Carter, in his Fiscal Year 1980 budget proposal, requested zero dollars for both the Health Professions Student Loan (HPSL) and Exceptional Financial Need (EFN) Scholarship Programs, in an attempt to eliminate new funding for the only need-based programs nationally available to medical students, and only enough money for the National Health Service Corps (NHSC) Program to maintain the current number of medical student enrollees at approximately seven percent of the total medical school enrollment. Coupled with his request to discontinue capitation to medical schools, it became apparent that increasingly the costs of medical education would be passed on directly to the student at the same time as sources of financial support continued to dry up. In May, 1979, the OSR Administrative Board, in conjunction with overall AAMC efforts, undertook the coordination of a "grass roots" letter writing campaign in support of the imperiled financial aid programs, medical school capitation and biomedical research funding. Individual OSR representatives were contacted by mail and by telephone in an attempt to generate a concerted lobbying effort from medical students aimed at the Senate and House subcommittees considering the FY1980 budget. The Spring issue of OSR Report supplied additional information to students on the federal budgetary process and on the programs at stake. While it is difficult, if not impossible, to assess the effects of our letters, the outcome was certainly favorable: funding for the HPSL and EFNS programs was restored and actually increased over the previous year's appropriations and funding for the NHSC was increased as well.

Since then, the AAMC Group on Student Affairs (GSA) Committee on Student Financial Assistance (which has OSR representation) has created the following "Recommended Criteria for Student Financial Assistance Programs":

1. There should be recognition that student financing of medical education is unique due to the norm of four years of undergraduate medical education followed by at least three years of graduate medical education for most students during which stipends range from $13,000 to $16,400 and the weekly curricular demands of undergraduate medical education which either prohibit or severely limit employment opportunities. There are also no teaching assistantships or fellowships available for undergraduate medical students.

2. As a consequence of their differentiation from other educational programs, administration of medical education financial assistance programs should reside in health, not education.

3. Financial aid programs should provide assurance of equal access to a medical education for applicants from all income levels.

4. To assure most effective and equitable use of financial aid funds, financial aid programs should be need-based and administered by the medical schools. Financial aid officers should be permitted discretion in performing needs analysis.

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5. There should be separate programs to correct physician maldistribution and to provide student financial aid, and the former should not imply that they are "scholarship" programs.

6. Financial aid officers should be able to provide students similar financial aid packages for four years provided that the financial circumstances of students and/or their families and/or school costs do not change substantially. Therefore, legislative authorities for student financial aid programs should be five years and funding should be "off budget" to avoid the necessity of annual appropriations.

7. Financial aid programs administered by the medical schools should include provision for a fair administrative allowance.

8. Loan programs should have reasonable aggregate and annual loan limits.

9. A full interest subsidy for loans to undergraduate medical students should be available while they are in school.

10. Repayment of loans should be deferred until completion of residency training.

11. Loan programs should have options for extended and/or graduated repayment and loan consolidation, all of which should include undergraduate debt.

12. There should be a forgiveness option for all loan recipients guaranteed at the time the loan is made for any type of loan provided that a legal note is signed.

13. The National Health Service Corps Scholarship Program and the National Health Service Corps and any future similar programs should be administered by a single agency.

14. National Health Service Corps service requirements and future similar requirements should be coordinated with state service requirements.

15. The period of required service in such programs should be varied according to practice locations as an incentive to bring physicians to the most needed practice areas.

16. There should be senior premedical preceptorships for the National Health Service Corps and Armed Forces Health Professions Scholarship Programs to inform students about the nature of both programs.

17. Specialty areas as well as primary care areas should be included in National Health Service Corps type programs.

These criteria have been sent the the AAMC Task Force on Support of Medical Education which is formulating its recommendations for AAMC policy regarding new health manpower legislation.

One of the 1978 resolutions dealing with financial aid urged the OSR Administrative Board to maximize efforts to obtain deferment through residency years for repayment of all federally supported loans (Resolution 'C'). As stated in item #10 of the recommended criteria, the OSR and GSA have made this suggestion to the appropriate AAMC task force and in addition have suggested graduated and/or extended repayment and loan consolidation options, including undergraduate debt.

Another resolution urged OSR and AAMC to strongly support legislation to change the policy which prohibits holding both Health Education Assistance Loans (HEAL) and Guaranteed Student Loans (GSL) in the same academic year (Resolution 'N'). The AAMC, at the suggestion of the OSR, has supported from the inception of the HEAL program deletion of the prohibition against holding both a HEAL and GSL loan during the same academic year and will continue to do so. At least one new financial aid bill, which is summarized below, supports this concept.

A resolution on tuition contracts was also passed; it urged the AAMC to encourage its member schools to develop tuition contracts or other agreemends by which a medical student, upon admission, may be able to reasonably predict the total cost of his medical education (Resolution 'K'). The Administrative Board discussed this highly desirable goal but was forced to recognize that because of the unpredictability of state and federal funding sources and of the actual costs of medical education, tuition charges are also often unpredictable from year to year. While cognizant of the hardships facing many students in predicting and funding the cost of his/her medical education and while supporting the concept that medical schools should make concerted, conscientious efforts to estimate tuition charges as far ahead as possible, the Administrative Board felt that attempts to hold medical schools to strict tuition contracts may not be in the students' best interests and may, in fact, compromise the quality of the education provided. Instead it felt that efforts should be concentrated on increasing the stability of state and federal funding of medical education and of financial aid sources.

The fourth financial aid related resolution (Resolution 'J') called for maximization of efforts to obtain accurate and much-needed information about the obligations, pitfalls, etc. of the NHSC and the Armed Forces Scholarship Programs and to disseminate this information to OSR members and financial aid officers. A development related to this resolution was the adoption in September by the GSA Steering Committee and the Committee on Student Financial Assistance of the following statement:

> "There has been a continuing problem with the information supplied to medical students regarding the Armed Forces Health Professions Scholarship (AFHPS) Program by the program representatives. The problem of the quality of the information supplied by AFHPS Program representatives is variable. Some schools are experiencing little or no problem but at other schools misinformation is rampant. Therefore, it is recommended that all student affairs deans and financial aid officers and health professions advisors familiarize themselves with these programs so that they may actively participate in counseling students about them and urge students not to sign documents without discussing them with medical school financial aid officers."

Also, with the support of the Robert Wood Johnson Foundation, the AAMC sponsored a series of financial assistance workshops in 1979 under the direction of Frances French, Director of Academic Services, U. of Michigan School of Medicine. Workshops were held in Atlanta, San Francisco and Chicago and included financial aid officers, student affairs, deans, admissions officers, health professions advisors and students from medical, osteopathic and dental schools (OSR nominated as many as six medical students to participate in each workshop). The purpose of these workshops is to exchange and distribute a wealth of information on such topics as new health manpower legislation, money/debt management, current status of existing student assistance programs, recruitment and retention of disadvantaged students, new directions of assistance programs, as well as a number of other financial aid related subjects. The OSR Administrative Board applauds the substantial efforts of Ms. French to increase the availability of this information to students and financial aid officers.

Following are summaries of three relatively new bills introduced in the House and Senate to reauthorize either the Higher Education Act of 1965 and its subsequent amendmends or the Health Education Assistance Act of 1976. A fourth proposal made by the administration is not outlined because it excludes health professions, business and law. At least oen other bill addressing student assistance is expected shortly. It must be emphasized that all of these are in a very preliminary state and there will be ample opportunity for comment and reaction to more mature versions as the legislative process moves forward.

Two bills have recently been introduced in the Senate to modify existing legislation pertaining to student financial assistance. The first is S. 1600, the Kennedy/Bellmon proposal, which would amend the National Direct Student Loan (NDSL) Program and the Guaranteed Student Loan Program (GSLP), thereby effecting financial assistance for undergraduate, graduate and professional students. The second, S. 1642 introduced by Senator Schweicker, would amend the Health Education Assistance Loan (HEAL) Program, the Health Professions Student Loan (HPSL) Program and the Exceptional Financial Need (EFN) Scholarship Program and so impact only on health professions students.

The Kennedy/Bellmon bill would create two loan programs extending through FY 1985, a direct loan program for undergraduate, graduate and professional students modeled after the NDSL Program and a guaranteed loan program similar to the GSLP whereby financially independent undergraduate, graduate and professional students and parents of financially dependent undergraduate, graduate and professional students may borrow. Under the direct loan program funds would be provided by the Federal Government and a student could borrow any amount necessary to finance expenses for a year according to the following formula as determined by the school financial aid officer:

Cost of attendance
Minus other financial assistance
Minus family contribution
Equals loan limit

Students who are independent of their parents could also borrow their family contribution under the guaranteed loan program as indicated below. The interest rate would be 7 percent during the 15 year repayment period, which would begin nine months after the student graduated or ceased to carry a one half academic load. Graduated and extended repayment and loan consolidation would be options. There would be a federal interest subsidy for undergraduate students and an option for graduate and professional students to defer interest payments. Funding and collection would take place through an expanded Student Loan Marketing Association, which would borrow from the Federal Government and receive federal appropriations for administration and defaults.

The guaranteed loan program would be financed through commercial lenders including all types of banks, credit unions, pension funds, insurance companies, and public or private state agencies. It would be the mechanism for independent students and parents of undergraduate, graduate and professional students to borrow an amount not to exceed the expected family contribution for a given year. Interest would be the ninty-one-day Treasury bill rate minus 1 percent, but not less than 7.5 percent and could be allowed to accrue until the 10 year repayment period. The Student Loan Marketing Association would guarantee the loan and provide a 5 percent maximum interest supplement to lenders.

The Schweicker bill, which would extend authority for the HEAL and HPSL Programs and for the Exceptional Financial Need Scholarship Program through FY 1983, proposes the following changes in these student assistance programs:

1. A full federal interest subsidy would be available to all HEAL loan recipients for up to seven years, after which the normal interest (12 percent) would apply. There is currently no interest subsidy.
2. The HEAL provision which precludes HEAL recipients from receiving other federal, state or nonprofit insured or guaranteed loans during the same year would be abolished.
3. The exceptional financial need requirement for a student to participate in HPSL would be abolished. Institutional discretion would be permitted for establishment of criteria for receiving these loans. Such criteria must include financial need.
4. The repayment period for the HPSL Program would be extended from 10 to 15 years.
5. Budget authority for the HPSL Program after a drop to 25 million dollars in FY 1981 would be increased from 26, 27 and 28 million dollars in FY's 1978, 79, and 80 to 30 and 45 million dollars respectively in FY's 1982 and 83.
6. Budget authority for the Exceptional Financial Need Scholarship Program would be increased from 16, 17, and 18 million dollars in FY's 1981, 82 and 83.

All other aspects of these programs would remain unchanged.

In addition, H.R. 5192 was introduced in the House on September 6, 1979 by Representative William D. Ford of Michigan. Title IV of this bill addresses student assistance. It would provide for extension of the authority for the Guaranteed Student Loan Program (GSLP), also known as the Federally Insured Student Loan Program (not the Health Education Assistance Loan), the National Direct Student Loan (NDSL) Program, and the College Work-Study (CW-S) Program from FY 1981 to FY 1985.

Under the Guaranteed Student Loan Program aggregate limits for loans to graduate and professional students would be raised from $15,000 to $25,000 while undergraduate loan limits would go to $12,500 for financially dependent students and to $15,000 for financially independent students. The Commissioner could increase these limits for "exceptionally expensive" programs. Rather than for only nine months repayment could be deferred for a period "at the request of the borrower during which the borrower is serving an internship...which is required in order to receive professional recognition required to begin professional practice or service." For the first time for the purpose of loan collection cooperative agreements with credit bureaus could be established. The bill would authorize a new program of loans to parents of dependent undergraduate students on basically the same terms as those to independent students. It would also provide an annual

administrative cost allowance of $10 per loan recipient. The Student Loan Marketing Association (SLMA) would continue to operate as a secondary market with increased authorization and the ability to consolidate these loans. It could also provide loan certainty by making these loans in states or population areas of states where they are not available.

The bill would increase the funds authorized for the National Direct Student Loan Program from the present $400,000 to $625,000 by FY 1985. Graduate and professional student aggregate borrowing limits would go from $10,000 to $12,000. Like the Guaranteed Student Loan Program, repayment could be deferred at the request of the borrower for an internship required to begin professional practice, collection would be enhanced by cooperative agreements with credit bureaus, and an annual administrative allowance of either $10 per loan recipient or a percentage of loan expenditures is provided. Loans cancelled for practice in a shortage area are prohibited from being considered income. There are extensive requirements for the information to be provided to prospective students including costs, student rights and responsibilities, refund policy, academic program, name of financial aid officer, facilities for handicapped, and the agency accrediting the school. A schedule of expected family contribution would be published annually by the Secretary considering income, dependents, dependents in college, family assets, unusual expenses, educational expenses, and child care for dependent children. A single application form with no processing fee would be mandated, and there would be criminal penalties of a fine of up to $10,000 or 5 years imprisonment for embezzlement, fraud, stealing, or misapplication of NDSL funds. Funds available to states to train financial aid personnel would be authorized.

H.R. 5192 would also create a twelve member National Commission on Student Loans charged to recommend by July 1, 1983 methods to reduce loan defaults and delinquencies; to provide a balance between loans and other types of financial assistance for postsecondary education; to ensure adequacy of capital for postsecondary students; to assess the impact of borrowing on educational performance, career choice and future educational choices of students; to assess the impact of parental borrowing for postsecondary education, of loan availability on availability of other types of aid, and of loan availability on postsecondary education costs; to identify the most appropriate source of loan capital, level of public subsidy, mechanism for flexible repayment and loan consolidation for postsecondary education, and the means to remove barriers to capital availability due to lender discrimination.

GRADING SYSTEMS

Resolution 'M' requested that a literature search on pass-fail versus ranked grading systems be undertaken and that an OSR Report be devoted to this topic. Administrative Board member Alan Wasserman has compiled a bibliography of sources dealing with this topic. Also, the 1979 Annotated Student Affairs Bibliography includes a section on evaluation which contains the results of recent research on pass-fail versus grading systems. A relatively low priority item in a survey of the OSR membership, an OSR Report has not yet been devoted to this topic. However, the attention of the membership is directed to the September 13, 1979 issue of the New England J. of Medicine (V. 301, #11: 607-10) in which there is an extended and sensitive discussion of grading policies with recommendations for developing rational evaluation strategies.

DUE PROCESS

Resolution 'L' called for OSR and GSA to address problems arising from the variable application of due process guidelines. In recognition of the complexity of the issue of due process for medical students, the Board approached this topic very carefully. As a beginning and in preparation for an OSR/GSA session on due process at the 1979 Western meeting, the Western region chairperson polled OSR members in that region about their schools' guidelines; the response was highly variable but this project served to spark a national survey of student affairs dean requesting that they forward to the AAMC Division of Student Programs copies of their due process procedures and an indication of the number of times that they had recently been invoked and their degree of satisfaction with their system. Over 60 schools have responded. This information is currently being reviewed in an effort to assess the range and diversity of due process procedures for disciplinary as well as for academic problems. One potential outcome of this effort is the development of model principles of due process for distribution to the individual schools for comparison and adaptation for their own use. Based on the documents received from schools, a few preliminary observations are allowable. One is the enormous range in types of arrangements which schools have developed to deal with student challenges to the promotions and graduation process. Another is that some schools have codified methods of dealing with disciplinary problems separately from academic questions; other schools view these two types of questions as being closely interrelated--bearing, as the both do, on progress toward "good physicianship". Another observation is that the degree of detail and scope embodied by due process guidelines appears to be unrelated to whether a school is satisfied with its system. Satisfaction with the method for dealing with student challenges does, however, appear to be closely linked to the accessibility and responsiveness of the student deans..

The OSR Administrative Board also met with Staff Counsel, Joseph A. Keyes, to discuss the issue of due process. He explained that it is important not to confuse the concept of due process with the existence of a specific set of procedures. Due process simply means fair treatment. With respect to legal requirements for due process, the courts have distinguished between academic and disciplinary situations; for the latter, more elaborate procedures have been required, however the courts have shown much greater deference toward the judgment of academic faculties unless there is a clear showing that a student has been treated unfairly. The OSR resolution appears to call for an appeals procedure above and beyond what the courts will require. He suggested that OSR and other student groups thus have two options: 1) to work with medical school faculty and deans to improve counselling, evaluation and promotion mechanisms or 2) to work toward further regulation of schools by somebody other than the courts, for instance, having the Liaison Committee on Medical Education (LCME) stipulate what the requirements should be. The latter is what AMA-SBS is currently proposing. In its policy documents and guidlines for

accreditation of medical schools, the LCME already has the following statement on its books: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and "due process" must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him/her of valuable rights." The Administrative Board will keep Mr. Keyes' comments in mind, as well as the current activities of AMA-SBS, as work continues on this project.

FLEXIBLE SCHEDULING

The issue of flexible scheduling was addressed in the resolution on due process as well as in two other related resolutions on planning families (Resolution 'F'). After careful consideration, the OSR Administrative Board decided that issues of students being able to arrange flexible schedules should be dealt with separately from issues of graduation and promotion. On the topic of flexible scheduling, the Administrative Board recognizes that some students do encounter problems arranging individualized schedules and/or being assured an orderly return to school after a leave-of-absence and is considering developing guidelines to help deal with such situations. However, it is recognized that these situations are of a very individualized nature--both intra-school, given the often personal reasons for the request and among schools, given restrictions which many schools must face related to class sizes.

The Administrative Board was very pleased to see recognition of the need for flexible scheduling included in the report of the Task Force on Graduate Medical Education, Working Group on Quality. The report sets forth six recommendations for improving the quality of graduate medical education, one of which addresses programatic flexibility; "There should be sufficient program flexibility to accomodate the diversity of an individual resident's abilities and goals. . .It is not sufficient to provide a common, rigid, and inflexible education paced the same for all residents. The maximum time permitted to complete a program and the rate of progress through each segment should be geared to the educational attainments of a resident and not based upon externally set minimum time requirements or upon the service needs of the institution."

STRESS IN MEDICAL EDUCATION

Resolution 'A' called for the OSR Administrative Board to review the available information on stress in medical education and, in conjunction with housestaff,to seek specific methods to reduce stress, e.g., more realistic workloads, support groups, etc. The Administrative Board approached stress in medical education on several fronts and discussed this complex issue at lenth. It was recognized that stresses vary alot depending on the milieu of the school, the expectations and preparation of a student, and what stage of his/her education a student is experiencing. It was also recognized that some stresses are necessary and can even be beneficial, such as stimulating professional growth. Negative sources of stress, however, need to be dealt with and the most appropriate arena for this is usually at the individual school where specific problems and complaints can be addressed by the parties involved. Tangible products of these discussions include the compilation of bibliographies on stress by Administrative Board members Molly Osborne, Arlene Brown and Seth Malin and a section on stress in the 1979 Annotated Student Affairs Bibliography. The Administrative Board also approached the AAMC Task Force on Graduate Medical Education at several points during its deliberations, highlighting the importance of providing adequate counselling services and support services during residency training as a requisite for a quality educational experience. In several areas the Task Force adopted a favorable attitude toward these student concerns which is reflected in several of the Task Force's recommendations.

Several OSR regions discussed at length in their spring meetings stress and stress reduction; the Southern and Western regions passed resolutions, which have been combined into one and included in the Annual Meeting agenda for the consideration of the membership. Furthermore, a demonstration of stress reduction techniques at the Western region meeting by Dr. Lester Libo was well-received and is being repeated at the 1979 Annual Meeting. As a means of assessing the value of the program, a short questionnaire will be distributed to all participants, once immediately following the session and again later in the year. Once the Administrative Board has assessed the value of "practical approaches to stress reduction", it can begin developing models which may be recommended to schools for possible inclusion into their curricula.

RESEARCH OPPORTUNITIES FOR MEDICAL STUDENTS

Resolution 'Q' called for the formation of a committee to investigate possibilities for improving and encouraging research opportunities for medical students. After passage of this resolution, it was forwarded to the AAMC Assembly for consideration at its meeting during the 1978 Annual Meeting. The Assembly adopted the OSR resolution. As a first step in carrying it out, a fact-finding effort was undertaken by Dr. Thomas Morgan, Director of the AAMC Division of Biomedical Research, in conjunction with the 1979 regional GSA/OSR meetings. Fifty-six medical schools responded to a survey on available research opportunities, sources of funding, counselling and advising about research opportunities, and general attitudes of faculty and admission committees toward research and/or academic career aspirations of their medical students. The results of this survey have already proven useful in a variety of ways. They provided valuable input to the ad hoc Committee on Clinical Research Training which was formed and met during the summer. Discussion by this committee included the trends in physician research manpower, basic considerations relating to the research training of physicians and recommendations to improve the research opportunities for medical students and residents. The committee's report has been presented to the Executive Council and mechanisms to carry out its recommendations are being worked out. Another tangible outcome of the resolution is the Fall OSR Report which presents the information on the clinical investigator shortage, on the benefits of research careers and on research opportunities at the National Institutes of Health.

STUDENT REPRESENTATION ON AAMC COMMITTEES

The OSR Chairperson accepted an instruction from the membership to attempt to maximize the number of students active on AAMC committees and to publish a list of persons holding these appointments. The list of OSR members presently serving on committees is provided below; the * designates those who were nominated by the 1978-79 OSR Administrative Board. The attention of voting members is drawn to the folder to be received at the Business Meeting which will include a listing of committees which anticipate openings for a student member during 1979-80. It is important in this regard to keep in mind that the number of these openings varies quite a bit from year to year depending on whether new committees or task forces are being created and on the length of the terms of student members who have already been appointed. The Administrative Board also discussed ways to increase the level of OSR members' participation on committees; this could be enhanced if OSR members serving on committees were more responsive to the constituency regarding their activities and input. The Board thus decided that as a requisite to acceptance of an appointment each student nominee should agree to submit periodic reports to the Administrative Board regarding the activities of the committee on which they serve.

Flexner Award Committee: Ronald C. Petersen, Mayo*
GSA Committee on Student Financial Assistance: Fred Emmel, George Washington*
Journal of Medical Education Editorial Board: Ron Louie, U. of Ohio, Toledo
Task Force on Support of Medical Education: Peter Shields
Task Force on Graduate Medical Education: Dan Miller
GSA-Minority Affairs Section Coordinating Committee: A. J. Rogers, Harvard*
ad hoc Committee on Clinical Research Training: John Cockerham, Virginia*
Liaison Committee on Medical Education: Lee Kaplan, Einstein (reappointment)
National Resident Matching Program Board of Directors: Mark Avery, Texas, Galveston*

AMERICANS STUDYING ABROAD

Resolution 'B' encourages all American medical schools to give the same consideration to American medical students from foreign medical schools as they give to any other applicants for openings in the second and third years. Since 1970 the AAMC has assisted schools in their consideration of U.S.F.M.S's through a cooperative agreement with the National Board of Medical Examiners. Through this system, known as COTRANS, the AAMC has sponsored U.S. citizens enrolled in foreign medical schools who have completed coursework in anatomy, physiology and biochemistry for the Part I exam of the Boards. The NBME has been concerned for some time about the utilization of its three-part exam for purposes other than certification for licensure. It has decided to limit access to Part I to students matriculated in medical schools accredited by the LCME.

It has been proposed that a special examination be developed and sponsored by AAMC to provide an alternative for U.S.F.M.S.'s now that they can no longer take the National Boards, Part I. For this purpose the Medical Sciences Knowledge Profile (MSKP) has been proposed; this examination will consist of questions in biochemistry, anatomy, physiology, microbiology, pharmacology, pathology and behavioral sciences. In addition, a special section will be developed to examine areas typically covered in introduction to clinical diagnosis. Any U.S. citizen or permanent resident alien will be allowed to sit for the exam. In spite of some initial reservations regarding the MSKP proposal, the OSR Administrative Board tentatively endorsed its development, realizing that it represents the only mechanism by which U.S. citizens studying abroad would be able to receive full and appropriate consideration by U.S. medical schools.

NATIONAL BOARD EXAMINATIONS

Resolution 'I' called for the formatior of an OSR study group to study the National Board exams and literature related to the Boards and to propose guidelines for insuring their appropriate use. As mentioned above, the National Board of Medical Examiners has reaffirmed that the sole purpose of the exams should be medical licensure. The NBME's Advisory Committee on Undergraduate Medical Evaluation has undertaken a study of the present uses of its exams by medical schools. The OSR Administrative Board has thus decided to await the results of this committee's deliberations rather than to suggest to AAMC a second study. In addition, efforts are being made to maintain communication between the Administrative Board and the AAMC's representatives on the Advisory Committee to relay OSR's concerns on this matter. The attention of the membership is also drawn to the section on evaluation in the Annotated Student Affairs Bibliography which includes several references related to the National Boards.

COURSE OBJECTIVES

Resolution 'E' requested the AAMC to encourage medical schools to institute and make available to students specific course objectives and overall curriculum objectives. This topic is not a new one at the Association. The AAMC Group on Medical Education,which is composed of individuals from the schools and teaching hospitals with responsibilities in evaluation and institutional resource development, in particular has been involved. Four years ago, the Southern region GME surveyed schools and composed a bibliography on the subject of educational objectives and a compendium of objectives currently in use by schools; numerous difficulties with this project were encountered related to the variability among schools and to the formulation of a meaningful definition of the term "educational objective". Also for a number of years, in the questionnaire completed by all schools which forms the basis for the annual AAMC Curriculum Directory, an item on the existence of stated behavioral and course objectives was included; this was later dropped because responses from schools were often extremely vague which again pointed out the problems involved with defining what is meant by course objectives and how these are employed by individual faculty members and departments. One of the current projects of the GME is developing ways to evaluate faculty performance in the context of promotion and tenure decisions; this is viewed as a promising, productive way to looking at instructional effectiveness. Thus, the issues addressed in this resolution are and have been of concern to the AAMC. But the questions involved are not simple, related as they are to how individual faculty members go about designing courses and communicating their educational goals. The Administrative Board feels that the most fruitful approach at this time would be to interact with GME and to develop an acceptable way to pursue this issue.

INTERNAL MEDICINE FELLOWSHIPS

Resolution 'P' asked the OSR to survey a sample of medical students on their plans, if any, to subspecialize; this request grew out of concern that a preliminary AAMC recommendation to reduce the number of fellowships in Internal Medicine was not the best approach in dealing with the need to limit the number of graduates entering subspecialty training. Once again the Administrative Board found itself in a position of advocating research which was already in progress. The Working Group on Specialty Distribution of the Task Force on Graduate Medical Education dealt extensively with this issue and this is reflected in their report. The AAMC Graduation Questionnaire was modified this year to provide more precise information on students' intention regarding subspecialty training. And the National Resident Matching Program is undertaking an extensive tracking study, beginning the graduates of 1977, toward the end of improving national and local databases on this as well as many other related questions.

SMOKING

Resolution 'G' urged that the OSR restrict smoking to designated areas at all meetings and that all other member organization of the AAMC do the same. There is already an established AAMC policy regarding designation of smoking and non-smoking areas of meeting rooms. The Chairperson of OSR will attempt to enforce this policy at all OSR meetings.

GOVERNMENT FUNDING FOR ABORTION SERVICES

Resolution 'H' called for the OSR to urge the AAMC to support all legislative and administrative efforts to reinstate government funding for abortions to insure that all women, regardless of their income level, are afforded equitable access and privacy rights with respect to abortion services. The subject of this resolution is a highly charged moral and political issue surrounded by questions of social equality and religious tenets, the latter certainly being an area inappropriate for AAMC comment. The AAMC has developed and communicated positions supporting equality of access to medical education and to health services of all types, but this area of debate is so involved with issues which transcend the basic questions of equality of access that it seems neither appropriate nor worthwhile for the AAMC to enter into it.

EQUAL RIGHTS AMENDMENT

Resolution 'D' resolved that the OSR urge that no AAMC-sponsored regional or national conventions be scheduled in states which have not ratified the passage of ERA. For the foreseeable future the AAMC Annual Meeting will be held in Washington, D.C. With regard to regional meetings, the OSR traditionally meets in conjunction with the GSA which is dependent on the hospitality and resources of schools which volunteer to host their meetings. In 1980 the regional meetings will be held in California, Tennessee, Wisconsin and New Hampshire--all states which have ratified ERA. However, there is no guarantee that the volunteers for 1981 will not include a school in a state which has not ratified ERA. In order for OSR to have opportunity to make its views known on this subject, the OSR regional chairpersons may attend the business meeting of the GSA at each of the regional meetings, which is usually the time when the site of the next regional meeting is discussed. In case of conflict, the individual OSR regional chairperson will have to use his/her best judgment about how to proceed.

ORGANIZATION OF STUDENT REPRESENTATIVES

1978 BUSINESS MEETING

October 21 and 22
New Orleans Hilton

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ORGANIZATION OF STUDENT REPRESENTATIVES

Business Meeting

November 5 and 6, 1977
Washington Hilton Hotel
Washington, D.C.

I. Call to Order

The meeting was called to order by Tom Rado, Chairperson, at 2:00 pm.

II. Declaration of Quorum

Tom Rado declared the presence of a quorum of the Organization of Student Representatives.

III. Consideration of Minutes

The minutes of the November 10 and 11, 1976 business meeting were approved without change.

IV. Welcoming Remarks and Orientation

Dr. John A.D. Cooper, President of AAMC, welcomed the OSR to the AAMC Annual Meeting. He stated that the Association valued the participation of OSR in policy discussions and decisions. He urged the representatives to be cognizant during their deliberations of not only the student viewpoint but also the concerns and interests of other constituent groups and to examine how issues and problems effect the totality of medical education. Following Dr. Cooper's welcoming remarks, Dr. Mark Cannon, 1974-75 OSR Chairperson, reviewed the history of the OSR and described the operational aspects of OSR's relationship to AAMC staff and other constituent councils and groups.

V. Report of the Chairperson

Tom Rado reported that the past year had been a turbulent year politically in terms of the health manpower law, the Thompson Amendment, and the FTC's challenge of the Liaison Committee on Medical Education (LCME). He stated that much of the year had been spent reacting to governmental actions of one type or another, and that it was difficult to review the year by pointing to specific achievements or by citing concrete evidence of progress gained. He expressed his view that the work of OSR during the past year must be seen as part of a continuum since all crucial medical education issues and problems are much too complex and multi-dimensional to be identified, analyzed, and solved during the course of a single year.

Dr. Rado reported that a major new undertaking of the OSR this year was the publication of OSR Report. He stated that although it is presently being published on an experimental basis, he hoped it would continue on a permanent

basis as a means for OSR to communicate with all medical students nationally. He noted that the one issue which had already been published received favorable comments from students who responded to a mail-back survey included in the newsletter. Two more issues of OSR Report will be published before the AAMC Executive Council decides whether to fund the publication on a regular basis.

Dr. Rado also reported that in response to a resolution approved at the 1976 OSR meeting and to long-term efforts by OSR and other medical student groups, the LCME decided at a recent meeting to include in its membership two non-voting student representatives. The LCME will refer this decision to its parent bodies (AAMC & AMA) for ratification. The mechanism for student appointments will be that the parent bodies will each nominate one student for a three year term. Dr. Rado expressed his feeling that the LCME's decision represented an important victory for OSR and all medical students.

Dr. Rado reviewed several other activities and events that occured during the year including the filing on an amicus brief in the Bakke case and the appointment of AAMC task forces on graduate medical education and on the support of medical education. He indicated that OSR continued to be actively interested in the areas of minority affairs, financial aid, women in medicine, and medical student stress and that discussion sessions would be held on these and other topics during the meeting.

VI. Report of the Chairperson-Elect

Paul Scoles reported that he had spent and active year becoming oriented to OSR and AAMC and attending meetings of related organizations such as AMSA and the AMA Student Business Session. He also reported that he attended two meetings of the Consortium of Medical Student Groups during the year. He expressed the opinion that the Consortium performed a vital function of providing an informal forum for the exchanging of ideas and information on issues of concern to all the medical student groups.

Mr. Scoles reported that one area of personal interest to him during the past year was communications. He felt that the OSR Report was an important accomplishment in the area of communication with the constituency, but that communication from OSR representatives to the Administrative Board members was still too sporadic and ineffective. He urged representatives to communicate with the new officers in order that the new OSR board could be responsive to the views and concerns of their constituency.

Mr. Scoles noted that he had been appointed to serve as the student member of the Working Group on Withholding of Physician Services. This group was charged with developing a statement about the ethical and professional issues involved when physician act collectively to withhold their services for financial or political reasons. Mr. Scoles reviewed some of the questions examined and preliminary conclusions reached during the group's first meeting. He invited interested representatives to attend the discussion session on this topic scheduled for the following day.

Mr. Scoles concluded his report by commending Dr. Rado for his leadership during the year and by thanking the OSR for a rewarding and educational year.

VII. Report of the Student Member on the AAMC Task Force on Graduate Medical Education

Cheryl Gutmann reported that the task force had held two meetings since its formation in January. Key issues identified by the task force during its first two meetings included: availability of positions for graduate medical education, the role of graduate medical faculty, institutional responsibility, governance and control, accreditation, specialty distribution, financing, and the role of housestaff with reference to their teaching and patient care responsibilities. Ms. Gutmann indicated that working groups were currently being organized to address certain focal areas. She also reported that she would be issuing reports periodically to keep the OSR abreast of the activities of this task force.

VIII. Report of Student Member on the AAMC Task Force on the Support of Medical Education

Peter Shields reported that he and Paul Scoles were appointed as student members of the AAMC Task Force on the Support of Medical Education. He stated that the overwhelming number of problems with the existing health manpower law prompted AAMC to form a task force The task force has held one meeting, and working groups have been formed to address the following areas: 1) relationship of the university to the federal government and the retionale for continuing federal support, 2) character and need for financial support, 3) number and distribution of physicians, 4) the role of the medical school in cost containment, and 5) special initiatives. Mr. Shields outlined the charge to each working group. He promised that he and Paul Scoles would keep the OSR informed of the discussions and conclusions of the task force during the next two years.

IX. Report of the Immediate-Past-Chairperson

Richard Seigle reviewed the results of the OSR-GSA Counseling Survey. Questionnaires were distributed to all OSR representatives and student affairs deans at the spring regional meetings and by mail. The purpose of the survey was to collect information on the types of counseling systems used by medical schools. The survey showed that virtually all schools provide some type of personal counseling usually through faculty advisors or student affairs administrators. Some of the problems highlighted by the questionnaire results were that students are reluctant to seek counseling from a potential academic evaluator and that many students are not aware of the types of counseling services which are available. Dr. Seigle indicated that a final report of the results of the counseling survey would be available later in the year.

X. Reports of Leaders of the Other Student Groups

Jannice Ownes, M.D., Past-Chairperson of the AMA-Student Business Session; Greg Lund, President of the Student Osteopathic Medical Association; John Barrasso, Trustee-at-Large of AMSA; Staley Jackson, President of Student National Medical Association, (SNMA); Ronald Martin, Chairperson of the Council of Student Council Presidents of the Association of Colleges of Osteopathic Medicine; and Carl Osier, representing the American Academy of Family Physicians reported on the activities and goals of their organizations. Several speakers pointed out that the goals and concerns of all student groups are strikingly similar and stressed the importance of liaison efforts to strengthen the student voice to all organizations dealing with medical education, legislation, and policy.

XI. Graduation Questionnaire

Dr. Swanson, Director of the AAMC Department of Academic Affairs, described the Graduation Questionnaire Project, a major new data collection project which AAMC will undertake beginning in 1978. The program involves annual surveys of all graduating medical students regarding their experiences in medical school, their plans for graduate medical education, and their ultimate plans for practice/career. The questionnaires will be distributed every year prior to announcement of the NIRMP results. Dr. Swanson explained that the Graduation Questionnaire will enable AAMC to provide important data to the medical schools about how the medical education process effects students' development as physicians. He emphasized that medical students participating in the survey will provide their schools with valuable information with which to evaluate the curriculum and other aspects of their education program. Representatives voiced general support for this project recognizing the value of the database the survey would provide. There was some question as to whether graduating medical students would be willing to participate in the survey. It was pointed out that students will be more inclined to respond to the questionnaire if it is emphasized that their comments about the strength and weaknesses of their own schools will be anonymously sent back to the schools and that their comments are likely to directly influence their own schools curriculum and educational program. Copies of the questionnaire were distributed. Dr. Swanson pointed out that Dan Miller (UC-San Diego) is the student member on the Medical Student Information Systems Committee and that comments or suggestions about the Graduation Questionnaire project should be directed to him or to the staff.

XII. Nominations for Office

The following OSR representatives were nominated for national office:

Chairperson-Elect: Peter Shields, SUNY-Buffalo
Alan Wasserman, Univ. of Missouri-Kansas City

Representatives-at-Large: Marjorie Barnett, Michigan
Fred Emmel, George Washington
Ernie Hodge, Texas-San Antonio
Bob Levine, Loyola-Stritch
Jim Maxwell, Univ. of Kentucky
Dan Miller, Univ. of California-San Diego

XIII. The meeting was recessed at 5:30 pm.

XIV. The meeting was recalled to order by Tom Rado at 1:30 pm on November 6.

XV. Dr. Rado declared the presence of a quorum of the Organization of Student Representatives membership.

XVI. Remarks of the Council of Deans Chairman

Dr. Julius Krevans offered some observations to the OSR about the difficulties and the rewards of working within a large, diverse organization. He expressed the opinion that the Association gives very serious consideration to strongly-held student views. He urged the OSR to give careful attention to electing officers in whom they will have confidence to carry out the business of the OSR and to represent them on issues which will arise during the year.

XVII. Report of the Student Member to the Working Group on Uniform Application Process for Graduate Medical Education

John Repke read a letter from Dr. Ann Peterson, Chairperson of the Working Group, to Dr. Cooper which reported the nature of the discussions and conclusions reached by the group at its meeting in July. The Working Group was charged with examining the feasibility of developing a uniform application form to be used by all graduate training programs. Mr. Repke reported that after careful consideration of all the issues involved, the group decided that the use of a uniform GME application form would create at least as many problems as it would solve. In light of this conclusion, the members decided to dissolve the group at least for the present time.

XVIII. Elections

In addition to the nominations offered the previous day, Clayton Griffin (Tulane) and Molly Osborne (Colorado) were nominated for the office of Representatives-at-Large.

ACTION: *On motion, seconded, and carried, the OSR elected the following representatives to national office:*

Chairperson-Elect: *Peter Shields*

Representatives-at-Large: *Cheryl Gutmann*
Jim Maxwell
Daniel Miller
Molly Osborne

XIX. Resolutions

A. Trends in Municipal Health Care

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

WHEREAS, the present solution to the fiscal crisis in New York City is resulting in crippling cuts of health services, with little regard for the impact on public health;

WHEREAS, these cuts most affect that portion of the population least able to afford such reductions in health services;

WHEREAS, these cuts seriously affect the status of the municipal teaching hospitals to provide a quality health education;

WHEREAS, the present situation in New York City is only a symptom of a national attitude which questions the existence of municipal teaching hospitals;

WHEREAS, all of these actions are contrary to the principle of health care as a right;

BE IT THEREFORE RESOLVED, that, we, the Organization of Student Representatives of AAMC, as representatives of future health providers strongly protest the continuation of these attacks upon health services and education. Be it also known that we, along with other concerned health providers, oppose further attempts to erode the municipal hospital system. To this end we ask that all medical students and health professionals unite in a nationwide effort to bring these issues to the public and legislators, and, furthermore, to actively work to insure peoples' right to health care.

B. OSR Meeting Schedule

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

WHEREAS, most of a medical student's academic responsibilities are during the week (Monday-Friday) and that it is often difficult for a student to be excused from these duties:

BE IT RESOLVED, that the OSR Administrative Board urge that the GSA-OSR regional meetings held in the spring of each year and the OSR national meeting held in the fall of every year be scheduled either entirely or partially during a weekend to facilitate student attendance and thus maximize student input.

C. Regional Meetings

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

In the past, interactions between the GSA and the OSR, especially at regional meetings, have proven to be informative and valuable experiences which have fostered improved and important communications/relations between the respective groups. In addition, the tone and atmosphere of regional meetings have traditionally been less formal and more conducive to increased communication among regional OSR representatives.

It is believed that the implementation of a national regional meeting with all regional meetings occurring at the same site at the same time potentially will decrease GSA-OSR future interactions and potentially will limit and/or exclude participation and representation from member OSR schools (for financial reasons, etc.).

THEREFORE, BE IT RESOLVED, that regional meetings continue in their present format with joint GSA-OSR participation at regional locations.

D. Responsibility of Medical Alumni

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

In as much as the physicians of this country are a priviledged group, they themselves are best able to contribute to the maintenance of freedom of choice in medical education. With approximately 350,000 physicians in the U.S., how can the general taxpayer be asked to support our educations if we ourselves do not make an honest effort.

BE IT THEREFORE RESOLVED, that as members of OSR and future physicians who feel daily the current financial burden of medical education, we investigate and then promote the full utilization of alumni contributions. We furthermore urge AAMC

to encourage the use of alumni contributions that are specifically geared for student support.

E. Tuition Increase Deliberations

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

WHEREAS, in recent months many medical schools have announced major increases in tuition, and

WHEREAS, these increases pose a substantial financial burden for many medical students, and

WHEREAS, these announcements have in some instances generated misunderstanding, mistrust, and hostility, and

WHEREAS, many of these decisions have been formulated without any student input, and

WHEREAS, some of these decisions have been formulated with minimum input from financial aid personnel,

THEREFORE, BE IT RESOLVED that the OSR and AAMC strongly urge all schools to include student representatives and financial aid personnel in their deliberations and decisions concerning increases in medical school tuition.

F. Medical Student Debt Level

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

The debt burden incurred by incoming medical students can in the foreseeable future reach a level of $15,000 per year. At an annual interest rate of 10% a student would accrue an additional debt of $1,500 per year.

It is clear that this level of debt would have an adverse effect on minority admissions, and a strongly selective effect on the applicant pool as a whole. This selection could be detrimental to the quality of medical students.

BE IT RESOLVED, THEREFORE, that AAMC maximize its efforts to obtain an interest subsidy for students with financial need who borrow under the HPSL program.

BE IT ALSO RESOLVED, that this subsidy be extended through the residency years while incomes are not adequate to accommodate the interest burden.

G. Contract on Tuition

The OSR considered a resolution that schools enter into a "Contract on Tuition" with entering students specifying a fixed price for the entire medical education program. Supporters of the resolution felt that it would be reasonable and appropriate for students to be fully informed before entering medical school of the total cost they would be expected to assume. Speakers against the resolution pointed out that many schools could not realistically project tuition four years in the future. Others who opposed the resolution pointed out that state schools would have a particular problem adhering to the resolution since state legislatures often determine tuition levels for state-supported schools.

ACTION: *On motion, duly seconded, the OSR defeated a resolution on tuition contracts.*

H. Directory of GME Programs

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

WHEREAS, students' selection of internship/residency programs, in the past, frequently have had to rely heavily on anecdotal information from peers, advisors, etc. rather than accurate, objective information, and

WHEREAS, the NIRMP directory ("the green book") is limited to a listing of available internship/residency programs, and

WHEREAS, there presently exists no formal mechanism whereby medical students may obtain information concerning the characterization of residency programs in the U.S., and

WHEREAS, the AAMC is currently extending its interests and activities to graduate medical education,

BE IT RESOLVED, that we hereby direct the OSR Administrative Board to coordinate the formation of a booklet containing information gathered from residents and program directors of all U.S. postgraduate training programs. This information shall be obtained from questionnaires circulated annually in the final month of each training year

to all first and second year residents and program directors. The content of these questionnaires shall be determined by a group designed by the OSR Administrative Board to include a majority of students, with appropriate input from other sources.

The content of the questionnaires should include items such as call schedule, average number of patients per resident, ancillary personnel, hours spent with attending physician per week, degree of independent thought encouraged (scale 0-6), degree of responsibility (scale 0-6), benefits (vacation time), and other items deemed necessary in order to provide a comprehensive description of each program. This booklet should be up-dated annually and circulated to all U.S. medical schools.

We furthermore direct the OSR Administrative Board to explore with NIRMP the expansion of the data in the NIRMP Directory to accomplish the goals of this resolution. The OSR Administrative Board may modify minor details in order to implement the spirit of the resolution.

I. Proper Use of the National Board Examinations

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

As medical professionals, we recognize the necessity for the profession to be held accountable for the capability of its members. In addition, we are cognizant of the need for medical schools to evaluate and, if necessary, modify their educational process.

It is our understanding that the National Board Examination was created solely for the purposes of national lisensure, thereby insuring a standard of competence. It has come to our attention that medical schools, perhaps improperly, have been utilizing the National Board Examination as a means of evaluating students for promotion, modifying curricula, and in addition, that teaching hospitals have used the scores as one criterion for selecting residents. We feel that there is no evidence to support any uses of the National Board Examination other than licensure.

THEREFORE, BE IT RESOLVED, that an OSR study group be established to study the National Board Examination and propose guidelines insuring its appropriate use.

J. Sleep Deprivation

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

WHEREAS, competent patient care requires the ability to make cogent clinical judgment, and often, skills requiring high levels of perception and intact reflexes, and

WHEREAS, house officers are supposed to be in a learning, service, and teaching situation, and

WHEREAS, research has shown that judgment, reflexes, perception and learning capacity can be impaired by sleep deprivation, and,

WHEREAS, present call schedules for housestaff often include frequent periods exceeding 36 straight hours of patient care responsibility, and

WHEREAS, patients have the right to be cared for by competent physicians,

THEREFORE, BE IT RESOLVED, that the OSR Administrative Board urge that AAMC teaching hospitals reassess their housestaff schedules and make adjustments to eliminate or substantially reduce periods of requisite or potential sleep deprivation in excess of 24 hours.

K. Medical Student Rights & Responsibilities

ACTION: On motion, seconded, and carried, the OSR approved the following resolution:

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

WHEREAS, housestaff organizations are increasingly finding it necessary to consider the use of striking or other job actions to secure improved conditions for their patients and themselves, and

WHEREAS, the rights, duties and responsibilities of students in hospitals affected by such strikes are unclarified, and

WHEREAS, examples have been brought to the attention of the OSR of threatened reprisals directed against students who support such strikes or job actions,

BE IT THEREFORE RESOLVED, that OSR feels it would be highly inappropriate for students to be pressured or permitted to perform the job of housestaff without supervision of interns and residents.

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

L. Opposition to the Easterly Bill

ACTION: *On motion, seconded, and carried, the OSR approved the following resolution:*

WHEREAS, the Easterly bill, which will be considered by the Kentucky legislature soon, and is gathering strong support, stipulates that all medical school applicants must sign an agreement to serve one year in Kentucky for each year in the state medical schools, or to repay the actual cost to the state of their medical education, and

WHEREAS, this bill is an ineffective means of addressing the physician shortage and maldistribution in Kentucky, and

WHEREAS, the bill has potential for detrimental effects on the quality of medical care in Kentucky, and

WHEREAS, if such a bill is passed in Kentucky there is increased likelihood of similar bills being introduced in other states, and

WHEREAS, the bill is discriminatory to the medical profession since state funds are used to fund the education of many other professions through the state colleges and university systems and yet require no similar commitment from these professions,

BE IT RESOLVED, that the OSR actively oppose the Easterly bill and all similar bills which are introduced in other states and request the AAMC to do all within its power to likewise oppose its passage.

XX. Installation of the Chairperson

Tom Rado turned over the chair to Paul Scoles, the new OSR Chairperson. Mr. Scoles expressed gratitude on behalf of the OSR for Dr. Rado's leadership and capable service to OSR and AAMC during his year as Chairperson.

XXI. The OSR Business Meeting adjourned at 6:00 p.m.

From: Paul Scoles, Chairman, Organization of Student Representatives

To: All OSR Representatives

Subject: Chairman's Report

Enclosed in your agenda book are copies of the actions taken by the OSR Administrative Board during the past year. They reflect, in schematic form, the activity of the Board for the past year. Much of the work the Board has done, however, does not appear in that listing, and this report is intended to fill in the gaps.

Financial Aid

No subject has occupied more of the Administrative Board's attention than financial aid. The report of the AAMC Task Force on Medical Student Financing is included in your agenda book; I urge each of you to read it. If you leave this meeting informed on no other topic, you should be informed on this one.

There is not time to consider the Task force report in full detail here, but I think that a few of the important points bear repeating. First, it has become abundantly clear that the era of low interest loans and scholarships for medical students is over. Government agencies and their representatives are unwilling to provide financial aid for medical students without quid pro quo; without getting something in return. In general, this means a service committment, usually year for year for time in medical school under gove nment support. As you know, this is the pattern of the armed forces scholarships, and the Public Health Service scholarships. These programs are by no means

bad; many students find them attractive, and many more find them an acceptable and even desirable trade off for financial support in the face of rapidly rising costs. The problem, however, is that these programs cannot possibly have enough places for the numbers of students who will wish to take advantage of them.

The alternative is the Federal Government's Health Education Assistance Loan, inaptly nicknamed "HEAL." The details of the program are spelled out in the report, but I think the most telling detail is the simple arithmetic of the program: a student who borrows the maximum allowed amount $8,000, each year for four years, and allows interest to accrue and compound during residency would pay pack over the life of the loan more than $125,000. The impact of that debt level on the career choices of students cannot be other than detrimental. There is already evidence which suggests that students from economically disadvantaged backgrounds are being discouraged from attending medical school by the cost.

Ironically, the HEAL program has been specifically designed to be unattractive, so that students will not be drawn away from the service-committment programs.

Unfortunately, the appeals made by the Association to government agencies for programs with less punitive terms have largely fallen on deaf ears. The reaction we hear is always the same:"Why should the government subsidize medical students to enter one of the most lucrative professions? " Measured by our success in developing alternative programs which are acceptable to the decision makers, we have no good answer to that. We will continue to try; I would be less than candid if I told you the outlook was good.

Minority Affairs

A second topic which has occupied the attention of the Ad Board and of the entire AAMC has been the issue of minority opportunities in medicine, particularly in light of the Bakke decision. An Association Task Force assigned to consider this issue has submitted its report, and the summary and recommendations are included in the agenda book. This report, which is incidentally an incisive and perceptive study of of the entire issue, provides a framework within which the AAMC can design its minority affairs programs for the coming years.

The Bakke decision itself in some ways provides as many questions as it does answers. The Supreme Court reaffirmed the validity of using ethnic background as a factor to weight the medical school selection process, but said that specific quota systems, such as the system challenged by Bakke at U.C. Davis, may not be used.

The Task Force report recognizes that the medical schools and the medical profession have a responsibility to the minority community not only to provide minority physicians, but also to develop in the profession as a whole an increased sensibility to the unique health care problems of the nation's minorities.

Graduate Medical Education

At last fall's annual meeting, a resolution instructing the Administrative Board to investigate methods of improving the availability of information on residencies and the residency selection process was passed. The topic has accupied the Ad Board throughout the entire year, and I would like to take this opportunity to thank the three members of the Ad Board who spearheaded the effort, Dan Miller, Molly Osborne, and Cheryl Gutman.

The Board decided on a three- part approach to the problem. Let me say at the outset that the directory proposed last year was carefully studied and determined to be impractical. To provide the information asked for in the resolution on over three thousand residency programs in the US would require a commitment of manpower, time and funds which would be beyond the scope of the association.

The first part of the effort you have already seen: the OSR Report for last spring was devoted to the residency selection process. It was enthusiastically received, and I think provided a useful framework for students setting out to find a residency. That issue was primarily the work of Diane Newman of the AAMC staff, and as usual, she did a suberb job.

The second phase has been a joint exploration with Dr. Jack Graettinger of the NIRMP of ways to increase the amount of information in the NIRMP Directory, the white book. This effort is continuing; the NIRMP Board has agreed in principle to explore the topic, and some preliminary changes will probably appear next spring. In the meantime, changes in staffing at the LCGME, and a request for our input in the preparation of the LCGME Directory of Approved Residencies (the green book) have occurred, and it may well happen that this is the most promising route to follow in this matter.

One of the most valuable ways for students to get information on prospective residency programs is from people in the programs. The third part of the OSR's effort is intended to help schools facilitate this process. With the help of Janet Bickel, of theAAMC staff, the OSR Ad Board has developed a prototype for a questionnaire which could be sent by student affairs offices to recent graduates, asking them to evaluate the programs they entered. Samples of the questionnaire will

be made available before the meeting is over, and we will seek your input into the final format.

Manpower

One of the most provocative topics considered by the AAMC and the OSR this year has been the supply and distribution of health manpower. Three AAMC task forces have considered various aspects of this issue. Peter Shields will report more fully on one of them, the Task Force on Support of Medical Education. I was invited to work with the AAMC Executive Committee on a related topic, manpower distribution. The Executive Committee was prompted to consider this topic by the appearance of reports from the Institute of Medicine, the General Accounting Office, and the Coordinating Council on Medical Education, all pertaining to various aspects of the issue. Pete Shields will address the issue of numbers of medical students; I would like to touch briefly on the matter of distribution by specialty.

Before I do so, however, I must point out that any long term solution to the health manpower problem which does not address the issue of geographic maldistribution is incomplete. The proper 'mix' of doctors by specialty has meaning only if those doctors are located where they are needed.

A study soon to be released by the American Board of Internal Medicine suggests that if present patterns continue, the number of subspecialists in internal medicine will exceed the number of general internists. In areas where the concentration of subspecialists is too high, the effects of this can already be seen: specialists practice general medicine, simply because there isn't enough specialty work available. That in turn means that specialists are not able to maintain their skills, and that the price of care rises.

Clearly, the best interests of the American public are

served by a greater concentration of generalists. A draft report being considered by the Association recommends, among other things, that the number of subspecialty fellowships in internal medicine be substantially decreased. A summary of the working paper is in the September Ad Board minutes; I urge you to read it.

Many other topics were considered by the OSR this year; you will hear about them in detail as this meeting progresses.

On the whole, I think this has been a good year for the OSR. We have strengthed our position within the Association, and we are an increasingly important part of the workings of the AAMC. I think I can say that the election of the Chairperson of the OSR one year before taking office has worked well; I know that the year I spent as Chairman elect was invaluable.

If there is one area in which the Ad Board in general, and especially its Chairman has fallen short this year, it may be that we haven't challenged the Association enough. To an extent, this was intentional: I felt it was necessary to strengthen the OSR's position within the Association, and I think we've done that. I also think, though, that we, as the students and the future of the Association, have a responsibility to the impossible, a duty to the un-do-able. Part of our job in this organization should be to help keep the rest of the Association steered clear of complacency, alert, and perhaps just a little bit uneasy.

ANNUAL REPORT
NORTHEAST REGION

In reporting about the activities of the Northeast Region, I'm finding myself reporting about what I, as chairman, have pursued and what we, the Northeast representatives, have done as a group in Toronto last Spring. Let me begin with myself.

As chairman, my first priority this year was to provide information to my representatives. I was able to do so by sending periodic newsletters covering the events of each Administrative Board meeting, and of the regional meeting. I've been answering a number of letters from students and reps alike who have had items of individual interest. And at each step along the way I've encouraged each representative to request from the AAMC that information which the AAMC has available which may be of help to other and all medical students. This depends, of course, on one's knowing what the AAMC has to offer, and it is this which I've tried best to do this year.

As a group, we spent the larger portion of our meetings discussing the AAMC, OSR, Graduate Medical Education, and the educational system of Canada. Many new members were present as were old, and although only one resulution was formulated, a better understanding of the OSR & AAMC developed amongst the group that is to return to New Orleans this October. Our one resolution was in support of further establishment of precise guidelines for evaluation and dismissal processes. Other areas of interest concerned the cost of medical education, the lifestyle of MDs, minority admissions, and the role of the OSR representative. As an informed group of representatives, the NE region looks forward to a productive session at the Annual Meeting this month.

Respectfully Submitted,

Fred Emmel

ANNUAL REPORT
CENTRAL REGION

At the Central Regional meeting, held in Madison, Wisconsin, our time was divided between OSR business meetings, GSA/MAS/OSR general assembly meetings, and an all-day workshop also involving all three groups. During the workshops, participants divided into small groups to discuss one of three topics: "Student Stress and Institutional Response," "Equitable Procedures in Dealing with Qualified Applicants," and "An Ideal Approach to Trasnition to Postgraduate Training." Group members signed up in advance for the topic that interested them most. The small group format allowed for free exchange of ideas and opinions as well as promoting new approaches to old problems. The program was well-received by both students and counselors.

OSR members joined with the GSA/MAS general assembly to discuss topics of particular concern to students. These included issues in admissions; discrimination on the basis of age and effects of the decreased applicant pool; the status of National Health Service Corps and the federal loan programs available; and a presentation on "peer counseling," i.e., training of medical students to counsel fellow students, by Carol Parrot (OSR) and Jo Shapiro (GSA) from Medical College of Wisconsin.

Discussions at the OSR business meeting spanned a variety of topics and generated several resolutions passed by the delegates. After discussing problems in financial aids Ora Hirsch (Northwestern rep) submitted a resolution adopted by the region which allows for deferment of FISL repayment until after residency. Marjorie Barnett, Regional Vice Chairperson and rep from Michigan State University, presented a resolution adopted by the region urging AAMC to hold meetings only in states which have ratified Equal Rights Amendments. Attempting to reduce unnecessary student stress, the assembly supported a resolution introduced by Chris Shearer, NU, urging medical schools to provide both curriculum goals and specific course objectives for the basic science years. Discussion of residency programs generated 2 resolutions adopted by the assembly. The first suggested that reduced schedule residencies be included in the NRMP. The second, introduced by Nancy Havernick, Univ of Minnesota, urged residency programs to extend maximal flexibility and support to residents planning families during their training. A final motion restricted smoking at meetings to only designated areas and urged AAMC to adopt similar resolutions.

Respectfully submitted,

Dennis Schultz

Curriculum Vitae

DANIEL STEPHEN MILLER — CANDIDATE FOR CHAIRPERSON-ELECT

Birthdate: October 27, 1953 Birthplace: Turlock, California

Education:
1967-1971 Thomas Downey High School, Modesto, California
1971-1975 B.S. Bacteriology, University of California, Davis
1975- M.D. Candidate, degree expected June 1980, University of California, San Diego
Present Status - On intercampus exchange to UC San Francisco for one year independent study

Employment Experience:

Consultant/Supervisor, 1967-1975, L.L. Miller & Son, Dried Flowers, Delhi, California
Preceptee, 1976 & 1977, Northern California Rural Health Project, Yuba City, California
Teacher's aide, volunteer tutor of math/science, 1974-75, Sacramento, California
Tutor, 1974-75, Biological Sciences, Department of Zoology and Department of Biological Sciences, University of California, Davis

Research:

Figurski, Meyer, Miller, and Helinski, "Generation in vitro of deletions in the broad host range plasmid RK2 Using Phage Mu Insertions and a Restriction Endonuclease," Gene 1: 107 - 119 (1976).

Extracurricular Activities (medical school):

Member of Admissions Committee, UCSD School of Medicine, 1976-78.
Member of the Editorial Board of UCSD School of Medicine newspaper: The Murmur, 1977-78
Member of American Medical Student Association, 1975 - present.
UCSD Student Representative to Organization of Student Representatives of the Association of American Medical Colleges, 1976-78.
Representative-at-Large to Administrative Board of Organization of Student Representatives of the Association of American Medical Colleges, 1977 - present.
Student Representative to the Association of American Medical Colleges Task Force on Graduate Medical Education, 1978 - present.
Member of UCSD Student/Faculty Working Group on Humanistic Dimensions in Medical Education, 1976-78.
Member of UCSD Medical Student Task Force on Admissions and Recruitment, 1976-77.
Member of UCSD Medical Student Task Force on Freshperson Orientation, 1976-78.
Member of UCSD Medical Student Task Force on Communications, 1976-77.
Member of UCSD Medical Student Task Force on Coordinating Committee, 1975-77.

Curriculum Vitae
Fred Emmel
Candidate for Representative-at-Large

Education:
1967-70 Public High School, West Harford, Connecticut
1970-75 Colorado State University, B.S. Physical Science, Phi Beta Kappa
1976- George Washington Univ. School of Medicine

Research:
Hartford Hospital Student Fellowship in OBGYN, Summers of 1973, 1974, 1975

Support-Team Member, 1977 High Altitude Physiology Study, Arctic Institute of North America, Yukon Territory, Canada

Medical School Extracurricular Activities:
1976-79 Student Council Representative
Contributor, GW Financial Aid Handbook
Student Member, Faculty Subcommittee on Financial Aid
Member, Wm. Beaumont Research Society

AAMC/OSR positions:
1977-78 OSR representative and Northeast Regional Chairperson

Research Opportunities for Undergraduate Medical Students

WHEREAS, firsthand research experience contributes greatly to the development of scientific thought processes which are of value in all areas of medicine and continuing education;

WHEREAS, medical undergraduates have the opportunity to devote smaller blocks of time to research endeavors than is required for post-graduate research commitments;

WHEREAS, many medical students have been unaware of opportunities or have been unable to fully utilize such opportunities because of problems with scheduling, funding, etc.;

BE IT THEREFORE RESOLVED THAT, COD-OSR-CAS form a joint committee to investigate possibilities for improving and encouraging research opportunities, basic as well as clinical, for medical students with an interest towards funding, scheduling, and student research presentations.

--Submitted by the Western Region

--Approved by the OSR Administrative Board
September, 1978

ORGANIZATION OF STUDENT REPRESENTATIVES
ADMINISTRATIVE BOARD ACTIONS

January 17 and 18, 1978

APPOINTMENT OF A SECRETARY-TREASURER

ACTION: The OSR Board endorsed the appointment of David Everhart as AAMC Secretary-Treasurer.

APPOINTMENT OF THE EXECUTIVE COMMITTEE

ACTION: The OSR Board endorsed the appointment of the AAMC Chairman and Chairman-Elect, the AAMC President, and the Chairman of COD, CAS, and COTH to the AAMC Executive Committee.

ELECTION OF COTH HOSPITALS

ACTION: The OSR Board endorsed the election of Children's Hospital Medical Center, Cincinnati; North Chicago V.A.Hospital; and Orthopaedic Hospital, Los Angeles, to COTH membership.

APPROVAL OF SUBSCRIBER

ACTION: The OSR Board endorsed the granting of Subscriber status to East Tennessee University College of Medicine.

LCME ACCREDITATION DECISION

ACTION: The OSR Board endorsed the LCME Accreditation decisions.

STUDENT REPRESENTATION ON THE LIAISON COMMITTEE ON MEDICAL EDUCATION

ACTION: The OSR Board supported the recommendation that the Executive Council accept LCME's invitation to appoint a student as a non-voting member.

COMMITTEE APPOINTMENTS

ACTION: The OSR Board nominated the following individuals to serve on AAMC Committees:
Flexner Award Committee--Gary Dubois
GSA Committee on the Financial Problems of Medical Students--Robert Tomchik
GSA Minority Affairs Section Coordinating Committee--Winston Griner

OSR RESOLUTION ON GRADUATE MEDICAL EDUCATION DIRECTORY

ACTION: The OSR Board recommended that the Executive Council table the OSR resolution on the creation of a graduate medical education directory and decided to pursue instead the following three approaches: 1) discussions with Jack Graettinger, Executive Vice President of NRMP, on items which the OSR believes should be added to the NRMP Directory; 2) development of an outline of what students should look for and inquire about when considering a residency program, to be circulated to students

via OSR Report; and 3) a survey of schools about counseling programs for residency selection and development of an outline for a model residency counseling program to distribute to medical schools.

COMMITTEE ON FUTURE STAFFING

ACTION: The OSR Board endorsed the recommendation that the Executive Council support independent staffing for the Liaison Committee on Graduate Medical Education.

REPORT OF THE COMMITTEE ON PHYSICIAN DISTRIBUTION

ACTION: The OSR Board endorsed this report.

ORGANIZATION OF STUDENT REPRESENTATIVES
ADMINISTRATIVE BOARD ACTIONS

March 22, 1978

GRADUATE MEDICAL EDUCATION DIRECTORY

ACTION: The OSR board approved, with a few modifications, a draft of a letter to Dr. Graettinger, prepared by Mr. Scoles, which outlines the types of items the OSR would like to have added to the NIRMP Directory.

DISCHARGE IN BANKRUPTCY OF STUDENT LOANS

ACTION: The OSR board recommended that, while the bankruptcy option should be exercised only under extreme circumstances, the Association should not adopt a statement precluding it as an option for the debt-burdened student.

ENDORSEMENT OF LCME ACCREDITATION DECISION

ACTION: The OSR board endorsed the LCME accreditation decisions.

CAS RESOLUTION ON THE LCGME

ACTION: The OSR board approved the CAS resolution about the role of the LCGME in accrediting graduate training programs.

HEW HANDICAPPED REGULATIONS AND MEDICAL SCHOOL ADMISSIONS

ACTION: The OSR board approved the recommendation that a task force be appointed to develop national guidelines on technical standards that schools might use to comply with the HEW handicapped regulations. The OSR board recommended that the task force include student representation.

AAMC RECOMMENDATIONS ON FY 79 APPROPRIATIONS FOR VA DEPARTMENT OF MEDICINE AND SURGERY PROGRAMS

ACTION: The OSR board approved the AAMC recommendations about FY 79 funding levels for the VA Department of Medicine and Surgery Programs.

EMERGENCY MEETING ON MEDICAL MANPOWER LEGISLATION

ACTION: The OSR board endorsed the recommendation made by the Steering Committee of the Task Force on Support of Medical Education that no further amendments should be made to P.L. 94-484.

WITHHOLDING OF SERVICES BY PHYSICIANS

ACTION: The OSR board endorsed the statement drafted by the special committee on the withholding of services by physicians.

AAMC STATEMENT ON INVOLVEMENT WITH FOREIGN MEDICAL SCHOOLS

ACTION: The OSR board approved the recommended statement about U.S. faculty participation as visiting professors in the programs of foreign medical schools.

INDUSTRY-SPONSORED RESEARCH AND CONSULTATION: RESPONSIBILITIES OF THE INSTITUTION AND THE INDIVIDUAL

ACTION: The OSR board endorsed the draft position paper as AAMC policy for transmittal to Congressman Rogers and to the medical schools.

AAMC BIOMEDICAL AND BEHAVIORAL RESEARCH POLICY

ACTION: The OSR board endorsed the proposed policy statement on biomedical and behavioral research.

ORGANIZATION OF STUDENT REPRESENTATIVES
ADMINISTRATIVE BOARD ACTIONS

June 21, 1978

LCME ACCREDITATION DECISIONS

ACTION: The OSR Board endorsed the LCME Accreditation decisions.

ELECTION OF CAS MEMBERS

ACTION: The OSR Board endorsed the CAS Administrative Board recommendations with regard to the election of the Association of Academic Departments of Otolaryngology and the Thoracic Surgery Program Directors.

AAMC AFFILIATE INSTITUTIONAL MEMBERSHIP

ACTION: The OSR Board endorsed the recommendation that the Executive Council require accreditation by the LCME as a prerequisite for election to Affiliate Institutional Membership.

ELIGIBILITY FOR CONTINUING COTH MEMBERSHIP

ACTION: The OSR Board endorsed the recommendation that the Executive Council approve and forward to the Assembly the following revision to the COTH Membership requirements:

1. That hospitals belonging to COTH prior to July 1, 1978 who do not have a signed affiliation agreement be retained as members provided they continue to maintain the required number of residencies;

2. That teaching hospital members that either do not sponsor or participate in four approved residency programs or do not have two programs within the required basic six residencies be reclassified as corresponding members; and

3. That the NIH Clinical Center be retained as a full teaching hospital member recognizing its specialty care nature.

AAMC BIOMEDICAL AND BEHAVIORAL RESEARCH POLICY

ACTION: The OSR Board endorsed the AAMC policy statement on biomedical and behavioral research.

REPORT OF THE TASK FORCE ON MINORITY STUDENT OPPORTUNITIES IN MEDICINE

ACTION: The OSR Board endorsed the acceptance of this report.

RECENT MANPOWER REPORTS FROM GENERAL ACCOUNTING OFFICE, INSTITUTE OF MEDICINE, AND COORDINATING COUNCIL ON MEDICAL EDUCATION

ACTION: The OSR Board concurred with the recommendation that an AAMC Committee be constituted immediately to analyze these documents and to develop an official AAMC position with respect to their recommendations, as well as the strategy for the most effective use of that position.

FINANCIAL CONSIDERATIONS FOR ADMISSION TO MEDICAL SCHOOL

ACTION: The OSR Board endorsed the proposed AAMC's policy statement on financial consideration for admission to medical school.

RECOMMENDATIONS OF THE CCME COMMITTEE ON THE OPPORTUNITIES FOR WOMEN IN MEDICINE

ACTION: The OSR Board endorsed the recommendation that the Executive Council approve these recommendations.

REPORT OF THE CCME COMMITTEE ON THE OPPORTUNITIES FOR WOMEN IN MEDICINE

ACTION: The OSR Board endorsed the recommendation that the Executive Council request the CCME to have this report revised along the lines outlined in the AAMC staff critique.

ORGANIZATION OF STUDENT REPRESENTATIVES
ADMINISTRATIVE BOARD ACTIONS

September 13, 1978

LCME ACCREDITATION DECISIONS

ACTION: The OSR Board endorsed the LCME Accreditation decisions.

PROVISIONAL INSTITUTIONAL MEMBER

ACTION: The OSR Board approved the election of East Tennessee State University to Provisional Institutional Membership subject to favorable recommendation by the COD Administrative Board and subsequent ratification by the full COD.

ELECTION OF COTH MEMBERS

ACTION: The OSR Board agreed to endorse the COTH Administrative Board's recommendation regarding the election of Mercy Hospital (Urbana, IL) and Baroness Erlanger-T.C. Thompson Children's Hospital (Chattanooga, TN).

ELECTION OF CAS MEMBERS

ACTION: The OSR Board agreed to endorse the recommendation of the CAS Administrative Board regarding the election of American Society for Pharmacology and Experimental Therapeutics, Association of Academic Health Sciences Library Directors, Association for the Behavioral Sciences and Medical Education, and Society for Neuroscience.

DISTINGUISHED SERVICE MEMBER NOMINATIONS

ACTION: The OSR Board agreed to endorse the recommendations of the Administrative Boards of COTH and COD regarding these nominations.

ELECTION OF EMERITUS MEMBERS

ACTION: The OSR Board endorsed the recommendation that the Executive Council approve and recommend to the Assembly the election to Emeritus Membership of the individuals submitted by the Executive Committee.

ELECTION OF INDIVIDUAL MEMBERS

ACTION: The OSR Board agrred to endorse the recommendations of the Executive Council regarding the applications of the individuals listed in the Executive Council Agenda.

SUBSCRIBER STATUS

ACTION: The OSR Board endorsed the recommendation that the first criterion for eligibility for subscriber status be changed to read: "Those subscriptions shall be open to any institution, organization or individual in the United States or Canada demonstrating a commitment to medical education and not eligible for any class of voting membership."

FLEXNER AND BORDEN AWARDS

ACTION: The OSR Board endorsed the nomination of Dr. Ivan L. Bennett, Jr. for the 1978 Flexner Award and of Dr. Bert O'Malley for the 1978 Borden Award.

REPORT OF THE TASK FORCE ON MINORITY STUDENT OPPORTUNITIES IN MEDICINE

ACTION: The OSR Board endorsed the acceptance of this report as revised.

REPORT OF THE TASK FORCE ON STUDENT FINANCING

ACTION: The OSR Board endorsed the acceptance of this report.

PRELIMINARY REPORT OF THE TASK FORCE ON THE SUPPORT OF MEDICAL EDUCATION

ACTION: The OSR Board endorsed the tentative approval of this report.

WITHHOLDING OF MEDICAL CARE BY PHYSICIANS

ACTION: The OSR Board expressed general agreement with the proposed, revised statement on the withholding of medical care by physicians.

REPORT OF THE TASK FORCE ON MINORITY STUDENT OPPORTUNITIES IN MEDICINE

This AAMC Task Force was established by the Executive Council in February 1976. An interim report was presented at the September 1977 meeting of the Executive Council. At its September 1978 meeting, the final report was approved. A summary of the goals and recommendations of the Task Force is presented below:

General Recommendations:

a. This report, upon receiving approval by the AAMC Executive Council, should be widely distributed, including presentation to the AAMC Assembly at the October 1978 Annual Meeting.

b. The AAMC Executive Council should establish appropriate mechanisms for monitoring the implementation of the recommendations in this report and for biennial review of the progress toward achievement of the goals of this report.

c. In recognition of the diversity of the member schools of the AAMC, we encourage each school to review its own minority affairs program in light of this report and to adopt those recommendations which relate to identified deficiencies.

d. The Federal government must regain its concern for increasing opportunities for racial minority groups, furnish leadership in the continuation of special programs for racial minority groups in the health professions and associated graduate programs, and provide as much financial support as possible toward their continuation. In addition, State governments should increase their support and leadership in the development and continuation of special programs for racial minority groups in the health professions.

e. We believe that medical schools should provide proper and stable funding for comprehensive and effective minority affairs programs, while recognizing that the absence of financial support from governmental and private sources will drastically limit the range of responses available to the medical schools.

GOAL 1: INCREASE THE POOL OF QUALIFIED RACIAL MINORITY APPLICANTS TO LEVELS EQUIVALENT TO THEIR PROPORTION IN THE U.S. POPULATION WITH PROGRESS TOWARD THAT GOAL REVIEWED ON A BIENNIAL BASIS.

Recommendations:

a. While recognizing the vital need for improvement of the entire educational pathway as it affects racial minority students, we believe that an appropriate

focus for medical schools would be the establishment of meaningful relationships with the colleges and senior high schools in their region to encourage, motivate, and prepare students from racial minority groups for careers in medicine.

b. Medical schools should develop internal financial mechanisms to insure the continuation of aggressive recruitment programs.

c. The AAMC should provide the leadership necessary to obtain the funds for a comprehensive study of career choices and career perceptions of racial minority students at the high school and college levels.

d. The AAMC should furnish the leadership for the development of a transferable model program for the retention and reinforcement of freshman and sophomore undergraduate premedical students with emphasis on skills acquisition using the vehicle of relevant studies in human and health sciences (biology, chemistry and physics). A consortium of medical schools and appropriate undergraduate colleges would perhaps be best suited to undertake such an effort.

e. Medical schools should increase their efforts to improve communication with undergraduate advisors, faculty in beginning science courses, and minority program officers at undergraduate institutions.

f. Medical schools should offer a variety of experiences (seminars, guidance and advising, special classes, evening research,etc.) to acquaint high school and racial undergraduate minority students with the nature of medical education.

g. Medical schools should use their influence to stress the value and importance of good advising on the undergraduate campuses, since this important function is often relegated to a minor role at many colleges and universities.

h. The AAMC and the Group on Student Affairs should continue all positive communication links between preprofessional advisors and the medical schools.

i. The AAMC should provide the leadership for recognition of the traditionally Black colleges and other colleges with significant minority populations as a national resource. In addition, the AAMC should encourage and support the development of programs to enhance these colleges as a means of increasing the pool of qualified racial minority medical school applicants.

GOAL 2: ENLARGE THE NUMBER OF QUALIFIED RACIAL MINORITY STUDENTS ADMITTED TO MEDICAL SCHOOL THROUGH IMPROVEMENT OF THE SELECTION PROCESS.

Recommendations:

a. The SMAE should be updated and broadened in its scope to include other racial minority groups in addition to Black Americans and Mexican Americans.

b. The AAMC should continue to work with medical schools toward the improvement of the interview as a tool of admission via SMAE workshops, publications, and training programs.

c. Admissions Committees should use New MCAT Test results with judicious caution prior to the completion of validation studies by the AAMC and by individual medical schools.

d. Admissions Committees should be cognizant of the demonstrated differences in performance on the New MCAT of racial minority students and place a special emphasis in assisting these candidates by using the criteria for predicting performance which have been developed in the Simulated Minority Admissions Exercises (SMAE) Program.

e. The AAMC should increase its effort to develop instruments and/or procedures for the use of noncognitive information in the admission of medical students and in the prediction of physician performance.

f. The AAMC should complete the development of a publication related to test-taking skills and studying approaches for the New MCAT.

GOAL 3: EMPHASIZE THE IMPORTANCE OF FINANCIAL ASSISTANCE FOR RACIAL MINORITY GROUP STUDENTS PURSUING CAREERS IN MEDICINE.

Recommendations:

a. AAMC should encourage foundations, corporations, and individuals to support the efforts to increase access of racial minority students in medicine by increased financial support of National Medical Fellowships, Inc.

b. Medical schools should encourage early counseling of pre-matriculating medical students regarding the realities of funding for medical education, the necessity for careful budgeting and planning, in addition to traditional explanations of current financial aid sources.

c. The Task Force endorses all of the recommendations presented in the Interim Report of the Task Force on Student Financing but places particular emphasis on the following:

(1) The Guaranteed Student Loan Program (GSLP) should be modified such that (a) annual borrowing limits for medical students would be increased from $5,000 to $10,000; (b) the aggregate borrowing limit would be increased from $15,000 to $35,000 and indexed to inflation; and (c) the repayment period for those who borrow over $15,000 would be increased from 10 to 20 years.

(2) The funding for the Scholarships for the First Year Students of Exceptional Financial Need should be increased and the program be expanded to include second year students of exceptional financial need. In addition, the Health Professions Loan Program, now restricted to students of Exceptional Financial Need, should be maintained at its current level.

(3) Because of increasing dependence upon private capital markets as sources of financial support for medical students, medical schools should develop better relationships with lending agencies in order to help their students secure access to loan funds.

GOAL 4: STRENGTHEN PROGRAMS WHICH SUPPORT THE NORMAL PROGRESS AND SUCCESSFUL GRADUATION OF RACIAL MINORITY STUDENTS ENROLLED IN MEDICAL SCHOOL.

Recommendations:

a. All medical schools should have individuals or an office with clear responsibility for representing the interests of racial minority medical students. These individuals or the staff of this office should be sensitive to minority needs and have an understanding of minority values and culture. This office should be an integral part of the medical school administration.

b. Medical schools should support organizations among racial minority students that serve vital social functions, and enable these students to contribute collectively to the cultural, political, and academic life of the medical school.

c. Medical schools should improve their academic support programs and provide academic evaluation on a regular and frequent basis.

d. Medical schools should improve their personal support programs. Specific programs should be developed to increase the emotional support base provided to racial minority students.

GOAL 5: INCREASE THE REPRESENTATION OF RACIAL MINORITY PERSONS AMONG BASIC SCIENCE AND CLINICAL FACULTY.

Recommendation:

a. The AAMC and the medical schools should seek funding for minority faculty development programs with strong training for research and teaching and with top level fellowship stipends. The Johnson Clinical Scholarship, the Markle Scholarship, the Macy Faculty Scholar Award and the Minority Access to Research Careers (MARC) programs are recommended as valuable prototypes.

GOAL 6: ENCOURAGE THE ESTABLISHMENT OF FACULTY DEVELOPMENT PROGRAMS AIMED AT FOSTERING AN UNDERSTANDING OF THE HISTORY AND CULTURE OF RACIAL MINORITY GROUPS AND AT IMPROVING THE QUALITY OF MEDICAL SCHOOL INSTRUCTION.

Recommendations:

a. The AAMC should encourage medical schools to establish faculty development programs aimed at fostering an understanding of the history and culture of racial minority groups.

b. Medical schools should develop mechanisms to involve the faculty in the planning, development, and implementation of minority affairs programs and to reward those who have been active participants.

c. The AAMC should encourage the development of programs to improve the teaching skills of the faculty. This should be done through such existing structures as the Group on Medical Education, the Council of Academic Societies, the Group on Student Affairs and its Minority Section.

GOAL 7: ENSURE THAT GRADUATE MEDICAL EDUCATION NEEDS AND OPPORTUNITIES FOR RACIAL MINORITY STUDENTS ARE MET.

Recommendations:

a. Academic medical centers and teaching hospitals should remain sensitive to the graduate medical education needs and opportunities of racial minority students.

b. The AAMC should monitor the career development during graduate medical education of racial minority students through the Medical Student Information System and the Career Development Data Base.

c. The AAMC should take measures to study the interface between undergraduate and graduate medical education. The investigations should focus on the issue of increased competition for available graduate training positions and whether or not racial minority students are obtaining desirable training positions.

REPORT OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TASK FORCE

ON

STUDENT FINANCING

SEPTEMBER 1978

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FOREWORD

The Task Force members are grateful for the participation in its deliberations of individuals from the Federal Government and from the private sector (see Appendix A). Those individuals helped acquaint the Task Force members with the problems involved in student financial aid programs from the perspective of the providers of financial aid.

The Task Force members were also aided in their effort by the wealth of information that was brought to their attention on the subjects of how medical students finance their education and of the availability of financial aid to medical students. Three studies deserve special mention because of their significant contribution to this report and are highly recommended for anyone interested in more detailed information on the above subjects than can be included in this report. These studies are Survey of How Medical Students Finance Their Education 1974-75, prepared for the Department of Health, Education and Welfare by the AAMC; "A New Era in Medical School Finance 1976-80," by Michael Koleda and John Craig of the National Planning Association; and a report issued by the Congressional Budget Office in August 1976 entitled, "The Role of Aid to Medical, Osteopathic, and Dental Students in a New Health Manpower Education Policy."

Mr. Kurt Kendis, of the Higher Education Finance Research Institute at the University of Pennsylvania, served as a consultant to the Task Force and provided the Task Force with computer simulations of the costs of borrowing to the student and government of a large number of different loan programs. These simulations have been particularly helpful in contrasting the costs of the new Federal loan programs to existing loan programs. Several of the tables prepared for the Task Force are included in the report. (Individuals with a particular interest in modeling loan programs with different parameters may find it useful to discuss their needs with Mr. Kendis.)

The Task Force also wishes to express its gratitude to Daniel C. Redmond of the University of Wisconsin and to Robert J. Boerner and Suzanne P. Dulcan of the AAMC staff for their efforts in assembling information and preparing the interim and final reports.

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INTRODUCTION

Until about 15 years ago, the cost to students of medical education was relatively low, and most of those who chose to study medicine were sufficiently affluent that their educational expenses could be paid from family resources or privately negotiated loans. Starting in the early 1960s, however, the costs of medical education began to escalate rapidly along with all other health care costs in the United States, and social consciousness began to require that the opportunity to study medicine should not be limited to the well-to-do. In response, the Federal Government initiated programs of scholarships and low-interest loans for health professions students which, in combination with traditional sources of funds, some privately sponsored programs, and the resources of the medical schools themselves, supported increasing numbers of medical students from all eocnomic backgrounds while preserving their freedom to practice medicine in the settings of their choice. Many medical schools and students became dependent on such programs of Federal funding.

More recently, public policy has reflected a shift in national priorities from expanding the numbers of health professionals to remedying their geographic and specialty maldistribution. Consequently, the nature of Federal financial assistance has shifted largely to scholarships which require a service commitment and loans which may be forgiven in part for practice in primary care. The most recent health manpower legislation embodies these concepts in its two major programs related to student financing, the National Health Service Corps and the Health Education Assistance Loans. This trend has had a major and often disturbing impact on students whose personal career goals are not compatible with the constraints imposed by Federal financial assistance but who, in the face of rising costs and diminishing private resources, are otherwise unable to finance a medical education.

The AAMC Task Force on Student Financing was established in February 1976 to "analyze how medical students are actually financing their educational costs, to examine existing and potential sources of financial aid to medical students and to present recommendations to the AAMC Executive Council." In June 1977 the Task Force submitted an interim report which included the following preliminary findings:

1. There is a shortage of financial aid for students enrolled in medical schools in the United States.

2. The financial aid shortfall will have its greatest impact on those students with limited access to personal or family financial resources.

3. The principal factors affecting the financial aid shortfall, its impact on economically disadvantaged students, and its eventual resolution are:

A. A shift in Federal policy away from grants and direct Federal loans awarded on the basis of financial need and toward grants with service obligations not awarded on a need basis and privately financed loans guaranteed by the Federal Government.

B. A reluctance on the part of private lenders to provide capital for Federally guaranteed student loans.

C. The minimal impact that the expansion of scholarship programs with a service commitment has upon the financial aid shortage.

D. Unrealistically low limits set for borrowing by medical students in present loan programs.

4. Increasing debt burdens will create serious repayment problems for physicians during the postgraduate education years.

5. The proposed Health Education Assistance Loan (HEAL) program for health professions students does not appear to be a workable program.

The interim report also described a model, Federally subsidized loan program for health professions students which would have been responsive to their unique circumstances. Subsequent to the interim report it became clear that the proposed new loan program would not be acceptable to Federal legislators or policy-makers. The Task Force has therefore directed its attention toward the following major goals for improvement of medical student financing.

GOAL 1: PROVIDE ADEQUATE AND APPROPRIATE FINANCIAL ASSISTANCE TO ASSURE THAT STUDENTS ASPIRING TO CAREERS IN MEDICINE ARE NOT DETERRED BY FINANCIAL CIRCUMSTANCES.

GOAL 2: INCREASE AVAILABILITY OF NEED-BASED SCHOLARSHIP FUNDS, WITHOUT A SERVICE COMMITMENT, TO ENSURE THAT FINANCIALLY DISADVANTAGED STUDENTS DO NOT HAVE TO BORROW UNMANAGEABLY LARGE AMOUNTS, PARTICULARLY DURING THE FIRST TWO YEARS OF MEDICAL EDUCATION.

GOAL 3: CREATE AN ADEQUATE LOAN MECHANISM THROUGH COMMERCIAL LENDERS, WITH A FEDERAL GUARANTEE, AN INTEREST SUBSIDY FOR NEEDY STUDENTS, AND REPAYMENT SCHEDULES WHICH TAKE INTO ACCOUNT THE FINANCIAL REQUIREMENTS OF BOTH BORROWERS AND LENDERS.

GOAL 4: PROVIDE TO MEDICAL AND PREMEDICAL STUDENTS THE INFORMATION AND COUNSELING NECESSARY TO GOOD FINANCIAL PLANNING FOR MEDICAL

EDUCATION.

GOAL 5: DEVELOP AND USE A VARIETY OF STRATEGIES APPROPRIATE TO INDIVIDUAL INSTITUTIONAL CIRCUMSTANCES TO PROVIDE ADEQUATE STUDENT FINANCING.

This final report presents discussion of these goals and recommendations for action to accomplish them.

BACKGROUND

The history of financial aid specifically directed toward students in the health professions is relatively short. Prior to 1962, financial support for medical students was largely limited to personal or family resources, the minimal funds available at some medical schools, and National Defense Student Loans (now National Direct Student Loans) which were inaugurated in 1958 under the National Defense Education Act but were intended for undergraduate and nonprofessional graduate students.

The first national program of financial support for medical students was established in 1962 by the American Medical Association through its Education and Research Foundation. Funded largely by contributions from practicing physicians, the AMA-ERF program guaranteed loans made by private lenders to medical students and residents in training.

The Federal Government first became involved in financial aid specifically for health professions students with the passage of the Health Professions Assistance Act (HPEAA) of 1963. The original objective of this legislation and subsequent renewals in the 1960s was to cure a perceived shortage of health professionals by increasing the supply. It was also expected that significant public support of health professions education would increase access to health professions careers by students from all income levels and that the geographic and specialty distribution of health professionals would improve as their numbers expanded. HPEAA created new programs of Federal grants, Health Professions Scholarships (HPS), and low-interest loans, Health Professions Student Loans (HPSL), directed only to students at MODVOPP* schools.

HPS and HPSL funds were awarded to participating schools; student recipients were selected by the schools. Criteria for selection included demonstrated "need" for HPSL and "exceptional need" for HPS according to the schools' own definitions of need. In FY 1965, $6.6 million in Health Professions Student Loans was allocated to over 7,000 medical students (23 percent of all medical students). By FY 1968, 37 percent of medical students were receiving HPSL assistance totaling $14.7 million. As recently as FY 1972, total HPSL awards of $15.9 million supported 35 percent of medical students, for whom costs were escalating much more rapidly than available financial aid. Significant numbers of medical students also received Health Professions Scholarship funds: e.g., $3.2 million to 22 percent of students in FY 1968 and $7.2 million to 20 percent in FY 1972.

Between 1963 and 1976 medical school enrollments almost doubled. During those years, however, medical students expenses more than doubled, and the Federal presence in the financing of medical education became

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*Medicine, Osteopathy, Dentistry, Veterinary Medicine, Optometry, Podiatry, Pharmacy

dominant. The total amount of financial assistance awarded annually to medical students (loans and scholarships from all sources) rose from $14 million in 1963-64 to $165 million in 1976-77. This almost twelve-fold increase was due primarily to the expanding role of the Federal Government which supplied, or was guarantor of, approximately two-thirds of the $165 million awarded in 1976-77.

By the early 1970s, however, the need for increasing the aggregate supply of physicians was undergoing re-examination. It was perceived that efforts to meet this original objective had succeeded and that further increases in medical school enrollments were not required. Further, the applicant pool for medical school had expanded even more rapidly than available first-year positions, indicating that incentives were no longer needed to encourage applications to medical school. Most important, the assumption that increased competition by increased numbers of physicians would change maldistribution of health care services was being proved false; the growing number of physicians was having little or no apparent effect on geographic or specialty distribution.

Consequently, the Federal Government changed the goal of its involvement in health professions student financing from increased production of health professions personnel to improved distribution of health care services. With this change came a major revision in the philosophical basis of student financing mechanisms. Federal scholarships and low-interest loans would be curtailed and would be replaced by programs involving student commitments to serve in underserved areas in exchange for financial support. Under the Public Health Service Scholarship program, initiated in 1973, grants covering tuition and fees plus a monthly stipend for living expenses were awarded to students who agreed to serve one year for each year of support either in the National Health Service Corps, providing care to medically underserved communities, or in medical facilities of the Public Health Service, the Indian Health Service, the U.S. Coast Guard, or Federal prisons. PHS Scholarships offered full funding to students willing to make the required service commitment; financial need was not a criterion for selection of Scholarship recipients.

The service scholarship concept grew rapidly. In 1973-74, 370 PHS Scholarships totaling about $1.8 million were awarded. In 1976-77, more than 2,000 medical students received over $18.5 million in PHS Scholarships, which had come to be called "PHS-NHSC Scholarships" because the vast majority of obligated students were to be assigned to the National Health Service Corps. Meanwhile, the Armed Forces Health Professions Scholarship program, authorized under the defense budget and providing benefits comparable to those of PHS Scholarships to students in exchange for military medical service, had begun operation in 1973 and had grown to the point that it awarded almost $21.2 million to nearly 3,000 students in 1976-77. Thus about 40 percent of the roughly $100 million in medical student assistance provided or guaranteed by the Federal Government in

1976-77 took the form of scholarships with a commitment for future service. But this major investment of public funds was allocated to less than 10 percent of medical students, without regard to their financial circumstances.

Meanwhile, the shift in national priorities had called into question the equity of non-service scholarships and low interest loans to students in those health professions where graduates are virtually assured of high future incomes. Although the service-related scholarships, with their disregard for the financial need of recipients, cannot be considered as real student financial aid, the early HPEAA assistance programs diminished as the service scholarships increased. In 1974 a complete phase-out of Health Professions Scholarships was initiated, and appropriations for Health Professions Student Loans began to decrease.

The most recent renewal of Federal health manpower legislation is the Health Professions Educational Assistance Act of 1976 (PL 94-484), signed by President Ford on October 12, 1976, and amended in late 1977 by PL 95-215. The major student financing provisions of PL 94-484, as amended, are summarized below.

National Health Service Corps (NHSC). The National Health Service Corps is revised and extended, and a new NHSC scholarship program (successor to the PHS scholarship program) is created. Scholarship recipients receive tuition, educational expenses, and a monthly stipend of $400 (adjustable with inflation). Recipients must in turn agree to serve in the National Health Service Corps one year for each year of scholarship support (minimum two years). Applicants failing to accept the scholarship are liable for damages of $1,500. The penalty for failure to perform obligated service is 3 times the amount of scholarship assistance plus interest at the maximum prevailing rate, payable in one year.

Health Education Assistance Loans (HEAL). This is a new program of Federally insured loans for health professions students. Medical students attending eligible schools may borrow up to $10,000 per year (up to an aggregate maximum of $50,000) at an interest rate not to exceed 12 percent (plus an insurance premium not to exceed 2 percent). Loans may be used solely for tuition plus other reasonable educational expenses or to pay interest due on previous HEAL loans. No more than 50 percent of the students in each class of a medical school may be HEAL borrowers. HEAL loans are repayable over 10-15 years, starting 9 months after the borrower ceases to be a full time student or 9 months after the borrower ceases to be an intern or resident if the borrower enters an accredited internship/residency program within 9 months of graduation. However, the loan must be repaid in full within 23 years after it is made. Interest must be paid from the date of origination of the loan; borrowers may elect either to pay the interest while in school or

to have interest accrue and compound. At the discretion of DHEW, it may be possible for HEAL loans to be forgiven in exchange for service in the NHSC or private practice in a health manpower shortage area.

Health Professions Student Loans (HPSL). This program is continued through 1980, but students must have "exceptional financial need" to qualify for HPSL funds. The maximum annual loan is modified to be "cost of tuition plus $2,500" (formerly maximum of $3,500), and the interest on HPSL loans is increased from 3 to 7 percent.

Scholarships for First-Year Students of Exceptional Financial Need (EFN Scholarships). Under this new program, Federal funds are awarded to schools which then select scholarship recipients in the first year of study. The scholarships provide the same benefits as NHSC scholarships, but recipients incur no service obligation.

Discussion of PL 94-484

The student assistance elements of PL 94-484, in combination and as a result of the history of Federal involvement in medical student financial aid, suggest an unsatisfactory resolution to the national societal goals of equal access to education and equal access to health care services. NHSC scholarships direct an abundance of financial support to a relative few who may or may not be genuinely interested in providing health care to the underserved. HEAL loans have the potential, if sufficient lending agencies are identified, to support the education of future health professionals, but only if today's students are willing to incur extremely high persoanl debts which, in turn, must be borne by all segments of society in the form of increased patient fees. The EFN Scholarship program takes cognizance of the particular problems of those who are economically disadvantaged and seek practice in primary care rather than a higher paying specialty. At its current funding level, however, the EFN Scholarship program is at best a token which will increase frustration and uncertainty for the very students it purports to assist.

Coercion abounds in PL 94-484. Since no more than half of the students in a class may in any case receive HEAL loans, large numbers of low- and middle-income students may be effectively forced into the obligations of the National Health Service Corps. EFN Scholarship recipients are accorded preference for NHSC scholarships after the first year of training; the vast majority of these disadvantaged students will likely have no alternative to regimented public service for at least the early portions of their careers. At every turn, all but the most wealthy of medical students have no choice but to enter highly remunerative medical specialties in order to repay high educational debts or to acquiesce to medical practice in a geographic or specialty setting that meets soci-

etal needs as perceived by the U.S. Congress in 1976.

The medical education community is hampered in its response to this complex situation by the fact that medical student financing has come to depend upon Federal support. From 1964 to 1971 the proportion of students relying upon family loans and gifts decreased as the HPS and HPSL programs were instituted. But that trend has reversed, and from 1971 to 1975 the proportion of students reporting gifts or loans from their families increased from 45 percent to 64 percent. At the same time the Guaranteed Student Loan Program* increased in importance as a source of financial aid, growing from 28 percent of borrowed funds in 1971 to 46 percent of borrowed funds in 1975. Health Professions Student Loans, although increasing during that period, became a less significant force, dropping on a per capita basis below their 1968 level. Service scholarships grew from 6 percent of total available aid monies in 1973 to 36 percent in 1976.

It is unlikely that this dependence on public funding can be reversed. Many medical schools have also come to rely on Federal support of various types, including capitation. As capitation decreases, tuitions must rise to fill the gap, thus escalating student costs and student dependence on whatever forms of financial assistance are available. Health professions students--because of the extraordinary expenses of all components of their particular educational setting--seem to have become vulnerable to a subtle form of indentured servitude to the public.

If, as seems clear, student financing of medical education will--in the absence of significant alternatives--reflect with precision the policies of Federal funding, then the wisdom of those policies must be carefully examined. The goals and recommendations which follow outline ways in which Federal programs, institutional initiatives, and AAMC activities can be directed to increase the equitability of the financing of medical education.

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*The Guaranteed Student Loan Program (GSLP), also known as the Federally Insured Student Loan (FISL) program, guarantees loans from private lenders and subsidizes the interest on the loans for financially needy students. The GSLP, first funded in 1966, was primarily targeted at undergraduate and vocational students and was never intended to be a major financial resource to graduate students in the health professions.

GOAL 1: PROVIDE ADEQUATE AND APPROPRIATE FINANCIAL ASSISTANCE TO ASSURE THAT STUDENTS ASPIRING TO CAREERS IN MEDICINE ARE NOT DETERRED BY FINANCIAL CIRCUMSTANCES.

The ability to finance a medical education may be a major determinant of who shall be the physicians of the future and where and how they will practice medicine. Data demonstrate that individuals from low- and middle-income families are significantly less likely than their more wealthy counterparts to receive baccalaureate degrees and thus to have any chance of considering or being considered for the study of medicine.[1] Similarly, for those who do receive undergraduate degrees, real and perceived inabilities to pay for professional training may well be responsible for the recent sharp decline in numbers of applicants to medical school.[2] It must be assumed that the rapid escalation of the costs of medical education in the recent past, coupled with a decline in financial need-based student assistance, has served not only to discourage potential applicants but also to threaten the chances for success of those who are accepted to medical school.[3] At the very least many students are tempted to change career choice because the pressure of indebtedness compels them to seek a high-paying specialty. These effects of economics on those who would be doctors must be reversed, not only because they run counter to national goals of equal opportunity and access but also because they will certainly be reflected in substantially increased costs of health care for all segments of the public.

The remainer of this report addresses strategies to deal with these

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[1]Boerner, Robert J. "Family Income of Medical School Applicants and Acceptees and of College Students." Journal of Medical Education, 52: 948-949, 1977

[2]The number of applicants for 1978 medical school entering classes was 10.2 percent lower than the number of applicants for the previous year. An American Dental Association study of a similar drop in the dental applicant pool between 1974 and 1976 revealed that the greatest decrease in applicants was among those from families in the socioeconomic lower middle class.

[3]According to data reported to the Liaison Committee on Medical Education, four students withdrew from medical school in each of the academic years 1975-76 and 1976-77 for what were described as "financial reasons." Prior to 1975, financial considerations had not been reported among reasons for withdrawal. Experience of several Task Force members indicates that financial pressures are often related to withdrawals for other reasons and dismissals.

problems. The views of the Task Force about this matter are based upon the perceptions of the many people who are consulted on this topic and the data available. The "hard" data, however, are incomplete. The Association through its Medical Student Information System is already gathering annually basic information on financial status, socio-economic background and career choice at the time students take the MCAT, apply to medical school and graduate from medical school. The Association has in the recent past performed studies for HEW on How Medical Students Finance Their Education 1974-75 and Medical Student Indebtedness and Career Plans 1974-75. The Task Force believes that these types of annual and periodic in-depth reviews of student financing should continue in order to provide the data necessary for examination of the relationships between costs and results of medical education. Should problems be found to exist, steps should be taken as outlined elsewhere in this report or as deemed appropriate to correct each situation, but it is most important that the data gathering and analyses continue independent of outside stimulation or funding.

Recommendation:

1. The AAMC should monitor changes in financial and socio-economic background of the applicant pool and of students enrolling in medical school. If the changing nature of student financial aid appears to be contributing to a decline in the representation of economically disadvantaged students in medical school or in the applicant pool, the Association should take appropriate action such as recommended elsewhere in this report to correct the situation.

GOAL 2: INCREASE AVAILABILITY OF NEED-BASED SCHOLARSHIP FUNDS, WITHOUT A SERVICE COMMITMENT, TO ENSURE THAT FINANCIALLY DISADVANTAGED STUDENTS DO NOT HAVE TO BORROW UNMANAGEABLY LARGE AMOUNTS, PARTICULARLY DURING THE FIRST TWO YEARS OF MEDICAL EDUCATION.

PL 94-484

A new Scholarship Program for First-Year Students of Exceptional Financial Need (EFN Scholarships) was created by PL 94-484. The legislation provides that EFN Scholarships include payment of tuition, all other reasonable educational expenses, and a stipend of $400 per month (adjustable for inflation). The legislation does not define "exceptional financial need." Although authorized for federal expenditures of $16-17-18 million in FYs 1978-79-80, only $5 million was appropriated for EFN Scholarships in FY 1978.

The EFN Scholarship concept is sound. It takes cognizance of the fact that economically disadvantaged students require some relief from financial pressures in order to be able to manage the multiple stresses imposed by demanding health professions curricula. But the EFN Scholarship program in its present form does not, in two important ways, fairly or adequately address the problem it seeks to solve.

First, without opportunity for public comment, DHEW announced in June 1978 that "exceptional financial need" for the purposes of the EFN Scholarship program would exist only when a student has "zero" financial resources. This definition may have emerged in an administrative effort to limit numbers of eligible students to the approximate number who can be funded under the $5 million appropriation. This approach totally ignores the reality that many students who are genuinely needy may nonetheless have marginal "resources" to contribute to their professional education. For example, an AAMC survey of 12 representative schools suggests that only 3.5 percent, or approximately 570 of all 16,800 first-year medical students in 1978-79, will qualify for EFN Scholarships. However, AAMC data also suggest that there will be approximately 1,600 first-year students in 1978-79 who are from families with annual incomes under $10,000 or who are identified as economically disadvantaged in other ways.

Secondly, EFN Scholarship support for only one year is inadequate. In most medical curricula, the first two years of study are equally critical and demanding--particularly for students who carry financial burdens as well as academic and personal stresses. After two years, the likelihood that medical students will complete their studies and receive the M.D. degree is high. After two years, students can accept substantial loans required to complete their education with confidence that the loans can be repaid from future earnings.

Other Federal Programs

The Health Professions Scholarship Program, which provided more than $51 million to needy students through FY 1977, has been phased out.

Armed Forces Health Professions Scholarships and National Health Service Corps Scholarships are not properly financial aid mechanisms. They are designed to meet goals of specialty and geographic practice distribution rather than goals of equal access to education; they require a service commitment from students who receive them; and financial need is not a criterion for selection of recipients (except that recipients of EFN Scholarships will be given priority for NHSC Scholarships after their first year of study). It must be assumed that some students who apply for and receive these scholarships are financially needy (although data to demonstrate this are not available due to the record-keeping procedures of the programs), and some of these students may find the service commitments compatible with their personal goals or preferences as physicians. But it must also be true that many recipients of these scholarships apply for them merely because economically they have no alternative and perform their service obligations without dedication. To the extent that this situation prevails, the service scholarships are not a satisfactory solution to the problems of students or to the health care needs of the nation, and these mechanisms should not be regarded as an adequate response to the costs of medical education.

Non-Federal Programs and Other Considerations

It should be noted that medical student scholarship funds of over $15 million in 1975-76 and over $15.6 million in 1976-77 were supplied by the medical schools themselves. This is a remarkable accomplishment in the face of the many other financial pressures on these institutions. But it is also true that virtally one-third of such scholarships were awarded by a dozen schools (fewer than 10 percent of all schools with students in those years) having unusually high endowments and other private sources of institutional funds. The vast majority of U.S. medical schools have demonstrated their willingness to contribute to the scholarship needs of students but do not themselves have the resources to make significant grant awards.

Scholarships for medical students from other (non-Federal, non-school) sources have also increased in recent years to a total of $7.9 million in 1976-77. Medical schools and the AAMC should continue to encourage and develop such sources of scholarship aid.

The Task Force views the difficult issues of default on student loans and declaration of bankruptcy by new graduates to be related to the need for grant support of economically disadvantaged students. Edu-

cational loans rely on future earning power for collateral. It is not acceptable for a student to declare bankruptcy before even making an attempt to put his or her educational collateral to work to earn the funds necessary to repay educational debt. Such bankruptcy actions do great damage to all sources of student assistance by suggesting unwillingness on the part of students to meet their financial obligations. Most lending institutions would prefer to renegotiate the terms of the loan than to have borrowers declared destitute. Student bankruptcy claims suggest, however, that (1) students are not receiving appropriate information and advice about how to borrow and how to manage high debt (see Goal 4 below), and (2) in some cases, student debt has simply become unmanageable. Scholarship funds must be available at every institution in amounts sufficient to guarantee that medical students are not forced or encouraged to borrow beyond their means to repay.

Recommendations:

1. The Scholarship Program for First-Year Students of Exceptional Financial Need should define exceptional financial need so that reasonable numbers of students are eligible. The funding should be increased significantly and the program should be expanded to include second-year students of exceptional financial need.

2. The medical schools should continue their efforts to generate scholarship funds from the private sector.

3. Scholarship funds from the Federal Government and private sources should be adequate to prevent the borrowing by medical students of amounts so large that either default on loans or declaration of bankruptcy is necessary during the loan repayment period.

GOAL 3: CREATE AN ADEQUATE LOAN MECHANISM THROUGH COMMERCIAL LENDERS WITH A FEDERAL GUARANTEE, AND INTEREST SUBSIDY FOR NEEDY STUDENTS, AND REPAYMENT SCHEDULES WHICH TAKE INTO ACCOUNT THE FINANCIAL REQUIREMENTS OF BOTH BORROWERS AND LENDERS.

In addition to adequate scholarship funds to ensure equal access to medical education to students regardless of their financial circumstances, the Task Force recognizes the need for a loan program with sufficiently high limits for annual and total borrowing and reasonable interest rates and/or an interest subsidy for financially disadvantaged students. Such a program would provide a source of funds for students who can afford to finance a part, but not all of their educational expenses. It would also provide an alternative to students with career goals in areas necessary to health care delivery such as research, academic medicine, specialties other than primary care, and the practice of primary care outside the National Health Service Corps (NHSC) or Armed Services. It would be best if funds for such a program were to come from the private sector stimulated by a Federal guarantee. Such a funding mechanism is removed from the annual uncertainties of Federal appropriations and the Federal Government is also relieved of the expense of providing direct funding.

The Task Force believes that, aside from the Health Professions Student Loan (HPSL) Program (described in the background on pages 4-5), the other Federal sources of support for health professions students in general and medical students in particular either existing or proposed under PL 94-484 all have serious flaws. The Task Force proposed in its interim report an alternative to the HEAL program. However, modifications of HEAL by PL 95-215 intended to make that program more acceptable to the lending community and to health professions schools and students forestalled consideration of the Task Force model. The Task Force does not believe that those modifications, the primary purpose of which was to permit interest on a loan to accrue and compound while the student was in school and during residency, will make HEAL a desirable program.

Summary of Federal and Major Private Loan Programs (See Appendix B)

Health Education Assistance Loan (HEAL) (Described in Appendix C) -- The borrowing limits of $10,000 annually and $50,000 total coupled with a maximum interest rate of 12 percent plus 2 percent for an insurance premium make this program most unattractive to students. While the actual interest will probably be approximately 10.5 percent at the outset of the program, an interest rate of 12.5 percent is readily possible. This high interest rate must either be paid from the inception of the loan or be allowed to accrue and compound while the student is in school and during residency. If the student pays the interest from the proceeds of the loan, the amount available to pay educational expenses is reduced. Accord-

ing to a recent AAMC survey, the average annual cost of medical school tuition, fees, room and board at private medical schools in 1978-79 will be $9,279. As summarized in Appendix D, U.S. Office of Education figures indicate that at 10 percent interest and a .5 percent insurance premium paid from loan proceeds, a student borrowing $10,000 each year would actually realize only $8,600, $7,650, $6,700, and $5,750 respectively in each of four years or a total of $28,700. Without other resources or financial assistance, that student could not afford to attend a private U.S. medical school borrowing from HEAL unless the interest on the loans was allowed to accrue and compound. If the student continued to pay interest during 3 years of residency and the 9-month grace period, the total repayment due would be $103,643 or the sum of the $26,300 paid in interest and for the insurance premium during the in-school and residency and grace periods and the $77,343 paid for principal and interest during the 15-year repayment period. However, as another example, a student who borrows $10,000 per year for four years under HEAL at 10 percent with a .5 percent insurance premium and permits the interest to accrue and compound during a typical 3-year residency period plus a 9-month grace period as allowed under the program, would repay $146,813 during the 15-year repayment period. The effect of an interest subsidy during the school years at an interest rate of 10 percent would be to reduce the outstanding educational debt to $78,643 and to make available to the student $9,600, $9,650, $9,700, and $9,750 respectively for educational expenses. See Appendix E for models of HEAL loans at varying amounts and interest rates.

Since the financially disadvantaged student is most dependent upon financial aid, it is the financially disadvantaged student who will be most affected by the HEAL program's high interest rate and lack of a Federal interest subsidy while in school. As the cost of medical education rises and as that cost is passed on to students who must borrow increasing amounts to pay for their education, it is likely that more and more students will find the promised future benefits of a medical career overshadowed by the more immediate prospect of large educational debt. As borrowing large amounts becomes the principal mechanism for students to finance their education, applications to medical school may begin to decline more dramatically than they have already and this trend would principally affect financially disadvantaged students. For those who are not deterred by the implications of high indebtedness, the temptation to alleviate those debt pressures by increasing fees and seeking careers in higher paying specialties may prove irresistable. Thus, the HEAL program may be a force to increase health care costs and reduce the numbers of physicians in primary care.

Other concerns about the HEAL Program have been voiced by the lending community. Since the objections to the low interest rate charged under the program were alleviated by raising the maximum interest from 10 to 12 percent, the major problem resides in the length of the repayment period which could be as long as 23 years and the concommitant cost of tracing

borrowers who change address frequently. Therefore, participation of lenders in the HEAL program relies heavily on the ability of the Student Loan Marketing Association (SLMA or Sallie Mae)* to purchase the notes from the lenders thus relieving the lenders of the cost of servicing the loans and freeing additional funds to be loaned to students under the program. However, in order for Sallie Mae to purchase loans they must be packaged in large volume which could cause problems for any relatively small lender and especially for schools desiring to become lenders.

Given these uncertainties the Task Force believes it would be premature to predict whether lenders will actively participate in the program. However, the Task Force is concerned that, to the extent that lenders do decide to participate in HEAL, they will withdraw their support from existing programs such as the Guaranteed Student Loan Program and American Medical Association-Education Research Foundation Guaranteed Loans which offer lenders a lower rate of return.

Health Professions Student Loan (HPSL) Program -- The Task Force believes strongly in the value of the Health Professions Student Loan (HPSL) program. It is the only currently viable, direct, Federal, need-based loan program available to medical students because many medical schools do not have access to National Direct Student Loan (NDSL) funds. Like HEAL, HPSL includes a forgiveness provision which encourages recipients to enter practice in physician shortage areas. As modified by PL 94-484, the HPSL program will be available only to students of "exceptional financial need" for tuition and related educational expenses. The Task Force is concerned that the definition of exceptional financial need for this program not be as restrictive as that for the Program of Scholarships for First-Year Students of Exceptional Financial Need. The HPSL program is functioning well and should continue to be available as it

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*The Student Loan Marketing Association is a Federally chargered private corporation whose purpose is to create a market for student loan notes. There are several mechanisms by which SLMA is able to improve the liquidity of student loan notes. The most frequently used method involves purchase by SLMA of blocks of student notes from lenders (such as state governments or private banks) with funds SLMA borrows at favorable interest rates from the Federal Financing Bank. The purchase of the notes by SLMA provides the lender with cash that can then be reloaned to other borrowers.

The importance of SLMA to the medical schools is its ability to provide new loan funds to lenders (private or public) to meet annual borrowing needs by the students.

is currently in amounts similar in proportion to present educational costs and number of student participants.

HPSL plays an important role in minimizing the educational debt that the economically disadvantaged student will have upon graduation. Not having the personal or financial resources to help absorb the increasing costs of medical education, these students will be forced to borrow the most heavily to pay for their education. The HPSL program will help insure that the consequenses of the apparent Federal policy of having medical students pay for a larger share of their educational costs does not fall disproportionately upon the economically disadvantaged student, thereby effectively further limiting access to medical school for these students.

National Direct Student Loan (NDSL) Program -- The NDSL program was available to medical students from its inception in 1958 until the Health Professions Education Assistance Act (HPEAA) created the Health Profession Student Loan (HPSL) Program in 1963. When that program became operational, the schools were then given a choice of whether to participate in HPSL or NDSL. Because it was devoted to the needs of the health professions schools virtually all medical schools chose to participate in the HPSL Program rather than the NDSL Program. In 1976 PL 94-484 once again opened the NDSL program to those health professions schools participating in HPSL. The NDSL program is not likely to become a major source of funds at most medical schools because the awards are made to the entire school and then apportioned among the respective colleges or divisions. Since the amount of funds available nationally have remained fairly static over the past several years and the needs of the other colleges or divisions within most universities have not decreased, most medical schools have found it difficult to obtain significant help from this quarter. A survey conducted recently by the University of South Carolina School of Medicine indicated that fewer than 50 percent of medical schools had access to NDSL funds and fewer than 20 percent had "adequate" access to the NDSL program. The aggregate borrowing maximum of only $10,000, repayment beginning nine months after graduation, and vagaries of Federal funding due to efforts by several recent administrations to significantly reduce the appropriations for the program also make it a questionable source of funds for medical students.

American Medical Association-Education and Research Foundation (AMA-ERF) Guaranteed Loan Program -- This program, begun in 1962 had arranged and guaranteed over 70,000 loans valued at more than $85 million as of April 1978. AMA-ERF guarantees all the loans against defaults by borrowers. In April 1978 AMA-ERF announced that to guard against overuse the program would in the future be limited to 50 students per medical school. At the same time in recognition of increased educational costs the annual

borrowing maximum would be increased from $1,500 to $2,500, the total borrowing maximum would be raised from $10,000 to $12,500, and the educational debt limit to qualify would be raised from $15,000 to $25,000. The limit of 50 loans per school reaffirms the last resort concept of the program and signals the end of the expansion of this program. Again, to the extent that bankers choose to participate in the HEAL program the capacity of the AMA-ERF Guaranteed Loan Program may be further curtailed.

Robert Wood Johnson Foundation/United Student Aid Funds, Inc., Student Loan Guaranteed Program -- This program is also a last resort program whereby a student can borrow from $500 to $5,000 based on demonstrated financial need. The simple interest rate may be varied. Interest is paid for the student while in school. Repayment begins upon graduation. The current interest rate is approximately 11 percent. This is a valuable source of funds, but the interest rate and its variable nature could make this program unattractive should market conditions change.

Income Contingent Loan (ICL) -- This section would not be complete without some mention of the ICL. This concept is much too complex for any but a very general discussion, but was a subject fully and carefully considered by the Task Force. Simply stated ICL's are repayed on a long term basis and at a rate that varies with the income of the borrower. While upon initial examination this type of program has attractive features such as repayment which varies with ability to pay and payments spread over a considerable period, it has several major negative aspects. First, due to the long term repayment, the capitalization required for such a program is enormous. Second, according to the principle of "ex ante adverse selection," there is a limit to the willingness of high earners to subsidize low earners. At some point high earners will simply refuse to participate in an ICL and instead borrow under conventional terms or will not select educational programs leading to high incomes. High earners also have a tendency to buy out of the program leaving no one but relatively low earners to share the long term repayment burden. The Task Force concluded that it would be extraordinarily difficult to devise an implementable ICL plan.

Guaranteed Student Loan Program (GSLP) -- The GSLP, also called the Federally Insured Student Loan (FISL) Program, began in 1965 with the Higher Education Act and the National Vocational Student Loan Insurance Act. These loans are guaranteed by the Federal Government either directly (FISL) or through agencies in 29 states (GSLP). Loan limits for graduate and professional students are $5,000 annually and $15,000 total. However, the annual borrowing limit was raised to $10,000 for 1977-78 for one year only because HEAL was not yet operational. Interest is 7 percent and is subsidized by the Federal Government while in school for students whose

adjusted family incomes are below $25,000 or who demonstrate financial need. As an incentive to provide funds for educational loans, a special allowance is paid to lenders quarterly as a function of 91-day Treasury notes. The special allowance is currently 3-1/4 percent. Over $10 billion has been loaned through the program. In FY 1978 an estimated 932,000 students received $1.6 billion to attend 8,120 schools. There are 14,140 lenders in the program. Problems with the program include the fact that some states lack participating lenders and students who borrow the full undergraduate limit of $7,500 are only eligible to borrow another $7,500 as graduate or professional students.

In an effort to derive an estimate of medical student dependence upon guaranteed loans, the Task Force and the Association of American Medical Colleges conducted a survey of borrowing in 1977-78 under the existing Guaranteed Student Loan Program (GSLP). The thirteen schools reporting in the survey included 8,219 students of whom 3,702 had borrowed $12,664,675 for the 1977-78 school year. Comparing these survey data with data from the 1976-77 AAMC institutional database indicates the average guaranteed loan increased from $2,147 in 1976-77 to $3,421 in 1977-78. The percentage of students receiving loans increased from 32.5 percent in 1976-77 to 45.0 percent in 1977-78. Projecting from the sample that 45.0 percent of the 1977-78 enrolled class of 60,039 or 27,018 students would borrow an average of $3,421, the 1977-78 borrowing could approach $100 million. Other information reported in the sample indicated that a significant number of third-year students had an aggregate debt of $10,000 or more in federally guaranteed student loans. One school reported that 120 juniors had an average aggregate debt in federally guaranteed student loans of $13,234.

If this information is considered to be representative, then several conclusions are obvious:

1. Medical school students from all medical schools will have borrowed in 1977-78 much more than the approximately $50 million which they were reported to have borrowed in 1977-78 according to the AAMC institutional database. Thus 1977-78 borrowing could conceivably go as high as approximately $100 million from the existing GSLP. One hundred million dollars would represent approximately 6 percent of all dollars expected to be loaned under the GSLP in 1977-78. If all health professions students are included in the estimate, the amount borrowed could go as high as approximately 10 percent of the expected total amount of $1.6 billion to be borrowed by all students.

2. Many medical students who have at least one more year of school are approaching the maximum amount that can be borrowed under the existing GSLP legislation.

3. Unless the GSLP maximum is increased, many medical students will have no alternative but to seek additional loan funds from the Health Education Assistance Loan Program.

The need for a loan program for graduate students in the health professions is clear. However, the Task Force believes that either as a short-term or a long-term solution to the shortage of financial aid, the HEAL program will have a negative effect on medical school enrollments, on physician attitudes, and on future costs of physician services. With the advent of HEAL it will probably be impossible to obtain support for a new alternative loan program for students in the health professions in the foreseeable future. What is needed is a loan program that recognizes the unique needs of medical students for larger annual borrowing and total aggregate debt to pay for the expense of medical school but one which also takes into consideration the several years of postgraduate residency training with its relatively low salary scale. Therefore, the Task Force believes that the best option at this time is to increase the annual post-baccalaureate borrowing limits under the existing GSLP from $5,000 to $9,000 and allow the borrowing of an additional $36,000 beyond the amount borrowed under the GSLP at the undergraduate level. Thus, total debt under the GSLP could reach $43,500 ($36,000 plus the $7,500 undergraduate limit). The repayment period for those who have a combined undergraduate and graduate debt of $15,000 or more should be increased from 10 years to 20 years. Such an expansion will permit students who have already reached the aggregate borrowing limit to continue to use the GSLP.

A graduated repayment schedule is suggested in order to ease the financial burden during and immediately following residency when earnings are relatively low and gradually increase the annual payments until they are highest at the end of the repayment period when earnings are expected to be greatest.

Indexing the borrowing maximum to inflation through a market indicator such as the Consumer Price Index on the Gross National Product Deflator would allow the loan limit to increase costs and help to avoid the present situation in which costs have increased steadily while loan limits have remained relatively static. Periodic adjustments in the maximum might still be necessary, but for the most part the limits would gradually tend to rise as costs increased.

Medical schools would have to encourage the participation of lenders in states where there are none.

The expansion of the loan limits of an existing program appears to be more likely to gain support than a recommendation for a new program with new regulations and requiring new legislation. The Task Force also hopes that expanding the loan limits of the existing GSLP would be supported by other professional and graduate schools.

The Task Force has observed with interest the movement toward a single Federal loan program. If such a concept were to be acceptable to the national academic community and were to provide the certainty that medical students in any geographic location within the U.S. could obtain such a loan in amounts and under terms and conditions favorable to the students, the Task Force would favor such a concept. There would be many benefits from a single Federal loan program, primary among which would be the simplification of the terms, conditions, and repayment schedules.

Recommendations:

1. The Guaranteed Student Loan Program (GSLP) should be modified such that (a) the annual borrowing limit for medical students be increased from $5,000 to $9,000; (b) the aggregate borrowing limit be increased from $15,000 to $36,000 for post-baccalaureate education; (c) the repayment period for those who borrow over $15,000 be increased from 10 to 20 years and a graduated repayment option offered; and (d) both the annual and aggregate borrowing limits be indexed to inflation.

2. The Health Professions Student Loan (HPSL) Program should have a realistic definition of exceptional financial need and should continue to be funded at levels which will keep it available in amounts equal to its current proportion relative to educational costs and number of recipients.

GOAL 4: PROVIDE TO MEDICAL AND PREMEDICAL STUDENTS THE INFORMATION AND COUNSELING NECESSARY TO GOOD FINANCIAL PLANNING FOR MEDICAL EDUCATION.

The individuals who counsel students about the various mechanisms for financing their education and the costs relative to future incomes have a difficult task. Particular attention should be focused on providing students from economically disadvantaged backgrounds with such information. The Task Force believes that workshops for financial aid administrators such as those sponsored in 1977-78 by the AAMC, with the support of the Robert Wood Johnson Foundation and under the supervision of Frances French, Director of Academic Services, University of Michigan Medical School, will improve the quality of advice to students and help to insure that students have knowledge of all available funds.

Such workshops also help to improve the administration of financial aid by providing counselors and administrators of financial aid programs with knowledge of workable systems in place at other schools. There is a continuing need for financial aid officers to keep in touch with the Federal programs. For example, in the past misunderstandings by the medical schools about the purpose and conditions of making grants under the Health Professions Scholarship program were used as arguments against continuation of this program.

Medical school financial aid officers and premedical counselors should develop skills for consideration of the relationship of total family resources to a student's financial aid planning. With growth in financial aid being outstripped by increases in educational costs and with greater reliance upon borrowing as a means of financing a medical education, student emancipation from parents has become an expensive luxury. A student's family can often obtain preferred interest rates on loans either becasue the family has an established relationship with the lending bank or because the family has collateral (e.g., a second mortgage) which is not available to the independent student. Also, for loans without interest subsidies, it is fiscally advantageous for a student's family to pay the interest on the student's loan as it becomes due rather than to let interest accrue and compound. The interest payment would be tax deductible for the family, and payment of the interest as it became due during the school years and residency would keep the outstanding debt at the end of that period at less than half what it would be if the interest were accrued and compounded.

One step toward expansion of relatively sophisticated financial planning techniques might be increased attention to this subject in settings where medical school financial aid officers and undergraduate advisors have an opportunity to meet together. Representatives of undergraduate financial aid offices and premedical advisors should be included at DHEW regional sessions for health professions financial aid personnel and at meetings of the National Association of Student Financial Aid

Administrators (NASFAA) where matters of graduate and professional financial aid are addressed. The continuum of financial aid, including discussion of what resources are most appropriate for undergraduate and for graduate and professional financial support, should also be emphasized at the annual regional meetings of the AAMC Group on Student Affairs (GSA). GSA membership includes medical school financial aid officers, and undergraduate health professions advisors often attend GSA meetings.

Clear, concise and complete regulations are necessary to the effective functioning of any financial aid program. It is unfortunate that nearly two years elapsed between the passage of PL 94-484 in October 1976 and the promulgation of regulations for any of its student financial assistance programs. Updated regulations for the Health Professions Student Loan program were not yet available in late August 1978. Guidelines for the Scholarship Program for First-Year Students of Exceptional Financial Need were published in June 1978 without any opportunity for public comment, and regulations for the HEAL program were published in August 1978 as "interim final," meaning that they became effective with virtually no opportunity for public comment. The Federal bureaucracy cannot continue to operate in a vacuum with regard to participation of the public and particularly the financial aid officers in the preparation of these regulations. Further, DHEW ought to provide a brochure listing all Federal financial aid programs available to medical students and should do the same for the other health professions so that both students and financial aid officers will have available in one publication information about all DHEW-administered aid programs.

Recommendations:

1. Information and counseling available to medical students and their families about the realities of student financing and expected future income should be improved through workshops to upgrade the counseling ability and information level of medical school financial aid officers.

2. Information and counseling available to premedical students about the continuum of financial aid and the role of the family in financial planning for postgraduate education should be improved through increased involvement of undergraduate counselors in discussions of the financing of health professions education.

3. In recognition of the dependence of a large proportion of medical students on Federal funding programs, DHEW should be encouraged to produce regulations implementing such programs in a timely and democratic fashion.

GOAL 5: DEVELOP AND USE A VARIETY OF STRATEGIES APPROPRIATE TO INDIVIDUAL INSTITUTIONAL CIRCUMSTANCES TO PROVIDE ADEQUATE STUDENT FINANCING.

There are major differences among medical schools regarding how they are financed, the availability of federal, state, and institutional student aid funds, and the financial needs of student populations. A workable approach to student financing at one school may not be appropriate to the situation that exists at another. In recognition of this fact there follows a brief listing of some of the major aid programs and funding mechanisms which might apply in various situations:

a. Encouraging full participation of local banks in the Guaranteed Student Loan Program (GSLP) to obtain loans for its own students is an option for most schools.

b. The Tax Reform Act of 1976 includes an amendment which permits the creation of non-profit organizations to provide secondary markets to purchase loans made under the GSLP through the issuance of tax exempt bonds. The Council for South Texas Economic Progress (COSTEP) is an example of such an organization (see Appendix D).

c. Schools with access to capital may wish to become lenders under the GSLP and rely on the Student Loan Marketing Association (SLMA) to act as a secondary market to purchase the loans from the schools.

d. Schools with employment opportunities for students and curricula which permit students to work during certain periods may want to use the College Work-Study program under which the Federal Government pays 80 percent of a student's salary and the school pays 20 percent.

Recommendation:

1. The individual medical schools assisted by the AAMC should take the initiative to provide from the Federal Government, state governments, foundations, commercial lenders, alumni and other resources the student financing appropriate to their individual needs.

SUMMARY OF GOALS AND RECOMMENDATIONS

GOAL 1: Provide adequate and appropriate financial assistance to assure that students aspiring to careers in medicine are not deterred by financial circumstances.

Recommendation:

1. The AAMC should monitor changes in financial and socio-economic background of the applicant pool and of students enrolling in medical school. If the changing nature of student financial aid appears to be contributing to a decline in the representation of economically disadvantaged students in medical school or in the applicant pool, the Association should take appropriate action such as recommended elsewhere in this report to correct the situation.

GOAL 2: Increase availability of need-based scholarship funds, without a service commitment, to ensure that financially disadvantaged students do not have to borrow unmanageably large amounts, particularly during the first two years of medical education.

Recommendations:

1. The Scholarship Program for First-Year Students of Exceptional Financial Need should define exceptional financial need so that reasonable numbers of students are eligible. The funding should be expanded to include second-year students of exceptional financial need.

2. The medical schools should continue their efforts to generate scholarship funds from the private sector.

3. Scholarship funds from the Federal Government and private sources should be adequate to prevent the borrowing by medical students of amounts so large that either default on loans or declaration of bankruptcy is necessary during the loan repayment period.

GOAL 3: Create an adequate loan mechanism through commercial lenders with a Federal guarantee, and interest subsidy for needy students, and repayment schedules which take into account the financial requirements of both borrowers and lenders.

Recommendations:

1. The Guaranteed Student Loan Program (GSLP) should be modified such that (a) the annual borrowing limit for medical students be

be increased from $5,000 to $9,000; (b) the aggregate borrowing limit be increased from $15,000 to $36,000 for post-baccalaureate education; (c) the repayment period for those who borrow over $15,000 be increased from 10 to 20 years and a graduated repayment option offered; and (d) both the annual and aggregate borrowing limits be indexed to inflation.

2. The Health Professions Student Loan (HPSL) Program should have a realistic definition of exceptional financial need and should continue to be funded at levels which will keep it available in amounts equal to its current proportion relative to educational costs and number of recipients.

GOAL 4: Provide to medical and premedical students the information and counseling necessary to good financial planning for medical education.

Recommendations:

1. Information and counseling available to medical students and their families about the realities of student financing and expected future income should be improved through workshops to upgrade the counseling ability and information level of medical school financial aid officers.

2. Information and counseling available to premedical students about the continuum of financial aid and the role of the family in financial planning for postgraduate education should be improved through increased involvement of undergraduate counselors in discussions of the financing of health professions education.

3. In recognition of the dependence of a large proportion of medical students on Federal funding programs, DHEW should be encouraged to produce regulations implementing such programs in a timely and democratic fashion.

GOAL 5: Develop and use a variety of strategies appropriate to individual institutional circumstances to provide adequate student financing.

Recommendation:

1. The individual medical schools assisted by the AAMC should take the initiative to provide from the Federal Government, state governments, foundations, commercial lenders, alumni and other resources the student financing appropriate to their individual needs.

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SCHEDULE OF 1979 OSR REGIONAL MEETINGS*

DATE	REGION	LOCATION
March 22 - 24	Southern	Little Rock, Arkansas
April 21 - 24	Western	Asilomar, California
May 3 - 5	Central	Rochester, Minnesota
May 10 - 12	Northeast	Boston, Massachusetts

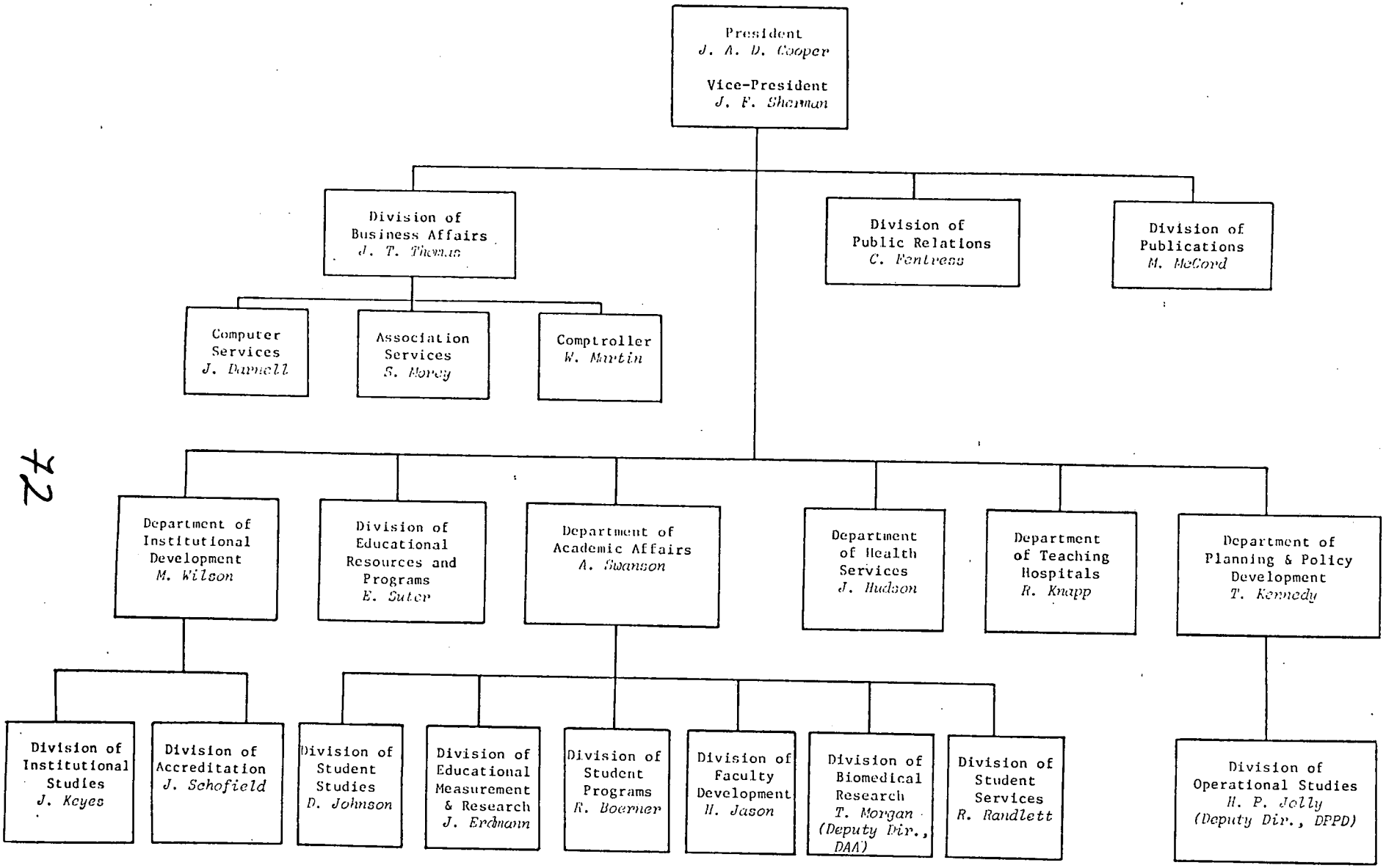
*held jointly with the Group on Student Affairs and the Advisors of the Health Professions

DATES OF OSR ADMINISTRATIVE BOARD MEETINGS

OSR Board	Executive Council
January 17	January 18, 1979
March 28	March 29, 1979
June 13	June 14, 1979
September 12	September 13, 1979

Annual Meeting

November 3 - 8, 1979--Washington Hilton Hotel, Washington, D.C.



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STAFF ORGANIZATION

June/1977

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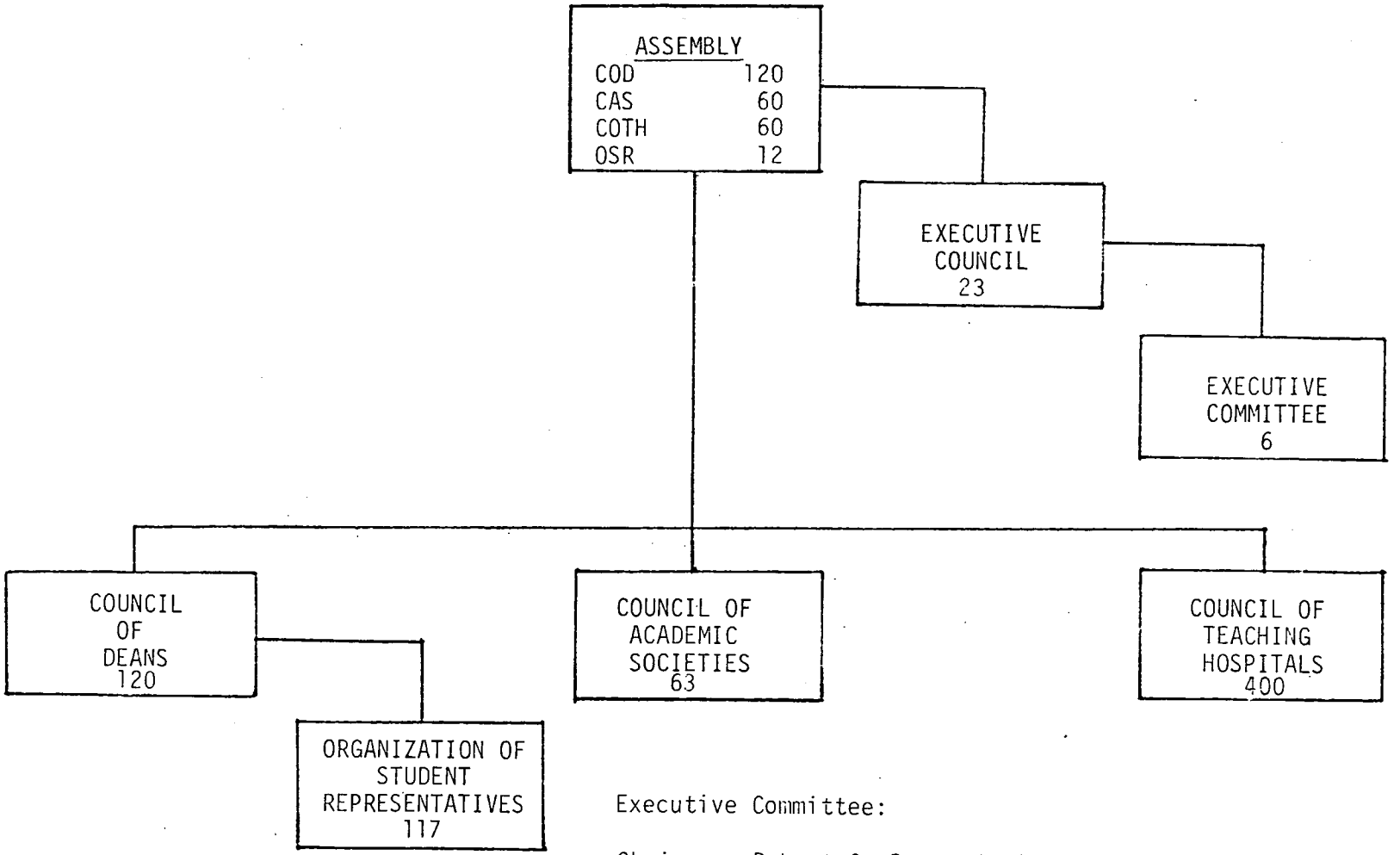

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John A. D. Cooper, M.D, *AAMC President*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #77-59 December 1, 1977

TO: AAMC Assembly

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

SUBJECT: OFFICERS OF THE ASSOCIATION AND COUNCILS (1977-78)

For your information, the following is a list of the Executive Council of the Association, and Officers of the Council of Deans, the Council of Academic Societies, the Council of Teaching Hospitals, and the Organization of Student Representatives for 1977-78.

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Association of American Medical Colleges

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