# ORGANIZATION OF STUDENT REPRESENTATIVES

1980 Business Meeting Agenda
October 25 & 26
Washington Hilton Hotel
Washington, D. C.

DRAFT

# ASSOCIATION OF AMERICAN MEDICAL COLLEGES

## ORGANIZATION OF STUDENT REPRESENTATIVES

### Business Meeting

November 3 and 4, 1979
Washington Hilton Hotel
Washington, D.C.



I. Call to Order

The meeting was called to order by Peter Shields at 2:15 p.m.

II. Declaration of Quorum

Peter Shields declared the presence of a quorum of the Organization of Student Representatives.

III. Consideration of Minutes

The minutes of the October 21 and 22, 1978 business meeting were approved without change.

IV. Remarks from Dr. Cooper

Dr. John A.D. Cooper, President of the AAMC, welcomed everyone to the 90th Annual Meeting of the Association and the tenth Annual Meeting of the Organization of Student Representatives. He said that, although the OSR is a relatively new constituent, its programs and publications have become integral to the Association in its attempts to improve the quality of medical services in this country.

Dr. Cooper expressed the hope that the students would take advantage of the variety of programs being offered at the Annual Meeting--not only those which are sponsored by the OSR but also those of the other councils, groups and organizations--and the hope that they would carry back to their classmates the information and ideas that are gained.

Dr. Cooper mentioned the Spring issue of OSR Report which was devoted to the complexities of the health care legislative process and what students can do to influence it; by virtue of their role as the health care providers, researchers and teachers of the next decades, medical students should keep informed about the important education and health issues and contribute, whenever possible, to their evolution. He agreed that the role of students in this process is understandably a frustrating one. Certainly it is true that the lion's share of students' energy should be devoted to medical studies and to the development of clinical skills and acumen. At the same time, despite the frustrations, it is the duty of students to take an active interest in and to keep abreast of the challenges facing their school and

facing medical education as a whole. The more informed students are, the more considered their judgments will be and the more their views will be listened to, respected and acted upon. He reminded them that while problems may appear to multiply rapidly, finding solutions is rarely so dramatic a process. The complexities of the legislative process as well as the organization of academic medical centers mean that hoped-for modifications evolve slowly. A great deal of patience is required to deal with these social institutions.

Dr. Cooper next turned to the role of the OSR in the Association. He drew the OSR's attention to the diagrams included in the OSR Orientation Handbook, illustrating the relationship between OSR and the Councils as well as the organization of the AAMC staff. The characteristic of the AAMC which Dr. Cooper emphasized is that it is a concensus organization, a bringing together of the views, goals and aspirations of deans, hospital administrators, faculty and students. The student presence is felt and it will be of value to the future of medical education if the OSR utilizes responsibly the opportunities at this meeting to conduct its business, to learn more about the important issues which must be faced, and to discuss thoughts about improving those aspects of medical education which appear to need changing. Dr. Cooper expressed the view that usually the place to begin effecting change is through serious discussion with the individuals at each school who have responsibility for the aspects which are found to be problematic. While in some instances, it is appropriate for the AAMC to recommend to schools a change in policy or an examination of their programs, by and large, it is felt that the diversity among schools is one of the chief strengths of medical education in this country. Therefore, ideas for improvement will find their most appropriate audience at home.

He next remarked upon some of the issues which the Association has been devoting a lot of attention to and noted that if many of them sound remote, it is because medicine is complex and political and seemingly distant threats to the autonomy and financial stability of training institutions can become very real in a very short span of time. For instance, the legislation to alter how teaching physicians are reimbursed for their professional services could have very unfortunate effects on most schools. Section 227 of the Social Security Act includes special restrictions on the way in which physicians providing care in teaching settings may be reimbursed for their services. In this regard he pointed out that one of the fastest growing sources of support for academic medical centers in this country for their educational programs is through the earnings of faculty. The Association has also been very much concerned about Section 223 of the Social Security Act; this is a section on which regulations have been written which do not recognize the special role that teaching hospitals play in providing complex tertiary care to a substantial portion of the population. These regulations tend to lump all hospitals together despite the variety in kinds of training they offer and the intensity of care they provide; Section 223 thus poses real problems for the academic medical centers in obtaining funds for financing the educational programs at teaching hospitals. Dr. Cooper next mentioned the Task Force on Support of Medical Education which is discussing the extension of the health manpower legislation which is due to expire in 1980. The AAMC is attempting to insure that the federal government provides some share of the

cost of medical education and that schools do not have to seek additional income through tuition increases or resort to cuts in their teaching programs. Another important part of the health manpower act is financial aid for medical students. He reported that AAMC staff and the GSA Committee on Student Financial Assistance have been talking with Dr. Robert Knouss of Senator Edward Kennedy's staff who is deeply interested in designing appropriate financial aid programs for medical students. The AAMC has also been working very diligently on issues related to the support of programs designed to increase the number of primary care physicians and to assure more adequate support for the ambulatory care portion of the training received by future generalist physicians. Among the other areas which the Association is deeply concerned about is the coming shortage of academic physicians; in this regard Dr. Cooper expressed the hope that a way could be found to rekindle the interests of students in careers in clinical investigation.

In closing, Dr. Cooper asked for the OSR's input into this wide range of issues, especially those most directly related to students, and welcomed the OSR's help in confronting the very serious challenges facing medical education now and in the next decade.

V. Remarks from GSA Chairman

Dr. Marilyn Heins expressed her thanks for the invitation to address the OSR and noted that there is a lot of overlap between their concerns and those of the Group on Student Affairs. She named a number of the issues on which the GSA has recently been concentrating, including non-compliance with the admissions traffic rules regarding the refunding of deposits, designation of a uniform application date for military residency programs, and the Forum on Financing Medical Education to be held on November 7. Another area of great importance is the quality of career counseling; she urged that it should begin early and that students should look into what is being offered at their schools with an eye toward improving the counseling, if necessary. She reminded the membership of their responsibilities to those who elected them as their representatives and of the importance of communicating to their constituents about OSR and GSA activities. In closing, she welcomed the OSR's help in confronting the very serious issues currently facing all those who work with medical students.

VI. Chairperson's Report

Peter Shields opened his report with the observation that this was a busy year for the OSR Administrative Board. He enumerated the following projects which had been initiated and completed.

Longstanding efforts to increase the amount of information available to students on graduate training programs, along the lines recommended by the Transition Working Group of the Task Force on Graduate Medical Education, saw some fruits. A model questionnaire for alumni to evaluate residency programs was developed and distributed to student affairs deans in the hope that deans will adapt it and institute this information-gathering method for the benefit of their students. Working closely with the Executive Vice President of NRMP resulted in a helpful addition to the 1979 NRMP Directory in the form of a grid showing data sources for a number

of items. Additional work is needed to expand the amount and the quality of published information, and the Administrative Board has begun a dialogue with the individuals responsible for the publication of the AMA Directory toward this end.

Three issues of OSR Report were published and mailed to OSR members for distribution at their schools. The first issue was entitled "Your Funds and Your Future: A Guide to Financial Planning" and offered suggestions on budgeting, keeping track of loans and debt management. The Spring OSR Report was part of a new effort on the part of the OSR, that is, mobilization of medical student support for capitation and existing need-base financial aid programs; this issue was a guide to the health legislation process and what students can do to influence it. Distribution of this issue immediately preceded members of the Administrative Board contacting OSR members to urge their student body to contact Congressmen regarding how cuts in capitation and financial assistance programs would exacerbate the already difficult financial plight of many medical students. While it is difficult to determine the impact of the letters written by students, funding for capitation and student assistance programs was approved at higher levels than had been anticipated. Peter said that the new Administrative Board and AAMC staff will continue to keep a close watch on these activities on the Hill and, if it is judged that letters from students are needed, OSR members will again be contacted to garner support. The Fall issue of OSR Report was devoted to the topic of the present shortage of clinical investigators and the implications of this shortage. Pursuant to the resolution which OSR passed last year to expand research opportunities for medical students, Dr. Thomas Morgan, Director of the Division of Biomedical Research, conducted a survey at the GSA/OSR regional meetings this spring on the availability of research opportunities for medical students. This survey formed the basis for the Fall issue which also described how students can benefit from research experience regardless of career intent.

Peter noted that last year in his report he had suggested to the membership three issues to be given priority. The first was to push for Congressional adoption of the recommendations of the Task Force on Student Financing. One activity which Bob Boerner has organized related to this effort is a Forum being held on November 7, which will bring together Congressmen and their staffs with deans, student affairs personnel and students to discuss the financial difficulties of medical students and the design of financial aid programs. Because of the importance of this topic, he urged the OSR to elect officers familiar with financial aid issues. The second issue was house staff representationin the AAMC. On October 5 and 6, a group of 32 residents were convened (five of which had been nominated by OSR) to discuss the report of the Task Force on Graduate Medical Education. While this was a fruitful conference with a number of important exchanges of ideas, it was not a precedent for future house staff conferences and he therefore urged the OSR again to push for the formal inclusion of residents in the year-round deliberations of the AAMC. The third area he had singled out was the need for a uniform application form for residency programs. This need was recognized by the Transition Working Group of the Graduate Medical

Education Task Force and by the GSA Steering Committee and an application has been developed, a copy of which is in the OSR Annual Meeting agenda book. Peter said that while the OSR can only take minimal credit for this effort, Bob Boerner should be applauded for the work that he and his staff have put into this project.

Other activities initiated by the OSR Administrative Board included: 1) a membership survey to establish a basis for improvement of communications with and continuity in the membership; 2) collecting from schools copies of their "due process" guidelines, with the goal of development of a document describing the kinds of procedures schools are currently relying upon to insure students' fair treatment when questions about promotion and graduation arise; and 3) because students often have difficulty obtaining information on clinical electives at other schools, student affairs deans were asked to provide basic information on extramural electives which will be compiled and distributed to OSR members and student affairs deans.

Lastly, Peter touched on the Thompson Amendment, also known as HR 2222, which would define residents as employees under the National Labor Relations Act. He stated that the AAMC has taken the position that residents are primarily graduate students and has not fully recognized the work functions that residents perform. Other agencies, such as the Internal Revenue Service, consider house staff to be primarily employees, and it is obvious that many residents work more that 120 hours per week and deal with life and death situations without the visible oversight of attendings. Peter stated the belief that either the educational component of graduate medical training should be increased or the OSR should urge the AAMC to modify its position on this legislation.

Peter closed by thanking the Administrative Board and Division of Student Programs staff and singled out the superb work of Dan Miller. Finally, he thanked the memmbership for the opportunity to serving them.

VII. Chairperson-Elect's Report

Dan Miller opened his report by drawing the attention of the membership to the report on the 1978 OSR resolutions distributed with this year's agenda materials. He hoped the background provided in this report would be helpful in informing the membership about the Administrative Board's work this year and as a jumping off point for discussion and in the design of new resolutions during the 1979 Annual Meeting.

He next listed several on-going projects of the OSR, including working to increase the amount of financial aid for medical and other health professions students, expanding research opportunities for medical students and house staff, increasing the amount and quality of information available to students on residency programs, and developing practical approaches to the reduction of stress in medical education. He said he is looking to the support of the new administrative Board in continuing the work on these projects. More importantly, however, he hoped that during this meeting new thoughts and approaches to these problems might be generated.

Dan explained that, when he became active in OSR three years ago, his first impression of the OSR and AAMC had not been a very favorable one. It had appeared to him that the OSR Administrative Board was an isolated body which spent a great deal of time discussing a variety of topics of national interest but had few practical projects with which individual medical students could identify. Over those three years, he has witnessed an important evolution of OSR's approaches and deliberations. While national policy issues are still discussed, OSR has also turned its attention to projects which could be implemented at individual medical schools and has provided raw materials to individual representatives to take back to their schools. This is an important change and should be continued. In this regard, Dan stressed the importance of the link between the Administrative Board and medical student bodies, that link being OSR representatives. He expressed concern about the lack of continuity in the involvement of many representatives and fear that, for some, being a representative means little more than a free trip to Washington. Most importantly, being an OSR member means being an information source for his or her student body and accepting the responsibility of keeping the Administrative Board informed about their concerns. In order to be effective participants, members need to have a clear picture of what the Organization is and how it fits into the Association. He said he hoped that this year's Orientation Handbook and attending the business meetings and discussion sessions would help in this regard.

Dan thanked the supportive, hard-working Administrative Board and expressed special appreciation for the counsel and support of Paul Scoles, the immediate-past-chairman. He closed with the hope that he and the new Administrative Board can continue to provide a clear and responsible student voice within the AAMC and asked for the support of the membership in this effort.

VIII. Report on the Task Force Graduate Medical Education

As the student member on this Task Force, Dan Miller described for the membership the scope and focus of its activities. He said that the complex and lengthy deliberations of the Task Force had resulted in an excellent report containing innovative suggestions in many areas. He drew special attention to the report of the Working Group on Financing which attempted to tow a middle-of-the-road approach to the student vs. employee question; he recommended that the membership carefully read this report and decide for themselves if the emphases as stated in the report are correct and appropriate. He noted that the Transition report delineates the problems facing senior medical students as they prepare for residency training and that the Specialty Distribution report deals with the controversial problem of meeting the nation's health manpower requirements; thus both warrant the close attention of the membership. He reminded everyone of the Special Assembly meeting scheduled for November 6, at which the entire AAMC constituency would have the opportunity to comment on the Task Force report.

IX. Due Process Project

Arlene Brown presented to the membership information on what had been accomplished on the due process resolution passed last year. The first step in considering this resolution was to clearly define what is meant by due process. Arlene explained that due process in a general sense means fair treat-

ment. It has also been more specifically defined in the courts, e.g. by Zeigler vs RaiTroad Co. (58 Ala. 599): "Due process...implies the right of the person affected thereby to be present before the tribunal which pronounced judgement...; to be heard, by testimony or otherwise, and to have the right of controverting by proof, every material fact which bears on the question of right in the matter involved. If any question of fact or liability is conclusively presumed against him, this is not due process..."

Arlene noted that confusion has stemmed from deciding under which circumstances the more specific judicial definition of due process applies. Joe Keyes, AAMC Staff Counsel, met with the Administrative Board in September and explained that in the past, state and federal courts have distinguished between academic and disciplinary situations--for the latter being more exacting and requiring more elaborate procedures to ensure fair treatment of students by schools (e.g. formal hearings, opportunities for appeal, etc.). In contrast, the courts have held that formal hearings before decision-making bodies need not be held in the case of academic dismissals. Arlene summarized the OSR Administrative Board's view that the line between academic and disciplinary situations may not be so clearly definable. Frequently the evaluation of academic achievement, i.e., the progress toward "good physicianship," involves assessment of personal conduct and evaluation in the clinical setting. Once the student enters the clinical rotations, the academic evaluation involves assessment of personal judgement, the application of medical skills, the ability to relate to patients, and the characteristics of the faculty-student interrelationship that have occurred during the rotation; these qualities do not readily lend themselves to objective quantification. Therefore, Arlene reported that in dealing with the OSR resolution on due process, the Administrative Board has attempted to address both disciplinary and academic dismissals and with the aid of AAMC staff, undertaken a survey and study of the due process policies and procedures of US medical schools. Thus far, about sixty schools have provided information about their promotion/dismissal policies and this is currently being reviewed in an effort to assess in a general way the range and diversity of the procedures currently being employed.

Simultaneously, she said, the Administrative Board is developing a preliminary draft of a "model" policy against which could be compared individual school policies. This comparison would be divided into academic policies and disciplinary policies. Ideally, a tabular comparison of existant policies with the drafted model would allow development of a model which could be shared with schools for comparison and adaptation for their own use.

Arlene closed her remarks with the comment that, while there may be advantages to addressing dismissal situations on a case-by-case basis, the OSR Administrative Board believes that the issue of due process with respect to dismissals needs to be more fully addressed in order to optimize fair treatment for all. However, the aim is not to develop rigid standards which must be imposed regardless of circumstances.

Steve Sheppard next presented principles of due process from the model developed

by AMA-Student Business Section approved by the AMA Council on Medical Education. He expressed the view that these principles clarify and protect the rights of medical students and said that he would provide a copy to anyone who was interested.

X. Stress Project

Molly Osborne explained that during her tenure on the OSR Administrative Board, stress in medical education was the concern on which she had spent the most time. She directed the attention of the membership to the information on the Administrative Board's work in this area contained in the report on the 1978 resolutions. She also urged the membership to read the section on stress in the "Annotated Student Affairs Bibliography," singling out the references on the desirable characteristics of a student mental health service and on the "academic frustration syndrome".

Molly next explained that her understanding of and approach to stress in medical education have changed over the years, especially as a result of her experiences as an intern. While she remains convinced that physicians in-training need more adequate ways to deal with the pressures they face, some stresses are most sucessfully dealt with on an individual basis. She said that rewards, such as increased self-confidence, accrue from dealing autonomously with stressful situations. This does not mean that support systems aren't useful or that students shouldn't share their feelings with their peers and faculty. She suggested that one way of gaining insight into oneself and of growing professionally is helping patients and their families to cope with a crisis situation in their lives and that such experiences, rather that test schedules or lack of sleep, could profitably serve as the basis for discussions among students about the stresses of the educational process.

XI. Report on Student Financial Assistance

Bob Boerner, Director of the Division of Student Programs, offered an overview of the current situation regarding financial aid programs for medical students. He noted that the present interval is a transitional one, as two major pieces of legislation are up for reauthorization: the Higher Education Act of 1965 and the Health Education Assistance Act of 1976. In reference to the former, about ten bills have been introduced, however it appears likely that one of these will hold sway, i.e., HR 5192 introduced by Representative William Ford from Michigan. The Ford bill would modify the Guaranteed Student Loan and the National Direct Student Loan programs and create a program whereby parents could borrow their expected contribution at a 7% interest rate. Another piece of legislation to watch is the Kennedy/Bellmon bill (S 1600) which would create a loan bank whereby students could borrow the entire cost of their education minus financial aid awarded and parental contribution. This bill would also set up a separate loan program for parents. With regard to the reauthorization of programs included in the Health Education Assistance Act of 1976, only one bill has thus far been introduced; the Schweiker bill proposes a number of changes in the Health Education Assistance Loan and the Health Profession Student Loan programs and continuation of the Exceptional Financial Need Scholarship Program. Bob noted that the situation with regard

to this legislation is still very fluid and that his office will keep the students informed as important developments occur. For more detailed information on these proposals and on the criteria for financial aid programs espoused by the GSA Committee on Student Financial Assistance, Bob referred interested students to the report on the 1978 OSR resolutions.

XII. Report from American Academy of Family Practice Student Affiliate

Herb Young expressed his pleasure for the opportunity to speak to the OSR about the activities of the American Academy of Family Physicians Student Affiliate. He noted that in the past two years, over 2000 individuals have joined for a total student affiliate membership of 7000. There are now 371 approved residency programs in Family Practice, and a major problem facing all prospective trainees is how to evaluate all the parameters of these programs. Herb expressed the hope that their recently published "Guide to Family Practice Residencies" would be a great help in this regard. He enumerated a number of the other concerns of his organization, including involvement of more minority students, improved health care for the underserved and counterculture segments of the population and the fact that some medical schools still offer no courses in family medicine.

Herb next explained that the real strengths of the student affiliate are the activities going on at the individual medical schools; 104 schools now have family medicine clubs or groups providing a broad range of offerings, including cources on office management and visits to physicians' offices. He announced the availability of packets containing information on how to start a club if any OSR members were interested. Finally, he mentioned that videotyped vignettes to aid students in dealing with stress in medical education have been distributed to departments of family practice and that interested students should contact their department head about them.

XIII. Nominations for Office

The following OSR members were nominated for national office:

Chairperson-Elect: Barbara Bergin (Texas Tech)
Lisa Capaldini (UC-San Francisco)

Representatives-at-Large: John Cockerham (Virginia)
Arlene Brown (New Mexico)
William Lenaburg (Southern California)
Greg Melcher (Minnesota-Duluth)
Mary Barton (Rush)
Michael Olding (Kentucky)
Peter Muelleman (Nebraska)
Claudia Morrissey (Chicago Medical)
Michael Tom (Yale)

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

XV. The meeting was recalled to order at 1:50 p.m. on November 4.

XVI. Peter Shields declared the presence of a quorum.

XVII. Elections

In addition to the nominations offered the previous day, Stephen Sheppard (S. Alabama) was nominated for the office of Representative-at-Large; Michael Olding withdrew his name from consideration for that office.

Action: The OSR elected the following representatives to national office:

| | |
|---|---|
| Chairperson-Elect: | Lisa Capaldini |
| Representative-at-Large: | Claudia Morrissey |
| | Stephen Sheppard |
| | Arlene Brown |
| | Greg Melcher |

XVIII. Resolutions

A. National Board Examinations

Action: The OSR approved the following resolution:

As medical professionals, we recognize that the profession is accountable for the capabilities of its members. We further recognize the need for medical schools to evaluate and if necessary modify their educational program.

It is our understanding that the National Boards were created solely for the purposes of national licensure, thereby insuring a standard of competence. It has come to our attention that medical schools, perhaps improperly, have been utilizing the National Boards as a means of evaluate students for promotion and to modify curricula and, in addition, that teaching hospitals have used the scores as one criterion for selecting residents.

We are also concerned that the apparently increasing importance of the Boards poses a threat to the increasingly diversified group of students attending medical school and jeopardizes the development and strengthening of diversified curricula.

BE IT THEREFORE RESOLVED, that the OSR recommends two fundamental and basic changes in the National Board Examination process: 1) The current system of scoring be replaced by a pass/fail performance being used as the only record of the test results and 2) Results of the exam be shared only with the student and the licensing board.

B. Medical School Curricula

Action: The OSR approved the following resolution:

Research increasingly documents the critical roles psychosocial factors play in health maintenance, throwing into sharp relief deficiencies in the curricula of many medical schools.

Criticisms from within and without the health care community indicate that physicians emerge from medical school ill-prepared to address many issues, including (but not limited to):

-the role of working environments in health;
-the special nutritional problems of many groups within the population;
-the broad range of feelings and behavior that express human sexuality;
-the moral and ethical responsibilities involved in physicians' interactions with their patients;

Therefore, the OSR resolves that;

1. Medical schools give more emphasis in their curricula to subjects such as occupational health, applied nutrition, aging, health economics, human sexuality, and ethical issues relevant to medical practice.

2. These subjects be addressed from an interdisciplinary perspective and be included in clinical as well as basic science instruction.

3. A medical school curricular reform workshop be offered at the 1980 Annual Meeting of the AAMC, addressing the extant external pressures for particular curricular emphases as well as ways in which medical students, faculty, and administrators may bring about curricular reform at their individual school.

C. Information on Graduate Training Programs

Action: The OSR approved the following resolution:

WHEREAS graduate medical education program vary considerably in their requirements, provisions, and quality, and

WHEREAS The OSR has long recognized that there is a need for more subjective and objective information on these program and this information should be available early on in the application process and

WHEREAS collecting such information on a regional basis represents a feasible method of increasing its availability and would provide experience for the project on a nationwide level, therefore

BE IT RESOLVED that the Northeast region undertake a pilot survey to determine the opinions of undergraduate and postgraduate medical trainees about the application process to and and the work experience in graduate medical education programs; the survey will be based on the OSR Model Questionnaire for Graduate Training Evaluation and given to students in medical schools and housestaff in residency programs of the Northeast region; the resulting information will be made available at each medical school in the region for use of all students; and

BE IT FURTHER RESOLVED that all regions be strongly urged to develop similar programs with the ultimate aim of forming a nationwide effort, and that the OSR Administrative Board be directed to provide organizational and administrative support to further this effort.

D. Representation of Housestaff in the AAMC

Action: The OSR approved the following resolution:

In recent years the AAMC has become increasingly involved in issues related to graduate medical education. For example, as one of the parent bodies of the Liaison Committee on Graduate Medical Education, the AAMC participates in the accreditation of residency training programs. The AAMC Task Force on Graduate Medical Education has undertaken a review of graduate medical education as it relates to financing, quality, transition, specialty distribution, and national standards and accreditation.

A major constituent of the AAMC is the Council of Teaching Hospitals under whose auspices resident physicians receive their medical training.

Recent opportunities by resident physicians to provide input into the affairs and policies of the AAMC, i.e. the AAMC Housestaff Conference on Graduate Medical Education, have proven to be unique and informative additions to AAMC deliberations.

Therefore, the OSR suggests that the AAMC explore, with appropriate student and housestaff input, methods and mechanisms by which housestaff physicians can provide organized and continuous input into the affairs and deliberations of the AAMC.

E. Truth in Testing Legislation

Action: The OSR approved the following resolution:

WHEREAS most medical colleges require the New MCAT for evaluation of applicants as an integral part of the admissions process, and

WHEREAS the State of New York has passed a truth in testing law which requires that, beginning January 1, 1980, the answers to each question of the New MCAT be made public following the test administration, and that studies of the validity of the test be made public, and

WHEREAS the AAMC has decided that compliance with the New York State statute would seriously compromise the integrity of the New MCAT and has decided not to offer the New MCAT in New York State, an action which poses great inconveniance and concern to New York residents who wish to take the New MCAT, and also to all applicants who apply to medical colleges in New York State,

BE IT RESOLVED that the OSR direct its administrative Board to appoint a committee to investigate the issue of truth in testing as it pertains to the medical community and to report its findings and recommendations as soon as possible.

F. Stress in Medical Education

Action: The OSR approved the following resolution:

Many kinds of stress are pervasive in our society. Medical students are concerned that undue stress in both medical school and residency programs may contribute to the alcoholism, drug addiction, emotional and mental disorders, and suicide seen in a percentage of practicing physicians. Medical students are eager to learn methods of stress reduction which might be utilized in the future for both medical students and housestaff orientation programs.

Therefore be it resolved that 1) programs be established to determine the existence and magnitude of stress in medical education and 2) multifocal programs be developed to aid in the reduction of stress, such as: a) less sleep deprivation; b) support groups; c) trained counselors to provide a system of ongoing counseling to all students, commencing with an orientation to the medical school experience; to provide special career counseling, directed by individuals who will not act as recruiters for their field and to make a separate advisor available for residency application counseling for those individuals having great difficulties coping with the stresses of medical education; d) assuring time for extracurricular activities; and e) instructing students in the techniques of self-relaxation.

G. Physical Diagnosis Courses

Action: The OSR approved the following resolution:

WHEREAS the mastery of basic information-gathering skills (taking a history and performing a physical examination) is a crucial component of medical education, and
WHEREAS a review of recent medical educational literature noted deficiencies in these skills throughout the spectrum of medical education and belief that this problem has its origin in undergraduate medical education.
THEREFORE, BE IT RESOLVED that physical diagnosis courses be devised with clearly defined objectives, descriptions of the skills to be acquired and provisions for supervision of learning, evaluation, and demonstration of proficiency; and that the GME of the AAMC be urged to assist medical schools in the development of such courses.

H. NHSC/Armed Forces

WHEREAS physician satisfaction with working conditions is directly related to effective health care delivery, and
WHEREAS the Public Health Service and military physicians will be serving a significant percentage of the United Sates population, and

WHEREAS it is currently possible for personnel to change from one branch of the armed services to another.

BE IT RESOLVED that OSR recommend that the AAMC take positive action to encourage the Surgeon General and appropriate governmental branches to provide at an individual's request an effective mechanism that would allow individuals to change on a one-for-one exchange basis from the armed services to the NHSC and vice versa.

## I. SCARPELLI VS. REMPSON et al

Action: The OSR approved the following resolution:

Scarpelli v. Rempson et al in Wyandotte County, Kansas is a civil law suit brought by a former member of the faculty of the University of Kansas Medical School against five defendants, Mr. Chester Rempson, former Assistant to the Vice Chancellor for Minority Affairs at the University of Kansas Medical School; Drs. Charles Lee, Nolan Jones, Ernest Turner, and Charles Floyd, former medical students at the University of Kansas Medical School. The plaintiff alleges defamation of character and interference with his contract rights and privacy.

The legal action against Drs. Lee, Floyd, Jones, and Turner resulted from actions taken in their capacity as members of the Executive Committee of the Student National Medical Association, University of Kansas Chapter. After two years of meetings and correspondence utilizing internal University processes, finally at the behest of the Executive Vice Chancellor of UK Medical School, the students filed a formal complaint alleging specific instances of discriminatory conduct on the part of various University of Kansas Medical School officials. The facts are clear; despite the gravity of the allegations and their seriousness of purpose, the students conducted themselves in a reasonable, responsible and professional manner in their attempt to resolve their grievances.

The legal action taken against Mr. Rempson was because his office assisted with the preparation of the students' formal complaint. In his role as administrator, this procedure was well within the scope of his express duties as the school's Affirmative Action Officer and rendered pursuant to the express instructions of his immediate superiors at the University of Kansas Medical School.

The facts of this case do not argue well for the protection of the freedom of minority students to bring complaints of discrimination. In fact, it addresses the even larger issue of any student, majority or minority, to seek redress when they have reason to think they have been discriminated against or treated unfairly in an educational setting. The replication of this case could present serious threats to the effort of students to stand up for their rights to pursue equal and judicious treatment in medical school. With this information as background, the following resolution is offered:

WHEREAS the Organization of Student Representatives of the AAMC acts as a voice to maintain the highest level of quality education and opportunities for all medical students; and
WHEREAS the OSR has already expressed concerns about the due process guidelines available to medical students for the resolution of grievance;
BE IT RESOLVED that the OSR direct its group studying due process to investigate this case;
BE IT FURTHER RESOLVED that the OSR submit information on this case to the GSA Section on Minority Affairs for their assessment of its affirmative action implications.

J. Parliamentary Procedure at OSR Business Meetings

The OSR Chairperson-Elect accepted as an instruction to the chair to appoint a knowledgeable parliamentarian/timekeeper for future OSR business meetings.

XIX. Installation of the Chairperson

Peter Shields turned the Chair to Dan Miller, the new OSR chairperson. Dan said that he looked forward to serving the membership during the coming year.

XX. The OSR business meeting adjourned at 6:00 p.m.

# MODEL DUE PROCESS GUIDELINES

The following four pages present the results of the OSR Administrative Board's work on the due process project; this work was primarily conducted by Dr. Arlene Brown. In her presentation of the project at the Business Meeting, Dr. Brown will offer additional considerations on the subject and then open the floor for discussion of the model guidelines. The recommendation of the Administrative Board is that the OSR approve these guidelines for dissemination to deans of student affairs at U.S. medical schools.

# DUE PROCESS PROJECT

At the 1978 OSR/AAMC Annual Meeting, a resolution was passed by the OSR which called for the OSR and GSA to address problems arising from the variable application of due process guidelines. The following represents a summary of our accomplishments on this project.

The first step in considering the resolution was to define clearly what is meant by the term, "due process." In a general sense, due process means fair treatment. In the courts it has been defined more specifically, for example, in the case of Zeigler vs. Railroad Co. (58 Ala. 599), "due process... implies the right of the person affected thereby to be present before the tribunal which pronounced judgement..., to be heard, by testimony or otherwise, and to have the right of controverting by proof, every material fact which bears on the question of right in the matter involved. If any question of fact or liability is conclusively presumed against him, this is not due process..." In the academic setting, however, due process is not quite as rigidly defined. Irby, et al* stated that "due process...requires the school to inform the student of inadequacies in performance and their consequence on academic standing. Due process also requires that the school's decision making be 'careful and deliberate'." They stated further that: "A medical school's dismissal of a student who fails academically will be upheld by the courts if the assessment is based on professional judgement and the school's procedures have been followed." The key issue, therefore, in assuring students of due process is that each school have a set of guidelines for use in dismissing a student and that those guidelines be made available to the student prior to their use.

Before making any conclusions or recommendations regarding due process for medical students, the Administrative Board elected to study the present state of affairs and requested the deans of student affairs at all American medical schools (125) to send us copies of their due process guidelines. We also prepared a model which we felt to be representative of adequate protection of the medical student's right to due process. We reviewed materials provided by the deans (103 schools responded, of these, five had no written guidelines) and analyzed their contents; the results are shown below. We then revised our model, and a copy of this is attached. Our hope is that this study will prompt schools to examine their policies and procedures for due process and to revise them as needed so as to more adequately protect the individual student's right to fair treatment.

* "Faculty Rights and Responsibilities in Evaluating and Dismissing Medical Students-a Legal Perspective," New England Journal of Medicine, in press.

## ANALYSIS OF EXISTING GUIDELINES*

| PROVISION | % WITH PROVISION STATED+ ACADEMIC QUESTIONS | DISCLIPINARY QUESTIONS |
|---|---|---|
| 1. Give the student written notice that he is being considered for dismissal 10 days prior to the hearing. | 45 | 36 |
| 2. Allow the student to inspect the material upon which his proposed dismissal is based. | 22 | 20 |
| 3. Permit the student to have an advisor present at the hearing. | 40 | 36 |
| 4. Conduct the hearing before the entire body which is to decide whether to recommend the student's dismissal. | 41 | 21 |
| 5. Give the student the opportunity to present his version. | 46 | 37 |
| 6. Confront the student with all the evidence against him, including grades, reports and evaluations. | 22 | 16 |
| 7. Base any recommendation for the student's dismissal solely upon the evidence presented at the hearing. | 8 | 12 |
| 8. Allow the student to record the hearing if he wishes. | 21 | 24 |
| 9. Give the student a written copy of all rules and procedures to be followed in the hearing at least 10 days prior to the hearing | 23 | 8 |
| 10. Give the student the opportunity to question any witness who presents evidence against him at the hearing. | 21 | 21 |
| 11. State the findings, decision and disposition of the case in writing. | 27 | 20 |

* obtained from 98 schools
\+ only schools which specifically stated these provisions are included

# MODEL SET OF DUE PROCESS PROCEDURES

In granting each student the M.D. degree the faculty at _____ School of Medicine is endorsing the particular student as having maintained the academic, moral and ethical standards appropriate to the practice of medicine. It is therefore the responsibility of the faculty to help the student recognize and correct any deficiences before the M.D. can be granted. The formality of any such correction should vary in proportion to the gravity of the deficit. The following presents a step-wise approach to this process.

1. Personal Communication - Whenever a faculty member (or the relevant committee) believes that a student has demonstrated a deficit, the faculty member shall approach the student in person as soon as practicable and inform him* of the deficit and of a proposed means of correcting it. If the deficiency can be corrected in a mutually satisfactory way, the matter need go no further.

If, however, either the student or the faculty member is not satisfied with the results of such a personal discussion he may, after informing the other party, request an informal hearing.

2. Informal Hearing - An informal hearing shall be held in the presence of an impartial third party (an ombudsman). The ombudsman must be agreed upon by the student and the faculty member, and may not be the Dean of the medical school. The purpose of the informal hearing shall be again to inform the student of his alleged deficit, to allow the student to present his version, and to work out, with the help and advice of the ombudsman, a mutually satisfactory remedy. The informal hearing shall be held in private and no records kept. Any remedial plan devised may be put into writing and placed in the student's file at the student's request.

In the event that either the student or the faculty member is dissatisfied with the outcome of the informal hearing, or if the student is, in the judgement of the faculty member or committee and/or ombudsman, unsuccessful in remedying the deficit, a formal hearing may be requested. If the deficiency is of sufficient gravity as to impair the student's academic progress or to require the student's dismissal from the School of Medicine, a formal hearing will be convened. If the student voluntarily waives his right to a formal hearing, it need not be held.

3. Formal Hearing - The purposes of a formal hearing are to provide a full and fair airing of the relevant evidence concerning a student's deficiency and to give the student a chance to present his version of the evidence and his views to a body with the authority to recommend its remedy or the student's dismissal. The following guidelines will apply:

a. The student shall be given a written statement that the formal hearing is upcoming. Such written notice shall be received at least 10 days prior to the hearing and shall contain a written copy of all rules and procedures to be followed in such a formal hearing.

b. The student shall be allowed to inspect his entire medical school file, including any material concerning the alleged deficiency.

c. The student will be permitted to have an advisor present at the hearing.

d. The hearing will be conducted before the entire body which is to decide the means of remedy or which may vote for the student's dismissal.

* For ease of reading, masculine pronouns are used and meant to include both genders.

e. The student will be given the opportunity to present his version of his performance, using any relevant evidence including affidavits, exhibits, and oral testimony.

f. The student will be confronted with all the evidence against him, including academic grades and the reports and evaluations used in arriving at those grades.

g. The student will be given the opportunity to question any witness who presents evidence against him at the hearing.

h. Any recommendations resulting from the formal hearing shall be based solely upon the evidence presented at the hearing.

i. The student will be allowed to record the hearing.

j. The findings, decision, and dispositon of the case shall be stated in writing.

4. Appeal - If the student is still dissatisfied with the outcome of the formal hearing he may appeal the decision to the Dean of the Medical Center. The final route of appeal may be to the Student Standards Committee of the Univeristy of _____, and finally to the President of the University.

## Improved Counseling of High School and Premedical Students

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

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

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

Therefore, we urge that the AAMC explore feasible means of providing more and better information to high school counselors and pre-medical advisors. Such an informational program should assist career counselors in their attempts to encourage students to broaden their outlook and might include information regarding pre-medical curricular issues, financial considerations, the diversity of approaches to preparing for a medical career, and the importance of considering other careers.

-- Approved by the OSR Western Region and OSR Administrative Board

## Instruction in Clinical Procedures

At the start of the clinical years, medical students have completed two years of intensive basic sciences laced with a few clinical experiences. Usually, instruction has included how to take a medical history and perform the physical exam. Rarely, though, do medical students receive adequate introduction to the clinical procedures that they must master during the final two years of school. Such procedures include venipuncture and culture, IV lines, "shots", CPR, arterial blood sampling, suturing, intubation, EKG, and local anesthetics. Fortunate students have had some prior experience or have an experienced person available to instruct them the first time these procedures are performed. Many juniors, however, receive no instruction and are expected to learn by trial and error. Such encounters between needle wielding students and reluctant patients can be traumatic to both parties. A quick and effective solution would be to provide a few days of instruction and practice prior to the beginning of the experience. By receiving introductory instruction on these skills in a low pressure environment, the medical student will be more competent, feel more confident and less stressed embarking on the clinical years. It is proposed that the OSR work with the Group on Medical Education (GME) of the AAMC to encourage medical schools to assure that students are prepared to perform effectively these procedures before starting the clinical experience.

-- Approved by the OSR Western Region and the OSR Administrative Board

# A COMPARATIVE ANALYSIS OF HOUSE AND SENATE PASSED HEALTH MANPOWER PROPOSALS AND CURRENT LAW

22

SEPTEMBER 1980

# INSTITUTIONAL SUPPORT

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Expires September 30, 1980 | As approved by the Senate 9/19/30. | As passed by the House 9/3/80. |
| Capitation Grants | Capitation Grants | Capitation Grants |
| 1) P.L. 94-484 continued the capitation grant program which provides flexible institutional support to medical schools through FY 1980 on the condition that medical schools in the aggregate and individually meet certain conditions. The conditions for participation in the capitation grant program are:<br>a) Maintenance of first year enrollment.<br>b) Maintenance of level of non-Federal expenditures.<br>c) Medical schools must have 40%, 45% & 50% of filled first year residency positions in direct or affiliated residency training programs in primary care for FY 78, 79, & 80 respectively. Unless requirement is met by a national average of all schools on July 15, before a fiscal year begins, schools individually must meet requirements on July 15 of the following year.<br>d) Schools must increase third year enrollment for 1978-79 by 5%. Enrollment increase designed for USFMS students. U.S. students excluded by statute from enrollment increases. | 1) Repeals Capitation Grant Program and replaces it with National Priority Incentive Grant Program.<br>2) National Incentive Priority Grants would provide $250 per student to the institution for FY 82, 83, & 84 for each of the objectives that are met by the school in the year the grant application is made. The objectives included in the bill are the following:<br>a) The school conducts, or will conduct within 12 months, 10% or more of its undergraduate clinical education in areas in which medically underserved populations reside or in ambulatory, primary care settings geographically remote from the main site of the teaching facilities of the school.<br>b) All fourth year students have had, or will have had before graduation, a significant educational experience in at least two of the following areas: nutrition, geriatrics, rehabilitation, health care economics & health policy or occupational & environmental health<br>c) Sixty-five percent of the school's filled first year positions in direct or affiliated approved residency training programs, are in general internal medicine, general pediatrics or family practice;<br>or | 1) Continues Capitation Grant Program with conditions very similar to PL 94-484 but phases it out at end of FY 83.<br>a) Maintenance of level of non-Federal expenditures.<br>b) Medical Schools must have 50% of filled first year residency positions in direct or affiliated residency training programs in primary care for FY 81, 82, & 83, respectively, after the number of individuals who transferred out of primary care after the first year of training is deducted. Unless requirement is met by a national average of all schools on July 15, before a fiscal year begins, schools individually must meet requirements on July 15 of the following year. |

## INSTITUTIONAL SUPPORT

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| | Twenty percent or more of the school's graduating students enter approved family practice residencies.<br>d) The school, in cooperation with other entities, conducts or provides evidence that it will conduct, within 12 months, a substantial community program of preventive health services (including health promotion and health information) designed to reduce the risk factors of the leading causes of death or morbidity in the community (including the risk factors among special population groups such as prisoners or institutionalized children) and in which students of the school receive substantial education in preventive and community medicine.<br>e) Twenty percent or more of the graduating class will have had substantial educational experience that will lead to careers in clinical investigation and research.<br>f) The enrollment of underrepresented minority groups in the first year class will be 12% for FY 82, 15% for FY 83 and 18% for FY 84.<br>3) In computing the enrollment of the institution, all institutions would double the number of minority students. | |

24

# INSTITUTIONAL SUPPORT

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Authorization Levels | Authorization Levels | Authorization Levels |
| FY 1978 $125 million | FY 1982 $37 million | FY 1981 $37 million |
| FY 1979 $132 million | FY 1983 $40.7 million | FY 1982 $24 million |
| FY 1980 $130 million | FY 1984 $44.5 million | FY 1983 $12 million |

25

# SPECIAL PROJECTS

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Funding | Funding | Funding |
| 1) Reimburses the school for the cost of the project. | 1) Reimburses the school for the cost of the project. | 1) Reimburses the school for the cost of the project. |
| Listing of Special Projects | Listing of Special Projects | Listing of Special Projects |
| 1) Department of Family Medicine<br>Establishment of Departments of Family Medicine<br>FY 80 Authorization $20,000,000<br>a) Family Medicine and General Practice of Dentistry<br>FY 80 Authorization $50,000,000 | 1) Department of Family Medicine<br>Project Grants for Family Medicine<br>FY 82 Authorization $9 million<br>a) Family Medicine Training and General Practice of Dentistry<br>FY 82 Authorization $32 million | 1) Department of Family Medicine<br>Projects Grants for Department of Family Medicine<br>FY 81 Authorization $15,000,000 |
| 2) AHECS<br>FY 80 Authorization $40,000,000 | 2) AHECS<br>Area Health Education Centers<br>FY 82 Authorization $21 million | 2) AHECS<br>Areas Health Education Centers<br>FY 81 Authorization $21,000,000 |
| 3) Education of USFMS Students<br>Education of returning U.S. students from foreign medical schools.<br>FY 80 Authorization $4,000,000 | 3) Education of USFMS Students<br>Not addressed. | 3) Education of USFMS Students<br>Not addressed. |
| 4) PA's and EFDA's<br>Programs for PA's Expanded Function Dental Auxiliaries (EFDA) and Dental Team Practice<br>FY 80 Authorization $35,000,000 | 4) PA's and EFDA's<br>Programs for PA's, Expanded Function Dental Auxiliaries and Chiropractics<br>FY 82 Authorization $16 million | 4) PA's and EFDA's<br>Physician Assistants and Dental Auxiliaries<br>FY 81 Authorization $14,000,000 |
| 5) Training in General Medicine and Pediatrics<br>Grants for training in general internal medicine and general pediatrics (not available to hospitals). | 5) Training in General Medicine and Pediatrics<br>Training in primary care internal medi- and pediatrics available to schools and hospitals. | 5) Training in General Medicine and Pediatrics<br>Grants for training in general internal medicine and pediatrics available to schools and hospitals. |

26

# SPECIAL PROJECTS

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| FY 80 Authorization $25,000,000 | FY 82 Authorization $17 million | FY 81 Authorization $23,000,000 |
| 6) Educational Assistance to Disadvantaged<br>FY 80 Authorization $20,000,000 | 6) Educational Assistance to Disadvantaged<br>FY 82 Authorization $22 million | 6) Educational Assistance to Disadvantaged<br>FY 81 Authorization $25,000,000 |
| 7) Projects in Preventive Medicine or Dentistry<br>Not in current law. | 7) Projects in Preventive Medicine or Dentistry, Occupational or Environmental Health<br>Projects for the establishment of departments or residency training programs.<br>FY 82 Authorization $3 million | 7) Projects in Preventive Medicine or Dentistry<br>Projects in Preventive Medicine or Dentistry for establishment of departments or residency training programs.<br>FY 81 Authorization $8,000,000 |
| 8) Miscellaneous Projects<br>Incorporated in list of 21 special projects in Sec. 788d. | 8) Miscellaneous Projects<br>a) Remote site training and support services in underserved areas.<br>b) Educational curriculum and program development.<br>c) Projects to reduce the total cost of health professions education.<br>d) Projects for women in health.<br>e) Grants for training in PM & R.<br>f) Special projects for physicians in graduate training. | 8) Miscellaneous Projects<br>(Included in Financial Distress authority below.) |
| 9) Start-Up Assistance Financial Distress Interdisciplinary training and Curriculum Development<br>FY 80 Authorization $25,000,000 | 9) Financial Distress Grants<br>Two kinds of Financial Distress Grants:<br>a) Similar to existing law but available for maximum of 3 years; can be used for operating costs, accreditation & carrying out operational, financial, and managerial reforms. | 9) Start-Up, Financial Distress, Interdisciplinary Training and Curriculum Grants<br>FY 81 Authorization $29,000,000 |

27

## SPECIAL PROJECTS

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| | FY 82 Authorization $3 million<br>b) Advanced grant available up to five years. School must have an approved plan to achieve solvency within five years.<br>FY 82 authorization $9 million | |
| 10) Start-Up Assistance<br><br>Incorporated in Financial Distress. | 10) Start-Up Assistance<br><br>There are no start-up assistance grants for medical schools. | 10) Start-Up Assistance<br><br>Incorporated in previous section. |

28

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 1. HEAL Program | 1. HEAL Program | 1. HEAL Program |
| Eligibility. MODVOPP and public health students. | Eligibility. MODVOPP, chiropractic, public health, physician assistant or expanded function dental auxiliary training programs, graduate program of health administration, and clinical psychology and advanced nurse training students. | Eligibility. Same as in current law. |
| Restrictions on Eligibility. Students may not hold GSL loan in same academic year. No more than 50% of each school's students can receive HEAL loans. | Restrictions on Eligibility. None. | Restrictions on Eligibility. None. |
| Limits. Aggregate of $60,000 for medical students. | Limits. Aggregate of $80,000 for medical students. | Limits. Aggregate of $80,000 for medical students. |
| Interest Rate. Maximum rate of 12%. | Interest Rate. Maximum rate cannot exceed current bond equivalent of 91-day T-bill plus 2.5%. | Interest Rate. Maximum rate cannot exceed current bond equivalent of 91-day T-bill plus 2%. |
| Deferment. Repayment on principal deferred during medical school and 3 years of: internship or residency service in Armed Forces, Peace Corps or NHSC. Interest must be paid during these periods. | Deferment. Repayment on principal and interest deferred during: medical school and 4 years of service in Armed Forces, Peace Corps or NHSC; or 5 years of internship or residency. | Deferment. Repayment on principal and interest deferred during medical school and 4 years of internship, residency; and, 3 years of service in NHSC, Peace Corps, or Armed Forces. |

# STUDENT ASSISTANCE

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Repayment. 10-15 years beginning 9-12 months after graduation. | Repayment. 10-15 years beginning 9-12 months after graduation. Provides for less burdensome repayment terms by requiring that borrowers be offered: 1) graduated repayment option with larger payments due later; and 2) a variable interest option to be offered at the option of the lender. | Repayment. 10-15 years beginning 9-12 months after graduation. Provides for less burdensome repayment requirements by requiring that the borrower be offered a schedule for repayment under which a portion of the payment is due later in the repayment period. |
| Overall Loan Limits. Current law authorized that total principal amount of HEAL loans that could be Federally guaranteed could not exceed $520 million for FY 80. | Overall Loan Limits. Total principal amount of HEAL loans that could be Federally guaranteed could not exceed: $100 million for FY 82; $120 million for FY 83; and, $140 million for FY 84. | Overall Loan Limits. Total principal amount of HEAL loans that could be Federally guaranteed could not exceed $520 million for each of FY 81-83. |
| Allowable Expenditures. Tuition & fees. | Allowable Expenditures. Tuition, fees, and reasonable living expenses. | Allowable Expenditures. Same as in current law. |
| Loan Forgiveness. Forgiveness of $10,000/year permitted at the discretion of the Secretary in return for a minimum of 2 years service in NHSC or in private practice in shortage areas. Loan totally discharged in cases of death or permanent disability. | Loan Forgiveness. Partial forgiveness of principal and interest in return for minimum of 2 yrs. service in NHSC or in shortage areas: 10% or $6,000, whichever is greater, for the first or second year of service; & 15% or $9,000, whichever is greater for the third or fourth year of service. Amount of debt that can be paid in this fasion is 50% of principal of each loan. Loan also discharged in cases of: death, permanent disability failed first year who are unsuccessful in retaking first year courses; students from disadvantaged families meeting certain income levels; those not expected to resume training within 2 yrs; and, to permit failed first year students to retake courses if they are not successful in this attempt. These provisions apply to all loans used to finance health professions education. | Loan Forgiveness. Same as in current law. |

30

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 2. HPSL Program.<br>Program funded by revolving fund using Federal and school funds. (9/1 ratio). After FY 1983, pursuant to individual agreements between the schools and the Secretary, each school shall begin returning these funds to the Federal government. | 2. HPSL Program.<br>Phased out. Schools are authorized to make loans in FY 82 to previous HPSL recipients who are enrolled in the last-year of study. Such loans will be made out of HPSL Revolving Fund. Requires that the Federal government begin to recover HPSL funds from the schools after FY 82. Federal government capital and income from the dissolution of this program be utilized to help finance new Service Contingent Loan Program set up by the Bill to replace HPSL. | 2. HPSL Program.<br>Reauthorized as in current law. Extends until FY 1986, the requirement in P.L. 94-484, that the Federal government begin to recover HPSL capital funds from the schools. |
| Authorization.<br>$28 million FY 81; $16.5 million appropriated. | 3. Service-Contingent Loan Program<br><br>Authorization.<br>To help finance loan fund:<br>$13 million, FY 82; $20 million, FY 83; $40 million, FY 84. If needed 25% of these funds allocated to nursing students. Also, authorizes the appropriation of such sums as the Secretary might request to meet insufficiencies of the fund for certain purposes such as discharge of loans upon death or disability or borrower. | Authorization.<br>$20 million, FY 81;<br>$22.5 million, FY 82;<br>$25 million, FY 83. |

# STUDENT ASSISTANCE

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Eligibility. MODVOPP students. Medical students graduating after 5/30/ 80 must be in exception financial need (resources equally less than $5,000 or half the cost of attending school, whichever is less.) | Eligibility. MODVOPP public health, nursing, graduate programs in health administration and programs for training of physicians assistants expanded dental auxiliaries, nursing anesthetists. Students must be in need of the amount of the loan. Need to be determined by the school. Students may not receive NHSC, IHS, Armed Forces, State-Service Scholarships in same academic year. | Eligibility. Same as in current law. |
| Limits. Tuition plus $2500/year. No aggregate limit. | Limits. Aggregate of $80,000 for medical students. | Limits. Same as in current law. |
| Interest Rate. Completely subsidized during school. 7%, one year after graduation. | Interest Rate. Subsidized interest rate of the lesser of 7% or half of rate on long-term obligations plus 1.5% during: medical school; first year of graduate training; service in a shortage area, Armed Forces, or for a Federal, State or local government entity; full-time teaching in a higher education institution; research on more than a half-time basis as part of full time position in health professions shcool, non-profit or Federal biomedical research facility; training or serving as a public health professional; internship, residency or practice in general or family practice, general internal medicine, pediatrics, preventive medicine, psychiatry, or rehabilitative medicine; and 3-5 years of advanced research training or a doctoral program leading to a career in biomedical or clinical investigation or academic health professions career. | Interest Rate. Same as in current law. |

32

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| | After these periods medical students would be charged interest at the rate of long-term obligations of U.S. plus 1.5%. | |
| Deferment. Repayment deferred for up 3 yrs. for Armed Forces, Peace Corps, NHSC, and up to 5 yrs. for further advanced professional training. | Deferment. Repayment of both principal and interest deferred (interested accrues and compounds) during service in: national priority position; 4 yrs. in NHSC, IHS, Armed Forces, Peace Corps; 5 yrs. internship or residency; 3-5 yrs. advanced research training or doctoral program leading to a career in a biomedical or clinical investigation, or academic career in a health profession. | Deferment. Same as in current law. |
| Repayment. Ten years beginning one year after graduation. | Repayment. Fifteen years beginning one year after graduation. | Repayment. Same as in current law. |
| Service Commitment. None. | Service Commitment. Requires commitment of all borrowers to serve in national priority positions. The number who are called to service in return for laon discharge are controlled by Congressional appropriations. | Service Commitment. None. |
| Loan Forgiveness. Secretary forgives 60% of the debt in exchange for 2 yrs of service in a designated shortage area and an additional 25% for a third yr. of service. | Loan Forgiveness. Same conditions as those outlined under the HEAL Program but also includes provisions providing for a waiver or deferral of service obligations or monetary penalties in cases where fulfillment of the service obligation would be unconscionable, impossible, involve | Loan Forgiveness. Same as in current law. |

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| | extreme hardship; the student fails to maintain acceptable academic standing, or the student is dismissed for disciplinary reasons. | |
| 3. Scholarship Program for First-Year Students in Exceptional Financial Need (EFN) | 3. Scholarship Programs for First-Year Students in Exceptional Financial Need (EFN) | 3. Scholarship Programs for First-Year Students in Exceptional Financial Need (EFN) |
| Eligibility. First-year MODVOPP students in exceptional financial need---those with virtually no resources. | Eligibility. Same as in current law. | Eligibility. First and second year MODVOPP students in exceptional financial need. |
| Limits. Tuition, fees and a living stipend of approximately $5500/year. | Limits. Lesser of tuition and fees plus $2500 or $5000. | Limits. Same as in current law. |
| Allocation of Awards. To all health professions schools with priority to MOD schools. | Allocation of Awards. Each health professions school will receive 2 scholarships. The remainder will be distributed to MOD schools based on proportionate enrollment of first yr. students in exceptional financial need. | Allocation of Awards. Priority to MOD schools. |
| Authorizations. $16 million FY 78; $17 million FY 79; and $18 million FY 80. (only $10 million actually appropriated in FY 80). | Authorizations. $15 million FY 82; $16 million FY 83; and, $17 million FY84. | Authorizations. $30 million FY 81; $40 million FY 82; and, $50 million FY 83. |

34

# NATIONAL HEALTH SERVICE CORPS PROGRAM

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 1. NHSC Programs. | 1. NHSC Programs. | 1. NHSC Programs. |
| Categories of Service. | Categories of Service. | Categories of Service. |
| a) Officers of the Regular and Reserve Corps of the Service. | Same as in current law. | a) Officers of the Regular and Reserve Corps of the Service. |
| b) Designated civilian personnel. | | b) Appointed U.S. civilian personnel. |
| | | c) Non-U.S. civilian personnel. |
| Designation of Shortage Areas. | Designation of Shortage Areas. | Designation of Shortage Areas. |
| Urban or rural areas in which the Secretary determines shortage exists; population groups or public or non-profit private medical facility or other public facility deemed to have such a shortage. | Same as in current law but also permits certain hospitals to be designated as such in order to reduce dependency on alien foreign medical graduates. | Same as in current law but requires HSAS & SHPDAS to approve or disapprove the designation. Also, requires the Secretary to undertake an evaluation of the criteria utilized to designate these areas. |
| Assignment of Corps Personnel. | Assignment of Corps Personnel. | Assignment of Corps Personnel. |
| To public or nonprofit entities located in shortage areas. | Same as in current law but specifies that in assigning personnel to a State, the Secretary must first assign those who have taken their training in that particular state. | Same as in current law but specifies that non-U.S. employees assigned to those entities must be assured by the entity a salary and employment benefits equal to that of Corps members who are serving as U.S. civilian employees. If the entity does not have sufficient funds, the Secretary may make a grant for this purpose. Also, in order to improve the assignment of Corps members, it provides for coordination with the States and other public and nonprofit entities to establish programs |

# NATIONAL HEALTH SERVICE CORPS PROGRAM

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| | | Assignment of Corps Personnel. for the planning, development and operations of centers for the delivery of primary health care in shortage areas. Establishes an NHSC Fund to carry out these purposes. |
| Authorizations. $70 million FY 80; $70 million appropriated. | Authorizations. Expectation that it will be reauthorized in FY 81 Continuing Resolution. | Authorizations. $94 million FY 81; $145 million FY 82; and, $205 million FY 83. |
| New Programs. Not applicable. | New Programs. Requires Secretary to conduct or support preparatory programs for NHSC Scholarship recipients. | New Programs. Permits Secretary to make grants for the conduct of preparatory programs for NHSC Scholarship recipients. |
| 2. NHSC Scholarship Program | 2. NHSC Scholarship Program | 2. NHSC Scholarship Program |
| Authorizations. $200 million FY 80; $85.5 million was appropriated. | Authorizations. $55 million; FY 82<br>$48 million; FY 83<br>$48 million; FY 84 | Authorizations. $92.0 million FY 81; $101 million FY 82; $109 million, FY 83. |
| Allocation of Appropriations. 90% of sums appropriated will set aside for MOD students; 10% of this must go to dental students. | Allocation of Appropriations. Same as in current law. | Allocation of Appropriations. Same as in current law. |

36

# NATIONAL HEALTH SERVICE CORPS PROGRAM

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| Selection Priorities.<br><br>1) Previous NHSC or EFN Scholarship recipients.<br><br>2) First-year students. | Selection Priorities.<br><br>1) Previous NHSC Scholarship recipients.<br><br>2) Previous EFN Scholarship recipients.<br><br>3) All other eligible individuals. Priority within these categories will be given to those individuals who agree to provide medical services to Indians through IHS. | Selection Priorities.<br><br>1) Previous NHSC or EFN Scholarship recipients.<br><br>2) First-year students---in determining priorities the Secretary must give special consideration to individuals who: intend to be primary care physicians in shortage areas; have resided or been employed in such areas; or, who meet other qualifications to assist in determining if the individual will become a primary care physician in such an area. |
| Apportionment of Awards to the States.<br><br>Nothing specified. | Apportionment of Awards to the States.<br><br>States participating in State-Service Scholarship Program cannot receive more than 10% of funds appropriated for the NHSC Scholarship Program. | Apportionment of Awards to the States.<br><br>Nothing specified. |
| Scholarship Recipients and National Research Service Awards.<br><br>Permits Scholarship recipients with "exceptional promise for medical research" to perform their service obligation under NRSA Program at the Secretary's discretion. | Scholarship Recipients and National Research Service Awards.<br><br>Same as in current law. | Scholarship Recipients and National Research Service Awards.<br><br>Mandates that service under the NRSA Program be counted against obligated service for NHSC Scholarship recipients. |

# NATIONAL HEALTH SERVICE CORPS PROGRAM

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 3. NHSC Private Practice Option<br><br>Secretary is required to release NHSC Scholarship recipient from service obligation in return for service in private practice in a shortage area. | 3. NHSC Private Practice Option<br><br>Same as in current law but renames it "Independent Practice". | 3. NHSC Private Practice Option<br><br>Same as in current law. |
| Income Equivalence Test<br><br>Shortage area must have sufficient financial base to provide individual with income equal to that of Corps members. | Income Equivalence Test<br><br>None. | Income Equivalence Test<br><br>None. |
| Technical Assistance<br><br>None. | Technical Assistance<br><br>Requires Secretary to provide such individuals with technical assistance by paying: $10,000 in 1st year; $7500 in 2nd year; $5000 in 3rd year; and, $2500 in 4th year; or the difference between the individuals income and that of a Corps member, whichever is less, plus the cost of the individuals malpractice insurance. | Technical Assistance<br><br>Secretary must, upon request, provide technical assistance to such individuals to assist them in the establishment of their practice. |
| Assignment of Medicare/Medicaid Patients<br><br>Requires that physicians under this option not discriminate against Medicare/Medicaid patients in providing health services. | Assignment of Medicare/Medicaid Patients<br><br>Requires that physicians under this option accept Medicare/Medicaid patients on assignment. | Assignment of Medicare/Medicaid Patients<br><br>Requires that physicians under this option accept Medicare/Medicaid patients on assignment. |

38

# NATIONAL HEALTH SERVICE CORPS PROGRAM

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 4. New NHSC Modelled Programs<br><br>Not Applicable. | 4. New NHSC Modelled Programs<br><br>Establishes a new State-Service-Conditional Scholarship Program modelled on the NHSC to off-set phase down of the NHSC Scholarship Program which would:<br><br>● Establish a program of matching grants (6/1) to the States to fund scholarships to students willing to serve in shortage areas.<br><br>● Require States to assume responsibility for assuring a minimum salary.<br><br>● Permit individuals to enter private practice in shortage areas in lieu of payback through State service.<br><br>● Not permit previous NHSC Scholarship recipients to be eligible for this program.<br><br>Authorizations:<br><br>$6 million for FY 82;<br>$13.5 million; and<br>$15 million for FY 83. | 4. New NHSC Modelled Programs<br><br>None. |

# CONSTRUCTION

| Current Law | Kennedy/Schweiker Bill (S.2375) | Waxman Bill (H.R. 7203) |
|---|---|---|
| 1) Enrollment Requirements<br><br>Requires the first year enrollment the year following the completion of the construction and for the next nine years to exceed the highest first year enrollment for any of the five preceeding school years by at least 5% or five students whichever is greater. | 1) Enrollment Requirements<br><br>Unilaterally repeals enrollment increase requirement under construction grant authority. | 1) Enrollment Requirements<br><br>Repeals enrollment increase. |
| 2) Construction Grants<br><br>Provides the Secretary with Construction Grant authority to assist in the construction of teaching facilities for the training of health professionals.<br>FY 80 Authorization $40,000,000 | 2) Construction Grants<br><br>Provides funds for renovation, modernization and conversion of existing facilities.<br>FY 82 Authorization $1 million | 2) Construction Grants<br><br>Repeals authority. |
| 3) Loan Guarantees and Interest Subsidies<br><br>Provides loan guarantees and interest subsidies for construction of teaching facilities.<br>FY 80 Authorization $3,000,000 | 3) Loan Guarantees and Interest Subsidies<br><br>Continues the authority for loan guarantees and interest subsidies but requires the subsidy to be either 6% lower than market rates or no higher than 7% whichever is less. The combined total of the principal of the loan guarantee and the principal of the interest subsidy for any entity must not exceed $10,000,000 for any fiscal year.<br>FY 82 Authorization $5 million | 3) Loan Guarantees and Interest Subsidies<br><br>Provides loan guarantees and interest subsidies for renovation projects.<br>No authorization noted. |

40

NRMP

# PROPOSED REVISIONS
# FOR THE 1982 MATCH

National Resident Matching Program
1603 Orrington Avenue, Suite 1155
Evanston, Illinois 60201
(312) 328-3440

September, 1980

# THE MATCH

- The Match is simply a mechanism by which appointments to residency programs are made at a uniform time.

  No applicant or program director has a time advantage over another if all those offering and seeking positions participate in the Match.

- In the Match, all steps of the admissions process are carried out — by computer — exactly as they would be without the Match, BUT at uniform times.

  Program directors decide on the order in which they will offer positions to candidates, BUT, instead of extending offers by telephone, telegram or letter, send their Rank Order Lists to NRMP.

  Applicants decide on the order in which they will accept offers from programs, BUT, instead of dealing with individual telephone calls, telegrams or letters, send their Rank Order Lists to NRMP.

- The Match obviates what can be possibly premature decisions and less-than-comfortable direct interchanges between program directors and applicants in the offering and acceptance or rejection of positions.

  Once confidential Rank Order Lists are sent to NRMP, one-to-one temporizing, indecision, use of buying and selling techniques, protestations of personal injury or dishonor, and coercion by program director and/or applicant over a protracted period are not possible.

- In the Match, applicants and program directors obtain their highest possible choices as determined by their Rank Order Lists.

  A position is "offered" to an applicant whenever his name appears within the quota of positions offered by a program.

  An applicant "accepts" (is matched to) a position in the program highest on his Rank Order List that "offers" him a position.

- In the Match, the confidential Rank Order Lists are the sole determinants of offers and acceptances of residency positions.

  The only reason an applicant does not "accept" an offer from a particular program director is that the applicant preferred (ranked higher) another program from which he also received an offer.

  The only reason an applicant does not "obtain" (match to) a position in a particular program is that the program director preferred (ranked higher) other applicants.

- Top choices on Rank Order Lists can be made by applicants and program directors in the order of desirability — they may ignore probability of acceptance.

  When an applicant is "offered" his first choice position, the match is final. His name is removed from the lists of all other programs, and their Rank Order Lists are adjusted, as necessary, to maintain their quotas by including the next person down the list. If an applicant matches to a lower-ranked program, the match is tentative. His name is removed from the lists of all programs ranked yet lower, but is maintained on the lists of his higher-ranked programs. If his name should subsequently be included within the quota of a program he has ranked higher, he will be moved to the higher-choice position.

  No matter how many top-ranked applicants "decline" offers from a given program, lower-ranked applicants who rank that program first will be matched to it as long as the program's quota remains unfilled.

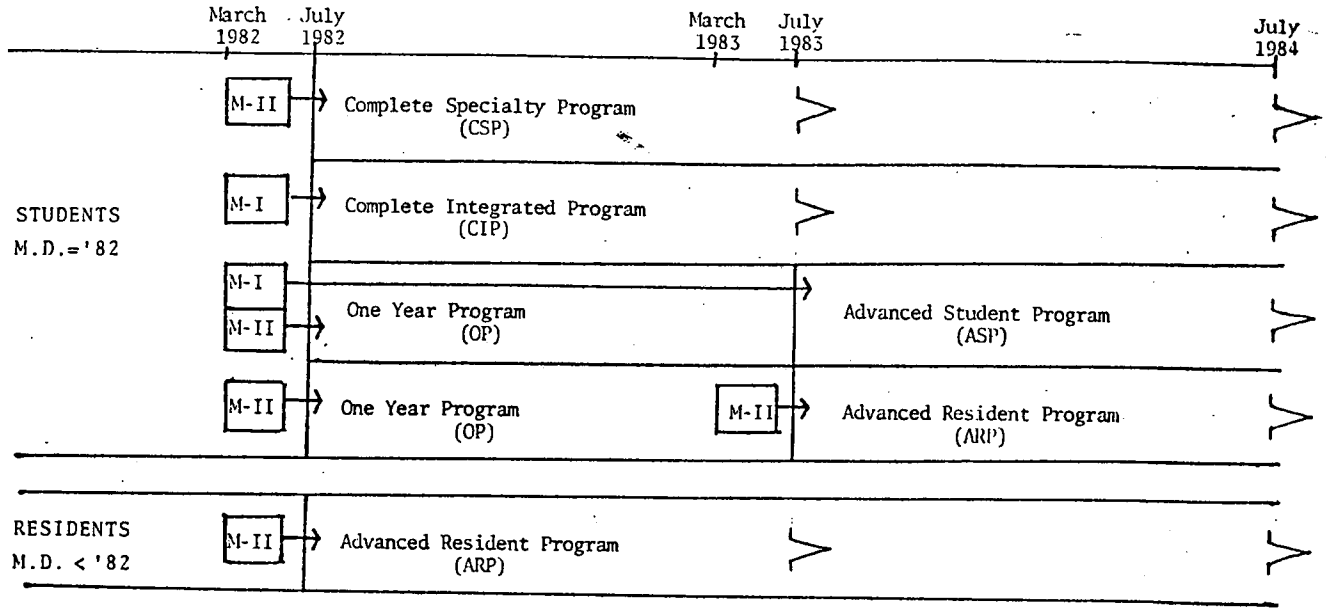
- For the Match to work optimally, applicants must list (rank) all acceptable programs to which they have applied and program directors must offer positions to (rank) all acceptable applicants.

  Applicants must, as in any admissions process, rank a range of programs on their Rank Order Lists including lower choices of less desired but satisfactory programs. Applicants who do not match tend to be those with shorter Rank Order Lists and those who list only highly competitive programs. Only the most highly sought-after students should obtain their first choices if the Match is being well used by students. If a high percentage of applicants from a school obtain their first choices, the students commonly have been counselled to rank programs based on probability of acceptance rather than on desirability.

  Program directors who rank only a few more of their applicants than they have positions or concern themselves about "how far down" their Rank Order Lists they go do not understand the Match. If, on the average, each applicant were to apply to five programs, the average program director would have an acceptance from only one out of every five applicants to whom he offered (ranked) a position!

15 July 1980

## REVISIONS IN THE MATCH




M = Match - Phase

NRMP NUMBERS FOR PROGRAM TYPES

| TYPE OF PROGRAM | COMPLETE PROGRAMS (CSP) | COMPLETE PROGRAMS (CIP) | ONE YEAR PROGRAMS (OP) | ADVANCED PROGRAMS (ASP)* | ADVANCED PROGRAMS (ARP) |
|---|---|---|---|---|---|
| Internal Medicine | 20 | -- | 10 | -- | -- |
| General Surgery | 24 | -- | 12 | -- | -- |
| Transitional | -- | -- | 14 | -- | -- |
| Emergency Medicine | 26 | -- | -- | -- | -- |
| Family Practice | 27 | -- | -- | -- | -- |
| Pediatrics | 32 | -- | -- | -- | -- |
| Allergy-Immunology | -- | -- | -- | -- | 75 |
| Anesthesiology | -- | 35 | -- | 55 | 76 |
| Colon-Rectal Surgery | -- | -- | -- | -- | 77 |
| Dermatology | -- | 36 | -- | 56 | 78 |
| Neurosurgery | -- | 37 | -- | 57 | 79 |
| Neurology | -- | 38 | -- | 58 | 80 |
| Nuclear Medicine | -- | 39 | -- | 59 | 81 |
| Obstetrics | -- | 40 | -- | 60 | 82 |
| Ophthalmology | -- | 41 | -- | 61 | 83 |
| Orthopedics | -- | 42 | -- | 62 | 84 |
| Otolaryngology | -- | 43 | -- | 63 | 85 |
| Pathology | -- | 44 | -- | 64 | 86 |
| Physical Medicine | -- | 47 | -- | 65 | 87 |
| Plastic Surgery | -- | -- | -- | -- | 88 |
| Preventive Medicine | -- | -- | -- | -- | 89 |
| Psychiatry | -- | 48 | -- | 66 | 90 |
| Radiology, Diagnostic | -- | 49 | -- | 67 | 91 |
| Radiology, Therapeutic | -- | 50 | -- | 68 | 92 |
| Thoracic Surgery | -- | -- | -- | -- | 93 |
| Urology | -- | 51 | -- | 69 | 94 |

* To begin in year after the Match

NATIONAL RESIDENT MATCHING PROGRAM

DESCRIPTION OF CHANGES *

In the redesigned NRMP all first year residency positions in all specialties may be offered to graduating senior medical students and to residents and other physicians who have graduated in previous years in the match regardless of the graduate level at which they begin. The need for an early match date will be eliminated. Program directors in those specialties in which some appointments to first year residency (R-1) currently are offered to seniors for the first postgraduate year (PGY-1) but others are offered to seniors to begin in the PGY-2 year are provided with opportunities to match all R-1 positions in the specialty simultaneously. Students who match to a PGY-2 program in such a specialty can also obtain a one-year program for the PGY-1 year in the same match. Resident matching is also provided. All R-1 positions may be offered by institutions and their program directors in one of three categories - as Complete Programs, One Year Programs or as Advanced Programs.

I. COMPLETE PROGRAMS

Complete programs will be offered by two groups of specialties:

Complete Specialty Programs (CSP). These are the specialties in which all programs offer R-1 positions, usually entered in the PGY-1 year, that will lead to the full residency training required in the specialty. Graduating seniors and any others who match to positions in the programs in these specialties can reasonably expect to complete the educational and training requirements of a certifying board. Complete Specialty Programs are currently offered as Categorical Positions in the broader specialties entered by most graduates and matching into them will not change.

Family Practice
Internal Medicine
Pediatrics
General Surgery

Complete Integrated Programs (CIP). The other specialties have commonly required prerequisite broad clinical training. Some of the programs in them have provided for integration of training in the broad specialties - either by arrangements for a first year or by rotation - and have also offered entry into complete programs beginning in the PGY-1 year to graduating students through the match. They may continue to do so in the redesigned match; such programs will be called Complete Integrated Programs (CIP). Most programs in obstetrics, pathology and psychiatry, for example, have made the necessary arrangements with other clinical disciplines

in their institutions to meet their Residency Review Committee requirements for broad clinical education and training for their residents and currently offer what will be called CIP.

II. ONE YEAR PROGRAMS (OP)

These are positions in programs of one year's duration designed to provide the preparatory experience required for residents who plan to enter training in their chosen specialty in their second graduate or for students who are undecided as to specialty choice. Examples of these are positions for one year in internal medicine programs for residents who will start their neurology or ophthalmology training the subsequent year or One Year Positions in general surgical programs for residents who will start training in a surgical specialty in their second year. The new Transitional Programs that are sponsored by institutions and provide experiences in several disciplines will provide another type of One Year Position.

III. ADVANCED PROGRAMS

Advanced Student Programs (ASP). The majority of programs in the specialties that require broad clinical experiences have, however, not been able to or wanted to make arrangements to offer Complete Positions. Some of them offer their positions to applicants to enter at the PGY-2 year of graduate training but want to appoint senior students at least a year in advance of their date of entry and leave the responsibility for arranging an appropriate first graduate year to the students. Examples of these kinds of programs are dermatology programs which select their residents from among graduating seniors who will start their R-1 year in dermatology one year after graduation and after completing a One Year graduate medical education program. In the new match, some or all positions in such programs may be offered to senior medical students as Advanced Student Programs (ASP). Graduating students will be able to match for these positions to begin residency training in them at the second graduate year level. In the same match, students will also be able to match into One Year Program Positions beginning the year of the match with their rank order preference for their One Year Program Positions dependent upon into which ASP they are matched.

Advanced Resident Programs (ARP). In other advanced programs, directors want to make some or all of their appointments from residents who are in their first or later years of graduate medical education or to physicians who are

re-entering graduate medical education; such appointments are usually made only a few months prior to the time of entry into them. These can be offered as Advanced Resident Programs (ARP). Examples of these are orthopedic surgery programs that want to select residents only after evaluation of their performance as general surgery residents and positions in colon and rectal, plastic or thoracic surgery programs that require completion of a general surgical program before entry. In the new match, residents can be matched to these positions (ARP) to begin their programs in the year of the match. A particular program can also offer some of its entering positions for an academic year to graduating students as ASP positions in the match that occurs the year before and the remainder, including any that did not fill, to residents as ARP positions in the match that occurs the year of entry.

## OPERATIONAL DETAILS

If all institutions and all program directors in all specialties participate, the re-organized match will provide a uniform timing for the appointment of all entering residents. Institutions and their program directors may offer any or all types of positions in the match. Residents and other physician candidates may apply for all types of positions; students may apply for all types with the exception of ARP positions which are available only to physician candidates. The match will be carried out in two phases.

## PHASE I

Phase I of the match will include all applicant choices and positions for the Complete Integrated Program (CIP) positions and Advanced Student Program (ASP) positions. Students who apply for ASP positions may submit a Supplemental Rank Order List for Phase II (see below) on which they list their set of choices for One Year Positions contingent upon their being matched into a position in a particular ASP.

New opportunities for the filling of unmatched positions will be provided following Phase I. These changes are designed to facilitate the offering of complete programs by all specialties. Categorical programs in internal medicine and general surgery may reserve some of their first year positions to serve as the first graduate year experience in another specialty (CIP) without concern about their not filling because of their being sequestered in another specialty track. If such donated positions are not filled in Phase I by applicants for the other specialty, the "donated" year positions will be re-entered into the second phase

of the match as One Year Positions in the parent medical or surgical programs. Furthermore, program directors in other specialties who offer but fail to fill ASP positions with graduating students in the match in a given year may offer the positions to physician applicants as ARP positions in the match the following year.

PHASE II

The second Phase of the match will be carried out immediately following Phase I. All of the Complete Specialty Program positions will be offered as in the current match. In addition, all One Year Program positions, augmented by any unfilled first-year positions which had been donated by programs in internal medicine and general surgery for Phase I, will be offered. All of the positions available only to residents and other physician candidates (ARP) will also be included in Phase II.

The candidates in the second match will include the great majority of graduating seniors whose Rank Order Lists include only choices for Complete Specialty Programs (CSP) and the few undecided graduates who list only One Year Program positions. Phase II will also include students who failed to match in Phase I whose Rank Order Lists also included CSP and/or OP positions plus the residents and other physician applicants.

The Supplemental Rank Order List submitted for the One Year Program positions by the students who matched into Advanced Student Program positions (ASP) in Phase I of the match will be included in Phase II of the match. Such students may have listed one set of One Year positions for a particular ASP and another set of One Year positions for a second ASP. If matched into the first ASP, the student will be matched against his or her choices of One Year positions for that program and, if matched into the second Advanced Program, he or she will be matched against another set of One Year Programs chosen for that program. Students also will have the option of ranking all One Year Program positions that they will accept or of indicating that they prefer to go unmatched for the first graduate year if not matched into one of the sets they chose for the Advanced Programs into which they match. These changes in the match will lessen the tendency of students to aver that they are planning to complete a program in internal medicine or general surgery when they are actually seeking only one year of experience. For program directors in these two specialties, this feature of the revised match will mean that the residents who will leave after one year to enter another specialty will clearly be identified.

A final feature of the revised match is that program directors in internal medicine and general surgery will have the opiton of recommending, and students will have the advantage of making, applications to One Year Program positions as well as Complete Specialty Programs in a particular hospital on the possibility that if a student is not ranked sufficiently high to match into the Complete Specialty Program, an open One Year position might be available. This feature will provide an added measure of opportunity for students who want to enter a particular hospital and for such categorical programs to fill all of their first year positions.

---

* These modifications have been developed because of strong interests in matching expressed by program directors in many specialties and the dissatisfaction expressed by students and their deans with the various routes and timing of appointments to some specialties.

The modifications are based on the results of tracking studies of U.S. medical school graduates (J. Med. Educ. 55:647-655, August, 1980).

The program designations used in these modifications are consonant with the changes that will be required when the revised "General Requirements" of the "Essentials of Accredited Residencies" approved by the Liaison Committee on Graduate Medical Education at its meeting on September 9, 1980, are approved by its sponsoring organizations.

11 September 1980

# MEDICAL SCHOOLS DUE FOR ACCREDITATION SITE VISITS IN 1981

Loma Linda U. - January 6-9

Arkansas - January 6-9

Baylor - January 19-22

U. California- Los Angeles - Riverside - January 19-23

Texas A & M - January 26-29

Texas, Houston - January 26-29

George Washington - February 9-12

Southern Cal. - February 9-12

South Alabama - February 17-19

U. of South Carolina - February 16-19

Ponce - February 23-26

U. del Caribe - March 1-6

Med. U. of S. Carolina - February 24-27

Morehouse - April 6 week

Medical College of Ohio at Toledo - March 2-5

Northeastern Ohio - March 2-5

Georgetown - Fall

Wayne State U - March 17-20

Rush - April 8-9

SUNY- Syracuse & Binghamton - April 14-16

North Dakota - April 21-22

Vermont - May 4

Dartmouth - May 4 week

Michigan State - Sept. 29 - Oct. 2

USUHS - Oct 6-9

Oral Roberts U - October 20-23

U of Colorado - October 26-29

U of South Dakota - Nov. 10-13

Columbia U - Nov. 16-19

Hahnemann Med Coll - Nov. 16-19

## SCHEDULE OF 1981 OSR REGIONAL MEETINGS*

| Date | Region | Location |
|---|---|---|
| March 29-April 1 | Western | Asilomar, Pacific Grove, Calif. |
| April 15-18 | Southern | St. Simmons Island, Georgia |
| April 23-25 | Central | Detroit, Michigan |
| April 27-30 | Northeast | Buckhill Falls, Pennsylvania |

*held in conjunction with the Group on Student Affairs

## DATES OF OSR ADMINISTRATIVE BOARD MEETINGS

| OSR Administrative Board | AAMC Executive Council |
|---|---|
| January 28 | January 29, 1981 |
| March 25 | March 26, 1981 |
| June 24 | June 25, 1981 |
| September 9 | September 10, 1981 |

## 1981 AAMC ANNUAL MEETING

October 31 - November 4
Washington Hilton Hotel
Washington, DC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

EXECUTIVE COUNCIL AND ADMINISTRATIVE BOARD MEMBERS

## EXECUTIVE COUNCIL

Chairman: Charles B. Womer
University Hospitals of Cleveland

Chairman-Elect: Julius R. Krevans, M.D.
UC - San Francisco

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

Representatives:

COD: Stuart Bondurant, M.D.
University of North Carolina

Steven C. Beering, M.D.
Indiana University

Neal L. Gault, Jr., M.D.
University of Minnesota

William H. Luginbuhl, M.D.
University of Vermont

Richard Janeway, M.D.
Bowman Gray

Allen W. Mathies, Jr., M.D.
University of So. California

John E. Chapman, M.D.
Vanderbilt University

Theodore Cooper, M.D.
Cornell University

Leonard M. Napolitano, Ph.D.
University of New Mexico

CAS: Carmine D. Clemente, Ph.D.
UCLA-Brain Research Institute

Daniel X. Freedman, M.D.
University of Chicago

David M. Brown, M.D.
University of Minnesota

Thomas K. Oliver, Jr., M.D.
University of Pittsburgh

COTH: John W. Colloton
University of Iowa

Stuart J. Marylander
Cedars-Sinai Medical Center

John Reinertsen
University of Utah

Robert M. Heyssel, M.D.
Johns Hopkins Hospital

Executive Council - continued

OSR: Dan Miller
UC - San Diego

Lisa Capaldini
UC - San Francisco

Distinguished Service Member:

Robert J. Glaser, M.D.
Henry J. Kaiser Family Foundation

## ADMINISTRATIVE BOARDS OF THE COUNCILS

### COUNCIL OF DEANS

Chairman: Stuart Bondurant, M.D.
University of North Carolina

Chairman-Elect: Steven C. Beering, M.D.
University of Indiana

Members:

Neal L. Gault, Jr., M.D.
University of Minnesota

William H. Luginbhul, M.D.
University of Vermont

Richard Janeway, M.D.
Bowman Gray

Allen W. Mathies, Jr., M.D.
University of So. California

John E. Chapman, M.D.
Vanderbilt University

Theodore Cooper, M.D.
Cornell University

Leonard M. Napolitano, Ph.D.
University of New Mexico

Richard H. Moy, M.D.
Southern Illinois University

### COUNCIL OF ACADEMIC SOCIETIES

Chairman: Carmine D. Clemente, Ph.D.
UCLA

Chairman-Elect: Daniel X. Freedman, M.D.
University of Chicago

Members:

F. Marian Bishop, Ph.D.
University of Alabama-Huntsville

David M. Brown, M.D.
University of Minnesota

Lowell M. Greenbaum, Ph.D.
Medical College of Georgia

Robert L. Hill, Ph.D.
Duke University

T. R. Johns, M.D.
University of Virginia

Joseph E. Johnson, III, M.D.
Bowman Gray

Thomas K. Oliver, Jr., M.D.
University of Pittsburgh

James B. Preston, M.D.
SUNY-Upstate

Virginia V. Weldon, M.D.
Washington University

Frank C. Wilson, Jr., M.D.
University of North Carolina

COUNCIL OF TEACHING HOSPITALS:

Chairman: John W. Colloton
University of Iowa

Chairman-Elect: Stuart J. Marylander
Cedars-Sinai Medical Center

Members:
Robert M. Heyssel, M.D.
Johns Hopkins Hospital

Mitchell T. Rabkin, M.D.
Beth Israel Hospital

James Bartlett, M.D.
Strong Memorial Hospital

Malcom Randall
VA Hospital - Gainesville

Elliott C. Roberts
Charity Hospital of Louisiana

Dennis R. Barry
Moses H. Cone Memorial Hospital
Greensboro

John Reinertsen
University of Utah

Mark S. Levitan
Hospital of the University of Pittsburgh

Robert K. Match
Long Island Jewish-Hillside Medical Center

Fred J. Cowell
Jackson Memorial Hospitals
Miami

Robert E. Frank
Barnes Hospital, St. Louis

Earl J. Frederick
Children's Memorial Hospital
Chicago

William T. Robinson
AHA Representative

ORGANIZATION OF STUDENT REPRESENTATIVES

Chairman: Dan Miller
UC - San Diego

Chairman-Elect: Lisa Capaldini
UC - San Francisco

Members:
Arlene Brown
University of New Mexico

Greg Melcher
University of Minnesota

Claudia Morrissey
Chicago Medical School

Stephen Sheppard
University of So. Alabama

Louis Van de Beek
Hahnemann Medical College

Susan Haack
University of Texas

Mary Barton
Rush Medical College

Doug Hieronimus
University of Oregon

Peter Shields
SUNY-Buffalo