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ORGANIZATION OF STUDENT REPRESENTATIVES

1983 Business Meeting Agenda

November 4, 5 and 6

I. Call to Order

II. INFORMATION ITEMS

A. Introductions and Overview of the Meeting, Ed Schwager, M.D.

B. Remarks from AAMC President, John A. D. Cooper, M.D., Ph.D.

C. Remarks from Wesley Clark, M.D., Professional Staff for Senator Edward Kennedy

D. Overview of Status of Student Financial Assistance Programs, Robert J. Boerner, Director, AAMC Division of Student Programs. 1

III. Recess

IV. Recall to Order

V. Determination of Quorum

VI. INFORMATION ITEMS

A. Report of OSR Chairperson, Ed Schwager, M.D.

B. Report of OSR Chairperson-Elect, Pamelyn Close

VII. ACTION ITEMS

A. Approval of Minutes of 1983 Business Meeting. 8

B. Nomination of Candidates for Chairperson-Elect and Representative-at-Large

VIII. Recess

IX. Recall to Order

X. Determination of Quorum

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XI. ACTION ITEMS

A. Election of Chairperson-Elect & Representatives-at-Large

B. Response to GPEP Report

XII. INFORMATION ITEMS

A. Reports from Leaders of Other Student Groups

B. Recommendations on Being an Effective OSR Member, Mary E. Smith, Miami Delegate

C. Closing Remarks from OSR Immediate-past-Chairperson, Grady Hughes, M.D.

XIII. Old Business

XIV. New Business

XV. Adjournment

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XVI. Additional Written Information Items

A. Student Participation on Committees. 24

B. Schools with Upcoming LCME Site Visits. 27

C. Schedule of 1984 OSR Regional and Administrative Board Meetings. 28

UPDATE ON FINANCIAL AID ACTIVITIES

HPSL

The saga of Health Professions Student Loan (HPSL) collection continues. On June 30, 1983 the final regulation went into effect specifying a performance standard of a 5 percent delinquency rate based on 60 days past due. The regulation also permitted a 6 month period of "probation" for schools unable to meet the performance standard by June 30, 1983. Those schools unable to meet the performance standard by December 31, 1983 or to make a 50 percent improvement in their delinquency rate would be put on suspended status and would have until June 30, 1984 to either meet the 5 percent standard or to improve their collection rate by 50 percent. Schools unable to conform to either the 50 percent improvement or 5 percent delinquency rate by June 30, 1984 would be terminated from the program.

Suspension and termination results in loss of ability to receive new or allocate current HPSL funds. At this writing 114 medical schools have reported HPSL collection data to the Bureau of Health Professions in the Department of Health and Human Services. Thirty-three of those schools, or 28.9 percent, were over the 5 percent standard. Eighteen of those schools had delinquency rates of 6-10 percent, nine had rates of 11-15 percent, three had rates of 16-20 percent and three were over 20 percent.

One of the principal purposes of this new HPSL regulation was to bring the schools' collection procedures and performance in line with those in the business or commercial fields. The justification used by the Bureau for the 5 percent delinquency rate for commercial loans was even less. However, the Bureau apparently was not cognizant of the fact that generally accepted business practice is to determine delinquency rates based on delinquent principal, not total outstanding principal on delinquent loans. For example, if John Jones were to borrow $5,000, pay off $1000 of the principal and then become 60 days overdue on a $50 monthly payment, by commercial standards his delinquency would be $50, but by HHS standards his delinquency is $4,000, or the total outstanding principal on his $5,000 loan.

Last June the Association asked that schools provide us copies of the HPSL Annual Operating Report. To date 71 have been received. Our analysis of these reports reveal that sixteen schools have delinquency rates over 5 percent based on the Bureau formula, but only three are over the standard based on the commercial practice previously outlined. The Bureau has also promulgated a new rule that would limit the delinquency formula to a calculation based on the principal rather than the number of borrowers delinquent. Presently either basis may be used. As of June 30, 1983 thirty-two schools had a lower delinquency

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rate based on borrowers rather than dollars. While in many cases the difference between the rates of borrowers and principal was less than one percentage point, this new rule appears to have the potential to affect a significant number of schools adversely.

Loan Consolidation

The status of loan consolidation for students remains cloudy. The Student Loan Marketing Association (Sallie Mae) has had the authority to consolidate Guaranteed Student Loans and National Direct Student Loans under their "Options" Program. The questions of whether this authority should continue, whether it should also be given to the state agencies which guarantee student loans and are lenders in the program in many states, and whether it should be expanded to include other loans such as Health Education Assistance Loans(HEAL) and Health Professions Student Loans (HPSL) were examined in a series of hearings before Congress adjourned this summer. It was anticipated that Sallie Mae's loan consolidation authority would be extended for at least one year. However, at the last moment figures on the cost of loan consolidation to the government were produced and the extension given Sallie Mae was only until November, 1983. Additional hearings are scheduled prior to that time to resolve these matters before loan consolidation is again considered by the Congress. Another issue involving the Guaranteed Student Loan (GSL) Program pertains to the authority of state agencies which serve as guarantors and lenders for the program in respective states versus national guarantors, such as The Higher Education Assistance Foundation (HEAF) and United Student Aid Funds (USAF). Recently the latter have been making inroads to the markets of the former. Specifically, the Law School Admission Council in conjunction with HEAF created a program which provided that law students could obtain GSL's through HEAF if unable to do so through the guarantee agency in their state. While intended to be supplemental to the present system, this program placed HEAF in competetion with state agencies for some of the most desirable, i.e., largest, loans in each state, those made to law students. It is unclear how this controversy will be resolved. An amendment has been introduced which would exclude "national" guarantors from infringement on state guarantee agency turf. However, some experts believe this amendment unlikely to pass since it would provide the state guarantee agencies a monopoly on GSL business in each state.

The Armed Forces Health Professions Scholarship Program

A proposal introduced in the Defense Appropriations Subcommittee of the House of Representatives to put a ceiling on tuition benefits under the Armed Forces Health Professions Scholarship Program has been defeated through the joint efforts of the AAMC and the potentially effected schools in states with Representatives on the Subcommittee. The proposal would have capped program tuition benefits at the 80th percentile of national tuition levels.

The Association wrote to the Chairman of the Subcommittee , Joseph P.

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Addabbo(D-NY), urging that this proposal not be adopted because it would have the potential to dissuade some of the most promising students at some of the nation's most distinguished medical schools from military service. We also suggested that, if adopted, this restruction apply only to new students in the program. Schools that would have been affected in states with representatives on the Subcommittee were ureged to contact their legislators about this issue. At present these two efforts have proved effective. However, it is always possible that this concept could reappear at the full committee level or elsewhere in the legislative process.

Suggestions for Health Manpower Reauthorization

It is important to remember that all the programs that provide financial assistance to medical students are due for reauthorization next year. As specific issues arise we will try to keep you informed. In the meantime, you may wish to initiate discussions at your own institution about what changes or totally new programs you would like to support. Remember that it is important to establish consensus and consistency at your institution regarding what is proposed to legislators or administrators of these programs and that proposals are offered through established channels of communication with these individuals at your institution.

LCME Questionnaire, I-B Data

The data on student financial assistance provided by the Liaison Committee on Medical Education Financial Aid Portion, Part 1-B, indicates that for academic year 1982-83 fewer students received less aid than in the previous year. This is the first such reduction since 1954 and occurred in spite of the fact that needs analyses performed by financial aid officers revealed more students to require more aid. Speculation is that perceived and real reductions in financial aid resources and lessening of students' expenditures brought on in part by awareness of the implications of debt are responsible. Full data on the financial aid awarded medical students in 1982-83 will appear in the Journal of Medical Education this winter.

Study of How Medical Students Finance Their Education

The Association has been awarded a contract by the Department of Health and Human Services to do a study of how medical students finance their education. Phase I, based upon data the AAMC has in house from the Annual Graduation Questionnaire and the Liaison Committee on Medical Education Annual Questionnaire, Part I-B, was begun October 1. A plan for Phase II which would be a survey of currently enrolled medical students will be developed as part of the Phase I contract.

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COMPARISON OF FEDERAL STUDENT FINANCIAL ASSISTANCE PROGRAMS AVAILABLE TO MEDICAL STUDENTS

	GUARANTEED STUDENT LOAN (GSL PROGRAM)	PARENTAL LOANS TO ASSIST STUDENTS/ AUXILLARY LOANS TO ASSIST STUDENTS (PLUS/ALAS PROGRAM)
PURPOSE	To make low interest loans to students to enable attendance at post-secondary institutions of their choice through interest subsidy, insurance/reinsurance and encouragement of state level insurance programs	To make loans to graduate students or parents of graduate or under-graduate students to enable atten-dance at post-secondary institutions of their choice.
ADMINISTERED BY	Department of Education, Bureau of Student Financial Assistance	Department of Education, Bureau of Student Finanical Assistance
LENDERS	Eligible banks, schools, etc., state agencies and designated non-profit agencies using private capital.	Elibible banks, schools, etc., state agencies and designated non-profit agencies using private capital.
ELIGIBILITY	Eligibility for the maximum loan amount requires a family income of less than $30,000. Above $30,000 family income, both eligibility and the amount of the loan are determined by a financial needs test.	Program open to graduate students and parents of graduate or under-graduate students.
LIMITS	For graduate and professional stu-dents a maximum of $5,000 per year with aggregate total of $25,000 (including those received during undergraduate years). An origina-tion fee of 5 percent is charged at the time the loan is made.	Up to $3,000 a year in addition to any amount borrowed in the same year through GSL Program with a maximum aggregate of $15,000. In no case may a PLUS/ALASloan exceed a stu-dent's estimated cost of attendance less estimated financial assistance.
REPAYMENT	Begins six months after student stops attending an eligible institution.	Required to begin 60 days after disbursement of the loan.
DEFERMENTS	Deferments of up to 3 years are allowed for service in Armed Forces, Peace Corps of VISTA or as a commissioned officer in the U.S. Public Health Service or if the borrower is temporarily totally disabled. Borrower may defer repayment up to 2 years for residency training.	Same as GSL Program deferments. This will mean that a full-time medical student is entitled to receive a deferment of principal payments on a PLUS/ALAS loan (although interest would need to be paid or forborne.
INTEREST	Nine percent. Students may quali-fy for federal interest subsidy whereby federal government pays interest during in-school period, during a 6-month grace period following graduation or termina-tion of enrollment, and during any authorized deferment of the repay-ment period.	Fourteen percent. No federal interest subsidy exists.
FUNDING	FY 1982=$2,752,012,000; President's FY 1983 Budget Request=$2,484,631,000 President's FY 1983 Budget Request proposes that graduate and profes-sional students'-eligibility for GSLs be terminated.	President's Budget Request for FY 1983 proposes an expansion of borrowing limits to $8,000 annually and to $40,000 aggregate.

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	NATIONAL DIRECT STUDENT LOAN (NDSL PROGRAM)	HEALTH EDUCATION ASSISTANCE LOAN (HEAL PROGRAM)
PURPOSE	To enable colleges to make low interest loans to needy students from revolving funds to enable completion of education. Original purpose was primarily national defense through developing needed manpower.	To encourage lenders to make loans available to health professions students to complete graduate degree programs; to strengthen national health delivery by encouraging service in shortage areas and by insuring an adequate level of trained manpower.
ADMINISTERED BY	Department of Education, Bureau of Student Financial Assistance	Department of Health and Human Services, Bureau of Health Personnel Development and Service
LENDERS	Eligible schools, using Federal and school funds (9/1 ratio) in revolving fund.	Eligible banks, schools, agencies, etc., using private capital.
ELIGIBILITY	Undergraduate and graduate students.	Students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractice, or in programs in health administration or clinical psychology. Student must be citizen, national or permanent resident of U.S.A. and accepted for enrollment as a full-time student or already in full-time attendance and in good standing at an eligible HEAL school.
LIMITS	Student may borrow maximum of $12,000; however, the limit includes any loans received during the student's undergraduate years of study.	Medical, osteopathic, dental, veterinary, optometric, or podiatric students may borrow up to $20,000 per year, with a maximum aggregate of $80,000.
REPAYMENT	Begins six months after graduation or leaving school for other reasons.	Repayable over 10-25 year period starting 9-12 months after completion of training.
DEFERMENTS	No payments required for up to 3 years while the physician serves in the Armed Forces, Peace Corps, or VISTA or as a commissioned officer in the U.S. Public Health Service or if the borrower is temporarily totally disabled. Payments can be deferred for up to two years for medical residency training.	Repayment of principal and interest can be deferred, but interest continues to accrue during school and four years of internship or residency; and three years of service in Armed Forces, Peace Corps, VISTA or NHSC.
INTEREST	Five percent, chargeable on the unpaid balance of the loan principal over a 10 year repayment period.	Maximum rate of 91-day T-bill plus 3.5%.
FUNDING	FY 1982=$178,560,000. President's Budget Request FY 1983 proposes that new Federal contributions to the NDSL be eliminated.	March Continuing Resolution FY 1982= $192 million; President's Request FY 1983=$80 million
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.	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.

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	HEALTH PROFESSIONS STUDENT LOAN PROGRAM (HPSL)	ARMED FORCES HEALTH PROFESSIONS SCHOLARSHIP PROGRAM
PURPOSE	To enable schools to make low interest loans to health professions students (all levels), to strengthen national health delivery by encouraging service in shortage areas and by insuring an adequate level of health manpower.	To provide service contracts for scholarship support to medical students in order to secure the health care professionals needed by the Armed Services.
ADMINISTERED BY	Deparment of Health and Human Services, Bureau of Health Personnel Development and Service	Department of Defense, Air Force Army or Navy
LENDERS	Eligible health professions schools, using Federal and school funds (9/1 ratio) in revolving fund.	
ELIGIBILITY	Full-time MODVOPP and public health students and those enrolled in graduate programs in health administration. Student must be a U.S.A. citizen or permanent resident of U.S.A and must have "exceptional financial need" defined as the lesser of one half the cost of education or $5,000 per year.	The Army, Navy and Air Force offer scholarships under this program to U.S. citizens enrolled in or accepted for admission to accredited schools of medicine and osteopathy in the United States or Puerto Rico.
LIMITS	Maximum of tuition plus $2,500 for each school year. No aggregate limit.	Excluding room and board, these scholarships provide full tuition and payment of usual educational expenses plus a stipend and pay allowances of about $7,350 per year.
REPAYMENT	Repayable over 10 years beginning one year after graduation.	Recipients are obligated to serve one year of active duty for each year of program participation. In addition, participants serve 45 days active duty for training annually with full pay and allowances prior to beginning full-time active duty.
DEFERMENTS	May be deferred for up to 3 years for Armed Forces, Peace Corps, NHSC and for residency training.	
INTEREST	Nine percent interest starts accruing on the unpaid balance at the beginning of the repayment period.	
LOAN FORGIVENESS	Secretary forgives 60% of the debt in exchange for 2 years of service.	
FUNDING	March Continuing Resolution FY 1982= $5.8 million; President's Request FY 1983=$0, only funds available from revolving funds in schools.	

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	SCHOLARSHIP PROGRAM FOR FIRST-YEAR STUDENTS OF EXCEPTIONAL FINANCIAL NEED (EFN)	NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM (NHSC)
PURPOSE	A federal program created by the Health Professions Educational Assistance Act of 1976 to provide non-renewable grants to first-year medical students with extremely limited financial resources.	The NHSC, a component of the U.S. Public Health Service, places health care professionals in the most seriously underserved areas of the U.S.A. The NHSC Scholarship Program, designed to secure the health care professionals needed by the NHSC, can meet most of the expenses incurred by students in return for a service commitment.
ADMINISTERED BY	Department of Health and Human Services, Bureau of Health Personnel Development and Service	Department of Health and Human Services Bureau of Health Personnel Development and Service
LENDERS	None	None
ELIGIBILITY	First-year full-time MODVOPP students who are U.S. citizens or permanent residents with "exceptional financial need," those possessing less than $5,000 per year or half the cost of attending school, whichever is less.	U.S. Public Health Service offers competitive support-for-service scholarships to applicants enrolled or accepted for enrollment as full-time students in M.D. or D.O. degree programs in nationally accredited U.S. schools of medicine or osteopathy.
LIMITS	Tuition, all other reasonable educational expenses, and a stipend that is adjusted annually to cost of living increases.	The scholarship, which may be continued through graduation (four year maximum), includes payment of tuition and other reasonable educational expenses plus a monthly stipend which may be taxable and is adjusted annually to cost of living increases.
REPAYMENT		Recipients are obligated to provide fulltime clinical patient care in assignments in federally designated health manpower shortage areas for one year foreach year of support, with a minimum service obligation of two years. Service may be fulfilled by recipients, in whole or part, as salaried federal employees of the NHSC or as non-Federal private practitioners.
DEFERMENTS		Are given for completion of family practice, general internal medicine, general pediatrics, general psychiatry, or obstetrics-gynecology residency training.
INTEREST	None	None
LOAN FORGIVENESS	None	None
FUNDING	March Continuing Resolution FY 1982=$4.8 million; President's Request FY 1983=$0.	March Continuing Resolution FY 1982=$36.3 million; President's Request FY 1983=$11 million. No new awards are projected for FY 1983.

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DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

OSR ADMINISTRATIVE BOARD MINUTES

Annual Business Meeting
November 5, 6, & 7, 1982
Washington Hilton Hotel

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I. Dr. Grady Hughes, OSR Chairperson, called the meeting to order at 3:15 p.m., November 5.

II. Remarks from AAMC President

Dr. John A. D. Cooper welcomed the students to the 93rd annual meeting of the Association and congratulated the OSR Administrative Board for the quality of their leadership over the past year. He reminded the individual representatives of the importance of becoming familiar with their own institution's goals, history and constraints and of keeping abreast of current events by careful reading of, for instance, his Weekly Activities Report. Dr. Cooper urged the students to establish continuing relationships with their elected officials in Washington, especially in view of the tough economic times the country is experiencing. He described the multi-directional assaults upon the academic medical centers which are struggling to preserve their essential service, research and teaching programs in the face of income reductions. Students can play an important role in helping the centers to meet these challenges.

III. Overview of the General Professional Education of the Physician Project

Dr. August Swanson, GPEP Project Director and Chairman, AAMC Department of Academic Affairs, opened with a summary of the Association's long history of concern for the quality of medical education. He emphasized the word "general" in the title of the project since the panel and three working groups are concentrating on the commonality of educational needs during the first professional phase. Dr. Swanson listed the four predominant concerns which the panel has thus far identified: rapid growth of knowledge applicable to the care of patients; ascendency of technology and procedures; coalescence of physicians and other health professionals into complex systems and constraints on financial resources; and some physicians' adaptational difficulties to demands placed on them by patients and the profession. He reviewed the schedule of hearings during which institutional representatives will be able to exchange ideas with the GPEP panel: January 27 (U of Calif.-S.F.); Feb. 24 (U. of Texas, Houston); March 24 (Northwestern U., Chicago); and May 5 (New York Academy of Medicine). Dr. Swanson urged students to be catalysts in their local settings. Over 90 of the medical schools have notified AAMC that a GPEP institutional representative/coordinator has been appointed to develop programs and discussions paralleling those of the working groups; OSR members can ask how they might assist this effort. In preparing for this undertaking, Dr. Swanson suggested a few questions that students might ask themselves and their faculty:

Are the learning approaches which are being utilized consistent with the need to become a life-long learner? Do you feel that your clinical skills are developing well and are your faculty adequately assessing them? Can students in basic sciences courses which have numerous lecturers be expected to comprehend all the material presented by each expert? He also drew attention to the list of academic societies and universities that will be engaging in discussions of the assumptions outlined in the working group charges and expressed the hope that discourse among various disciplines and schools will result in the modifications necessary for physicians' education to be for the future rather than for the past. He closed with the encouragement to galvanize their colleagues to move these discussions along at their schools because the only way to evoke change in education is to gain the attention of the faculties.

IV. Remarks from Group on Student Affairs (GSA) Chairman

Dr. Robert Keimowitz (Associate Dean for Student Affairs and Admissions, George Washington U.) expressed his pleasure at being able to address the OSR and noted that its focus is very clearly similar to GSA's. He spoke of the need to work together to keep the focus on student concerns, particularly in the areas of financial aid and the increasing competition for postgraduate positions. Congress listens to students who should therefore do whatever they can to protect those programs essential to their remaining in school. He also mentioned a number of other areas in which OSR can play an important role, including GPEP and the reporing of irregularities in the National Resident Matching Program. Dr. Keimowitz expressed the hope that OSR members would communicate their thoughts to him as appropriate and that the coming year would contain much productive interchange between OSR and GSA.

V. Financial Aid Overview

Mr. Robert Boerner, Director, Division of Student Programs referred students to their agenda containing an overview of the current status of the Guaranteed Student Loan Program (GSL), Health Education Assistance Loan (HEAL) Program, and Health Professions Student Loan (HPSL) Program -- plus tables showing appropriations for federal financial aid programs and comparing the various programs available to medical students. He reminded students that the GSL is an entitlement program, meaning the government is obliged to make funds available for it. Its use has grown so rapidly that understandably ways are being sought to limit additional growth. The needs test for families with incomes exceeding $30,000 which has been instituted is forecast to save 12% this year. Mr. Boerner noted that Congress had not supported President Reagan's earlier request to eliminate professional students' eligibility as a method of controlling the program's growth -- largely, he believed, because students presented a united protest.

He described also the stupendous growth rate of HEAL, the so-called last resort loan. It is presently operating under a Continuing Resolution until December 15; what happens after that regarding the Administration's attempt to cap the program is unclear. Turning to the HPSL default problem, Mr. Boerner stated his belief that the Department of Health and Human Services had over-reacted by issuing regulations so stringent that perhaps two-thirds of the schools will no longer be able to participate. He said that he and others are working with Senator Percy's staff to lessen the impact of the new rules and that OSR would be kept apprised of the outcome. With regard to the National Health Service Corp Scholarship Program, he reported that there would be

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no new starts, i.e., scholarships, offered in FY 1983 (there were virtually none in 1982 either) and that this program has dried up as a major source of funds for students.

Mr. Boerner recommended that students take this information back to their schools and do what is necessary to heighten the awareness of students and others that important federal sources of assistance require protecting. He reiterated that student efforts are of primary importance at the same time that student messages to elected officials need to be coordinated with other institutional concerns and voices.

VI. The meeting was recessed at 4:30 p.m.

VII. Chairperson's Report

Dr. Hughes recalled the meeting to order at 8:30 the following morning. He opened his report with the remark that most projects require continuing effort in order to work maximally and then listed a number of OSR projects that have reached fruition over the past few years: a) continuing publication of OSR Report (three issues in 1982), b) due process guidelines, c) graduate program evaluation form which may be used by individuals interviewing at programs but was designed to help create a file of alumni impressions for use by senior students, d) booklet titled "The Role of Students in the Accrediation of U.S. Medical Education Programs" for use at schools with upcoming LCME site visits, e) extramural electives compendium of contact persons and application deadlines, and f) model memo for creating a housing file in the student affairs office so that students taking clerkships away can share apartments. Dr. Hughes pointed to two Association efforts of particular importance which were recently published in the Journal of Medical Education: a) "Management of Academic Information" (October 1982, Part II) and "The Maintenance of High Ethical Standards in the Conduct of Research" (November 1982). He reported that the Consortium of Medical Student Groups (which meets in conjunction with the national conferences of the groups) continues to work increasingly well as a forum for issues of mutual concern, most notably, financial aid. He encouraged OSR members to keep in touch with AMSA chapter head and the AMA-MSS member in addition to other student leaders and to cooperate on projects whenever feasible. He also drew the attention of OSR members to the handout on career counselling programs; the Administrative Board is attempting to gather as many ideas as possible about programs that assist students in deciding among specailties so that a listing can be shared with student affairs deans. In conjunction with this effort, he has sent a summary of students' need for assistance in choosing a specialty to the Council of Medical Specialty Societies which has agreed to place this item on its agenda.

He reminded the OSR members that they are in a unique position to address many issues in medical education because of their access to individuals with the greatest influence. He emphasized the need to work simultaneously at the local and national levels in providing the student perspective. He also urged students to keep their views as broad as possible because anything that relates to human health relates to medical education. In particular he stressed the need to become more

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involved in the concerns of those who are not able to pay for health care; medical students should lobby Congress just as insistently about the need for medical care for the poor as they do about their own financial needs. Dr. Hughes singled out as well the need to establish that physicians cannot go on prescribing health maintenance plans for their patients in the absence of such programs during their own undergraduate and graduate medical education so that they learn how best to take care of themselves. Finally, he urged that the OSR members take as their charge the use of their activism and humanity to make this organization an instrument for improving health care and medical education.

VIII. Report of the Chairperson-Elect

Mr. Ed Schwager began by commenting on the importance of reviewing past OSR accomplishments so that new members glimpse what is possible to achieve within the OSR structure and old members see the work of the outgoing Administrative Board which did its utmost to follow through on its assignments from last year's annual meeting. He suggested an analogy between the guidelines contained in an article entitled "How To Swim with Sharks" and his own year as Chairperson-Elect. Learning to work within the AAMC arena cannot be learned from books but takes practice; the key is to try the waters and if injured, try not to bleed. He offered his view of the year ahead for OSR members including their roles as future physicians and present members of society. It is important for students to take charge of their own education and to pay attention to many related issues as well, such as the threat of nuclear war and the fact that increasing numbers of individuals are not going to medical school because they cannot afford it. It is the duty of OSR members to deal with numerous legislative and decision-making bodies, from school committees where they may have direct effect on policy and program design -- to local and state offices which have great control over funds for health and education purposes -- to the federal level. The Administrative Board's responsibility is to keep representatives as informed as possible about the issues and to cajole and encourage them to be active and do whatever is necessary to further these causes.

Mr. Schwager quoted from one of the articles in the most recent OSR Report regarding what creative people do: challenge assumptions, take risks, see things in new ways. He proposed that many OSR members are creative and urged everyone to try to be even more so as they participate in the weekend's programs. He said that the greatest strength of OSR is communicating with each other, especially with the Administrative Board, and exhorted the members not to sit still but to direct him as their leader about directions OSR should take in the coming year.

IX. Nominations for OSR Office

The following OSR members were nominated:

Chairperson-Elect:

Dan Cooper (Colorado)
Mary Beth Graham (Northwestern)
Pamelyn Close (Tennessee)
John Dietz (Duke)

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Representative-at-Large: Steve Bova (Cornell)
Ricardo Sanchez (Brown)
Beth Watterson (Missouri-Kansas City)
Yvonne Kuczyuski (Michigan State)
Jesse Wardlow (Yale)
Roger Hardy (Cincinnati)
Nora Zorich (Illinois)
David Baum (Albany)
Carol Mangione (Calif-San Francisco)

X. The meeting was recessed at 9:30 a.m.

XI. Dr. Hughes recalled the meeting to order at 9:45 a.m. the next day and shortly thereafter declared the presence of a quorum.

XII. Elections

ACTION: The OSR elected Pamelyn Close to the office of Chairperson-Elect.

The following additional nominations were made for Representative-at-Large:

Michael Laufer (Stanford)
Dan Cooper
John Dietz
Mary Beth Graham

ACTION: The OSR elected the following persons to the office of Representative-at-Large:

John Dietz
Carol Mangione
Richard Sanchez
Nora Zorich

XIII. Reports from Leaders of Other Student Groups

A. Ron Davis, representing AMA-MSS, thanked OSR for the invitation to speak and expressed the hope that past disputes among the different medical student organizations are over because the roles they play are complementary rather than mutually exclusive. Like OSR, the major function of MSS is to provide input to the parent body. Very frequently this is a truggle, with many student members' not espousing many of the AMA stances. Mr. Davis did describe, however, several instances in which students and residents had positively influenced AMA policy development and noted that students now participate on six of the seven policy-making councils. In addition to these notable achievements, more recently MSS has established an on-going committee on financial aid sources and an ad-hoc task force on the medical aspects of thermonuclear war. He urged OSR members who are interested in learning more about medical student involvement

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in the AMA to read the article in the June 4 JAMA and noted that the MSS Semi-annual Assembly will meet in Miami during the first week of December.

B. Dr. Jim DeLine representing the American Academy of Family Physicians Student Affiliate stated that, again, financial aid is a major concern. The Academy has helped to produce an extensive booklet including loan repayment information and is conducting a study of the effects of debt level on practice location; he suggested canvassing alumni to provide support for medical students in addition to or instead of sports teams. He mentioned also their recent conference on nuclear war and the externship directory being published this spring which is limited to rotations in Family Practice but does include community-based programs. Dr. Deline spoke with excitement about GPEP which has the potential to stimulate a great deal of positive changes.

XIV. Remarks from GPEP Working Group Student Members

A. Nora Zorich (Essential Knowledge) noted that some of her initial enthusiam about GPEP has been diminished by the lack thus far of organized OSR input and by the traditional views held by some faculty members on the panel and working groups. She expressed the hope that OSR members will work to become worthwhile critics of their education and will take some of the burdens and responsibilities for needed improvements. She requested continuing feedback from OSR on concrete, realistic changes that can be implemented, saying that she can be a much more effective representative of student views if she can backup her statements with evidence beyond her own campus.

B. Martha Sanford (Personal Qualities, Values & Attitudes) remarked that nothing is static in medical education and pointed to evidence of definite deterioration, e.g., return to grading systems, increased depersonalization, subspecialization during the undergraduate years. She said that while much of the GPEP work had been nebulous so far, many of the discussion have focused on the bases of healing and have provided a useful philsophical underpinning for future discussions. Ms. Sanford noted that the fifteen members on her working group are strong student advocates who want change, and she listed the personal qualities it identified at its first meeting as most desirable for physicians to possess: moral courage, internal focus of control, self-esteem, coping abilities, love of learning, compassion, social responsibility, sensitivity in interpersonal relations, clinical judgment staying power. Working group members are preparing papers on what facilitates and impedes the development of these qualities as a basis for their next meeting in January. She reiterated the importance of students involving faculty in dialogues about all these issues and the belief that, under the aegis of GPEP, students can combine and put to good use much of their idealism.

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XV. Report of the Immediate-past-Chairperson

Dr. Lisa Capaldini admitted that her report would have a different tone from her predecessors' because rather than commence residency training she is doing health policy analyses for the Office of Management and Budget in New York City. She stated that students' and physicians' tendency to remain detached from politics is elitist and highly unfortunate because participating in the many political decisions that affect health care is part of their responsibilities. She noted that the list of predicted changes from the Delphi survey (compiled by Dr. Davis Johnson, AAMC, Division of Student Studies) includes many political issues, e.g., applicants from low socio-economic families not applying to medical school, medical centers becoming so dependent on federal grants that teaching takes backseat to research. Next, Dr. Capaldini disspelled some commonly held beliefs about Medicaid in order to illustrate the complexity of many issues students read about in the paper, e.g., Medicaid costs are going up less quickly than private insurance, there are fewer people on Medicaid now than in 1977 despite the worsening economic climate, Medicaid is not just for poor people but also for the blind, disabled and elderly. She stated that medical students have a responsibility to themselves (in terms of teaching hospitals' reliance on these funds) and to those who cannot afford to pay for health care to press the government to provide these funds for the poor, who will not go away.

XVI. Small Group Reports

Dr. Hughes asked one of the leaders of each of the preceeding day's small group sessions to give a summary of the conclusions, recommendations and/or plans.

A. HOUSESTAFF CONCERNS

The discussion group on Housestaff Concerns began their deliberations by defining operational premises:

1. Medical students have a particular interest in the rights, responsibilities and concerns of residents for the following reasons:
    a. as students much of their "hands-on" experience (and often didactic education) is provided by residents;
    b. most medical students enter residency training programs after completing medical school.
2. The current state of housestaff programs in general is less than ideal; they do not maximize the creativity and productivity of residents, nor do they encourage humane and effective health care delivery.
3. There exists a multitude of interrelated factors which influence the philosophy and functioning of residency training programs. Some of these factors include: competition for

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increasingly fewer positions; the duality of health care delivery (especially the view that residents are "cheap labor"); and the lack of viable communication between residents, program directors, administrators and students.

4. The OSR occupies a unique role within the AAMC and has the resources and interested individuals with which to address the concerns of housestaff.

It is the recommendation of this discussion group that the Administrative Board of OSR form a Task Force on Housestaff Concerns with the following charges:

1. Review the pertinent literature and gather the necessary data to define (as accurately as possible) the current state of affairs of housestaff education.
2. Review the existing mechanisms for housestaff to represent their own interests within formal medical education channels, specifically AAMC and AMA.
3. Establish a network of former OSR reps currently in residency programs to be used as a resource base.
4. After an initial period of information gathering, reconvene and critically evaluate the charges of the Task Force with the specific goal of creating a representative and effective housestaff voice within AAMC.

The following issues may serve as "trigger points" for the Task Force's discussions:

1. The need for residents to receive high quality instruction and supervision from interested and competent instructors.
2. The need for residents to have an active and influential voice in the planning and evaluation of their programs.
3. The need for training programs to provide prospective and current residents with accurate, comprehensive and reasonable job descriptions.
4. The need for residents to be taught how to teach and to evaluate medical students.
5. The need for residency program directors to consider health and quality of life issues in the design and implementation of residency education.

It is felt that many of these objectives could be addressed in the formation of "Residents Bill of Rights" which could be assembled by OSR and distributed through the auspices of AAMC. It is further suggested that an interim project could involve the gathering of "Survival Hints in Residency" for distribution to OSR members. From the start it is recognized that this will be a difficult task involving the cooperation of many diverse "vested interests" within medical education. However, the unique resources of OSR and the difficulties of the transition from student to resident make this a critical issue with a reasonable possibility for constructive change.

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B. PERSONAL GROWTH AND DEVELOPMENT

This group discussed the current trend toward a medical educational system designed to promote personal well being along with academic growth. It became apparent that a wide variety of appraches are being tried at different institutions with admirable success. In order that all may benefit from each other's experiences, it was decided to collect more data from OSR members about personal and community ventures. The need to assess ethical teaching during medical school was also evident. Therefore, a survey was designed and distributed with the following introduction:

"We are excited by trends toward more humane medical education, dealing with the real issues of personal as well as academic growth. The variety and anecdotal nature of the information shared triggered the idea that this would make a creative, interesting and informative publication and would be useful to the OSR and the individual institutions and students. We need descriptive, anecdotal summaries of some of the most successful groups or methods of dealing with those issues at your school. Examples would include: support groups, peer counseling, impaired student programs, career choice and planning, time management in terms of life values and survival values, supports including significant others, recreation, and also any individual or organized "Great Escapes".

We envision compiling responses into a humanistic, entertaining and informative booklet that will be distributed and shared among students at all of the schools with OSR representatives. Hopefully, this publication will stimulate the development of more participation in groups that facilitate helping attitudes and make our time spent in med school a more rewarding experience."

C. EDUCATIONAL ISSUES

In increasing numbers, medical students are indicting the present structure of medical education as an uncreative, demeaning and frustrating experience that poorly prepares them for future careers as healers. Students express the concern that the present system produces doctors unschooled in social issues and overly preoccupied with factual trivia. Specifically, the manner and educational atmosphere in which material is delivered fail to stimulate students to excel in their chosen profession. Professors are often ill-trained to adequately convey information and attitudes; research often takes precedence over teaching. Moreover, the lecture format causes students to suffer a sense of detachment from the educational milieu and is decried by most students to be a passive and uninteresting process. As a result, attentions wander and attendance declines. In addition, this acquisition of factual information by memorization remains a favored approach to education. This is encouraged by the misuse of the National Boards in promotion and grading criteria. Sacrificed is an emphasis on conceptual learning, problem solving and critical thinking.

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Students require a stimulating environment if they are best to learn, digest and sythesize the vast amount of information that is required to become effective physicians. Central to this is the role of the teaching faculty. The group devised some suggestions to improve the present situation in which many faculty are not fully undertaking their responsibilities resulting in less than optimal educational programs. Following is a suggested list of goals and resources:

1. Utilizable Resources:
   a) AAMC Group on Medical Education (GME)
   b) Student evaluations (which encourage student input through written forms and student/faculty committees)
   c) Research in teaching and education by individual faculty and staff members (this should be both encouraged and financed by medical institutions)

2. Products:
   a) Development of workshops for improving medical educational techniques and implemented locally with the aid of RIME (AAMC).
   b) Development of the following qualities in teaching faculty:
      -- knowledgeable in educational evaluation techniques
      -- using an organized approach, i.e., established learning objectives, effective communication skills
      -- fostering independent creative thinking by the students
      -- being motivated and enthusiastic about teaching
      -- having an approach that is broad enough to instruct at a basic level
      -- discussing social, economic and ethical concerns of the subject
      -- being free from the "publish or perish" syndrome
   c) Analyses of instructional modalities: comparison and and effective use of various formats, i.e., lectures, small groups, directed peer-group study.
   d) Student evaluations -- on both individual faculty teaching abilities and courses, to be used at the administrative and student levels. Needed are establishment of an administrative area responsible for utilizing these evaluations in the improvement of teaching abilities and course format and establishment of student bodies which also have access to summaries of these evaluations and which can monitor areas identified as needing improvement.

3. Creation of an environment to promote teaching excellence:
   a) Monetary rewards as incentive to faculty, e.g., "Golden Apple" awards for the faculty members judged by the students to be excellent teachers, establishment of a salaried position which is periodically rotated among interested faculty with the purpose of promoting teaching excellence and research in education.

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b) Institutional efforts, e.g., require continued education credits of faculty, award continuing education credits to faculty participating in AAMC teaching-workshops, allow the option for faculty not to teach topics in which they have no interest.

In order to seek implementation of this program, OSR should create a task force to study the qualities that contribute to teaching excellence, to serve as a resource on programs for improving instruction methodology, to make recommendations to the GPEP working groups as appropriate, to act as the agent to advocate this program and any other recommendations they deem appropriate.

D. SOCIAL RESPONSIBILITY

Three subgroups addressed their image of the physician as a community-oriented professional. The three groups approached this goal from the viewpoint of the professional who is: ethically aware, understanding of the economics of health care, and competent as a positive leader in the community.

1) Ethics - This group formulated recommendations for the Ad Board which were to: a) develop a model program for a professional ethics presentation to be given at orientation in medical schools, b) promote to the GPEP group the possibility of undertaking a study of the development of personal values of physicians as it relates to undergraduate medical education, c) elicit the support and activity of the Consortium of Medical Student Groups, d) enlist the AAMC's support in creating an awareness of the problems and possible solutions within administrative and faculty populations, e) promote wherever possible the limiting of medical educational demands (physical, intellectual and emotional) to allow students to view problems from a human perspective.

2) Economics - These industrious OSR's created a curriculum for an 18 hour course for medical students to educate them about the needs of the indigent and economically disadvantaged. This curriculum description can be disseminated by the OSR Ad Board. It includes both clinical and didactic experiences.

3) Leadership - A task force was created to address ways to promote student-sponsored community projects as learning and motivating experiences. The primary way elected to accomplish this goal was to create a written collection of existing projects. Therefore, students who know of any student-sponsored community projects or organizations which involve medical students, were urged to write Coordinator, Douglas Borg (Apt. 3A/1503 Anthony/ Columbia, MO 65201 (314-442-0305). A one-to-two page description of the program as well as a list of resource persons to contact for more information are preferred.

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E. FINANCIAL AID FOR MEDICAL EDUCATION

The group discussing financial aid for medical education was composed of students from public and private schools across the country who had had a variety of personal experiences in financial aid. From its discussion, the group identified the following goals:

Highest Priority:

1. To protect and foster government sources of financial aid. This goal includes improving the public image of the medical student loan recipient, increasing the number of non-military service contingent loan options, and increasing awareness among medical students and the public of the financial aid problems of medical students.

2. To increase private sources of financial aid.

3. To document the costs of medical education and the uses of tuition money. Such documentation would be used to provide a rational basis for determining the reasonableness of tuition costs and to evaluate claims that current tuition costs pay for only 1/4 or 1/3 of actual education costs.

Additional Goals:

1. To examine the effects of financial aid barriers and decreases in class sizes due to budget constraints on access to medical school for minority and low income applicants.

2. To increase the information and guidance available to students regarding debt management.

3. To develop more equitable methods of dividing financial aid resources at individual medical schools.

Forces affecting the three highest priority goals were analyzed and specific actions suggested:

Goal #1: Positive Forces:

a) Student concern and the large number of students, parents of students and friends of students.

b) Public concern about decreased access to medical school for middle and lower class applicants and the increasing costs of health care which may, in part, be engendered by high physician debts.

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c) Desire by the public for a more equitable distribution of physicians, which may be hindered by post-graduate financial pressures on M.D.s to practice in more lucrative areas.

Negative Forces:

a) Poor public image of medical students as loan recipients.

b) Student time constraints

c) Current poor economic and political climate.

d) Lack of support from AMA, state and local medical societies and many current M.D.s.

Recommendations:

a) A letter writing information packet, similar to the one distributed by the Ad-Board this year, should be provided again this year to all representatives.

b) OSR representatives should explore the possibility at their school of writing a letter from concerned medical students to delinquent alumni borrowers, to be mailed via the office at their school which collects these loans.

c) OSR should seek greater press coverage of student financial aid issues, e.g. by inviting the press to a conference on such issues at the national meeting.

d) A mechanism should be instituted whereby financial aid information from other student groups (e.g., AMSA legislation alerts) could be available to OSR representatives.

e) Students at individual medical schools could contact local media, go on radio talk shows, create a presentation on medical student financial aid problems for presentation to community groups, etc.

f) OSR Administrative Board would write letters regarding student financial aid to NEJM, JAMA and other relevant publications.

g) Available information contradicting Senator Percy's findings regarding student delinquency rates should be compiled and made available to OSR Representatives.

Goal #2: Positive Forces:

a) Innovative methods and programs being instituted at individual medical schools to obtain private financial aid.

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b) Tax incentives available for private contributions to medical education.

c) Financial resources of current M.D.'s.

d) Concern of medical students and parents about rising medical school costs.

e) Community contacts of local M.D.'s which can be used to find local sources of financial aid.

Negative Forces:

a) Lack of communication among medical schools about ways of obtaining private financial aid money.

b) Competition with other educational programs for the same private money.

c) Lack of understanding, by private funding sources, of financial needs of medical students.

Recommendations:

a) OSR should compile a list of innovative financial aid programs at individual schools and provide this information to OSR representatives and to financial aid officers via GSA. Three examples of such programs provided by group members follow:

Dartmouth: Melco has provided money for student loans which are at 11% interest with graduated repayments beginning during residency.

St. Louis University; Each year, the 2nd year class contacts alumni by phone to solicit funds for student loans. The amount of money obtained by each class is used to make loan to members of that class in their senior year. When the loans are repaid, they are repaid to a general student loan fund in the financial aid office.

Loyola: Via the alumni association students held a phone-a-thon to solicit pledges which will be used for medical student financial aid.

b) Information on tax incentives for medical education contributions should be obtained and provided to OSR representatives and to financial aid officers via the GSA.

c) OSR should investigate the possibility of service contingent loans and scholarships from corporations/HMOs.

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d) A task force, composed of interested OSR representatives not serving on the Ad Board, should be formed to carry out many of these recommendations.

Goal #3: Positive Forces:

a) Government and public belief in accountability for institutions, such as medical schools, which receive public funds.

b) Student interest in the uses of their money.

Negative Forces:

a) The complex logistics of such documentation.

b) Opposition by medical school administrators due to a perceived loss of autonomy.

Recommendations:

a) Encourage local OSR representatives to attempt to get deans to document medical education costs at their schools.

b) Explore the possibility of LCME documenting medical education costs as part of the accreditation study.

c) Construct a model medical education budget as a yardstick for evaluating current tuition levels.

F. THE MEDICAL USE OF INFORMATION SYSTEMS:

It is reasonable to expect that the tremendous advances in the field of information systems will have a great impact on medical training and health care delivery. The Annual OSR meeting offered an opportunity to hear about some of the experimental applications of this technology. Having noted a substantial interest in the pros and cons of these developments, it was decided to form an Ad Hoc Committee for Study of Information Systems. An initial report will be prepared identifying areas that need to be addressed in order to become informed about these systems. Areas to be discussed will include the specific pros and cons of integrating computers into medical education; reviews of various types of programs now in use for teaching medical students; and hopefully some inquiry into the impact that this new technology will have on the way medicine is practiced. We will also try to explore ways to improve medical students' access to computers, including Congressional actions that could facilitate donations of computers to educational institutions.

XVII. Report on the AAMC Clinical Evaluation Project

Dr. Xenia Tonesk, Project Director, summarized this AAMC effort begun in 1978 to describe the problems of evaluation of medical student performance in the clinical setting. The importance of pursuing improvement in this area is highlighted by the response of the clinical faculty surveyed to the "Do evaluation methods and the organization of evaluation data from the clerkships ensure that deficiencies in students' knowledge, skills, and attitudes are identified?" Eighty-two percent responded "no". For a discussion of the

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findings, she referred the students to the discussion draft entitled "The Evaluation of Clerks: Perceptions of Clinical Faculty" and briefly summarized some of the findings: 1) faculty must broaden their perspectives about evaluation and acknowledge that the primary responsibility for obtaining meaningful evaluations rest with them and that psychometric solutions cannot be viewed as substituting for but only as supplementing their judgments; 2) there are important specialty differences in the definition of characteristics to be assessed; 3) persons who have first-hand information about clerks should be identified and afforded the opportunity to transmit it formally. Dr. Tonesk noted that faculty identify and handle well the superior student, identify reliably but do not handle well the failing student, but neither identify nor handle well three quite different sub-groups within the catch-all category of adequate: a) unremarkable, b) not enough information to rate and c) marginal. She also offered an overview of the categories of content that were identified and stated that each school should have a process whereby it examines whether these are being covered so that gaps can be remedied. AAMC is therefore proposing to develop a set of guidelines of self-study for the diagnostic phase of the institutional evaluation system.

XVIII. Recommendations on Becoming a Maximally Effective OSR Representative

Dr. Beth Fisher, OSR Administrative Board member, offered the membership suggestions on maintaining some of the energy from this meeting back on campus and on remaining active in OSR affairs: 1) keep in close touch with the dean of student affairs and be aware of institutional committees and their activities; 2) write the Dean a memo about what was gained from this OSR meeting and follow this up with an appointment; 3) communicate with the student body by creating an OSR bulletin board, distributing the OSR Report, and giving overviews to student government leaders; 4) stay active in community projects; 5) maintain contact with other OSR regional members to share ideas and concerns; 6) be ready to launch letter-writing campaigns as necessary; 7) do what is possible to change the OSR member selection process so that representatives can stay active for more than one year. Dr. Fisher closed with the hope that all of those in attendance would come to share in the enthusiasm and concern that she has experienced in this organization.

XIX. Dr. Hughes turned over the chair to Mr. Schwager who urged the membership once more to care enough to be active at their schools and to focus energies on one area rather than trying to address the whole spectrum of issues. He commended to everyone Dr. John-Henry Pfifferling's recommendation that it is important while engaged in hard work to pause occasionally and reward oneself.

Mr. Schwager adjourned the meeting at 1:35 p.m.

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STUDENT PARTICIPATION ON COMMITTEES

An important way in which student perspectives are brought to bear on issues and opportunities facing medical educators within the scope of the AAMC is through participation on committees. Please read the descriptions of the committees listed below which have an opening for a medical student which needs to be filled during 1983-84. One does not need to be an OSR member to apply for these positions. Interested students should either complete the self-descriptive sheet or submit a curriculum vitae to Janet Bickel by January 6. At its first meeting, on January 17, the OSR Administrative Board will consider the applications received and recommend to the AAMC Chairmen students to fill the openings. In considering applicants for #1 through #4, the Board appreciates also having a supporting letter from a dean.

1. Group on Student Affairs' (GSA) Committee on Student Financial Assistance:

This Committee is composed primarily of financial aid deans and meets in Washington, D.C. usually in early February, June and in the fall in conjunction with the Annual Meeting. AAMC does not cover travel expenses to these meetings. The Committee studies and monitors legislation affecting and developments regarding provision of financial assistance to medical students. During 1983-84 it will be planning ideas for the reauthorization of the education and health manpower legislation. Its recommendations provide much of the basis of AAMC's policy and program formation in this area.

2. GSA-Minority Affairs Section Coordinating Committee:

Coordinates all the activities and functions of GSA-MAS, which advises the Association on all issues of concern to minorities in medicine. This committee meets two times/year. The AAMC will fund travel for one meeting.

3. Liaison Committee on Medical Education(for a one-year term beginning July 1984):

This joint Committee of the AMA and AAMC has responsiblity for certifying the quality of American medical schools. It has established the following criteria for the appointment: a student a) who has commenced the clinical phase of study by July '84; b) in good academic standing; c) whose performance warrants the judgment that the responsibilities to the LCME would be capably executed; and d) whose academic standing will not be jeopardized by his or her responsibilities on the Committee. The term of the present student member expires on July 1, 1984. Applications for this position will be accepted through May 15, 1984. The appointment entails extensive reading and attendance at four meetings/year (during 1984-85 most meetings will be in Washington,DC).

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4. Journal of Medical Education Editorial Board:

Members of this editorial board are asked to read and comment on a number of papers submitted to the Journal; because the editor is very flexible, the work load can vary with the student's schedule, but at least 15 papers/year can be anticipated. Students presently in their second year of medical school will be given highest consideration. The term extends through December of the year of graduation.

5. Women in Medicine Planning Committee:

This group meets once each spring in Washington, DC to plan the Women in Medicine Annual Meeting activities. AAMC funds travel to this meeting.

6. Flexner Award Committee:

This Committee nominates to the AAMC Executive Council an individual selected for "extraordinary contributions to medical schools and to the medical education community as a whole". Committee members are mailed information on nominees and the Committee meets via a conference call in early summer.

STUDENTS CURRENTLY SERVING

National Resident Matching Program Board of Directors:
Patricia Pellikka '83, Mayo Medical School, Rochester, Minnesota

Liaison Committee on Medical Education:
Warren Newton '84, Northwestern Medical School, (home address: 636 Arlington Chicago, IL 60614 (312/248-2491)

Journal of Medical Education Editorial Board:
Stuart Shapira '83, U. of Chicago Pritzker School of Medicine, Chicago, IL

GSA-MAS Coordinating Committee:
James A. Thompson '84, Washington U., St. Louis, MO

GSA Student Financial Assistance Committee:
Vickie James '83, U. of Texas Medical Branch, Galveston, TX

Women in Medicine Planning Committee:
Carol Mangione '85, U. of California-San Francisco

COMPLETE AND RETURN TO JANET BICKEL, AAMC, 1 Dupont Circle, WDC 20036

NAME: ______________________ SCHOOL: ____________ CLASS OF: ____

ADDRESS: ______________________________

____

Phone: Day: ____________________ Evening: ____________________
(area code) (area code)

Education:

year | institution | degree

Academic Honors/Research or Extracurricular Activities:

Committee or Area of Special Interest:

Other comments:

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U.S. Schools With Upcoming LCME Accreditation Site Visits

Listed below are those schools scheduled to be visited by a site vitis team from the Liaison Committee on Medical Education (LCME) during the rest of 1983-84 and (tentatively) during 1984-85. The LCME is the body which periodically assesses and has the authority to accredit medical schools. It is vital that a representative group of students be involved in an appropriate way. A handbook titled "The Role of Students in the Accreditation of U.S. Medical Education Programs" has been prepared to inform you about what can be done, and OSR members at the schools listed are urged to request a copy from Janet Bickel at AAMC. Those schools designated with an * are engaged in a self-study prior to the site visit; these activities begin more than a year in advance--so don't put off becoming involved.

1983-84	U.S. Schools
Nov. 14-17	*Medical College of VA
Dec. 12-15	*Stanford
Dec. 12-15	U. of South Alabama
Jan. 16-19	*U. of Texas-Galveston
Feb. 6-9	*Howard
Feb. 27-Mar. 1	E. Tennessee/Quillen Quillen Dishner
Feb. 27-Mar. 1	*U. of California/Irvine
Feb. 27-Mar. 1	Texas Tech
Mar. 5-8	*Med. College of Penn.
Mar. 5-8	Morehouse
Mar. 5-8	Ponce
Mar. 19-22	Albany
Mar. 26-29	Albert Einstein
Mar. 26-29	*New York U.
Mar. 26-29	U. of Nevada
Apr. 9-12	Wright State
Apr. 9-12	*SUNY-Stonybrook
Apr. 24-25	U. of Kentucky(Limited)
Apr. 24-27	Northeast Ohio
May 8-11	*U. of Oregon

Tentative Schedules

1984-85	U.S. Schools
Sept. 24-27	*U. of North Dakota
Oct. 9-12	U. of Alabama/Birmingham
Oct. 9-12	SUNY/Buffalo
Oct. 16-19	*Eastern Virginia
Oct. 16-19	*U. of Pennsylvania
Nov. 6-9	*U. of Maryland
Nov. 6-9	Rush
Nov. 13-16	East Carolina
Nov. 13-16	U. of Missouri/ Kansas City
Nov. 27-30	Brown
Nov. 27-30	U. of Mississippi
Dec. 10-13	Chicago Medical
Dec. 10-13	Med. Coll. of Ohio/Toledo
Dec. 10-13	*Mercer
Jan. 14-17	Oral Roberts
Feb. 4-7	*Meharry
Feb. 4-7	U. of South Carolina/ Columbia
Mar. 5-8	*Emory
Apr. 23-26	*U. of South Dakota

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MEETINGS SCHEDULED IN 1984

OSR/GSA Regional Meetings:

South	April 12 - 15	Tampa, Florida
Central	April 15 - 17	St. Louis, Missouri
Northeast	April 26 - 28	Baltimore, Maryland
West	April 29 - May 1	Asilomar, California

OSR Administrative Board Meetings:

January 17 & 18 & 19

April 11 & 12

June 13 & 14

September 12 & 13

OSR Annual Meeting

October 26 - 30 in Chicago, Illinois

FOR IMMEDIATE RELEASE
November 4, 1983

NEWS RELEASE

Association of American Medical Colleges

CONTACT: CHARLES FENTRESS
(202) 828-0455

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FIRST YEAR MEDICAL SCHOOL CLASS SIZE DROPS

Washington, D.C., November 4 -- For the second consecutive year the total number of students admitted to U.S. medical schools is less than the number admitted the preceding year, according to figures released by the Association of American Medical Colleges (AAMC).

Dr. John A.D. Cooper, president of the Washington based AAMC said that the 16,480 students admitted to the 127 U.S. medical schools is down 0.5 percent this year from those admitted last fall. While four medical schools increased their entering class size by five or more students, seven have reduced their entering classes, citing reduction in state funds and note a Federal prediction that the U.S. will soon have a surplus of physicians for these declines.

The total number of individuals applying to medical school slipped to 35,200 from 35,730 a year ago. "This 1.5 percent drop continues the decrease in the applicant pool since its peak in 1974-75," Dr. Cooper said.

With the decreases in the national applicant pool and in the number of newly admitted medical students, the ratio of applicants to those entering dips to 2.1 to 1 from the 2.2 to 1 level of the past three years. The present ratio is significantly lower than the 2.9 to 1 ratio experienced in the 1974-75 cycle. The largest single decrease in newly admitted students is a 2.5 percent decline in the number of white males admitted to medical schools and parallels their similar decline in the national applicant pool.

Total enrollment in the nation's medical schools continues to increase, Dr. Cooper said. A total of 67,327 medical students are registered this fall representing the largest total enrollment ever. The increase from 1982-83 is 0.9 percent as compared with a 0.7 percent increase for the previous year.

"With the larger entering classes of prior years still enrolled, a national attrition rate of only 2.9 percent and four medical schools changing from a three year to a four year curriculum, it will be a minimum of three years before the current decline in new entrants has any effect on the annual supply of new physicians," Dr. Cooper explained.

Women admitted to medical schools continue to show an increase in number and comprise 32.6 percent of the 1983 entering class, as compared to the 31.4 percent reported for 1982. A total of 20,635 women are enrolled this year,

-more-

compared to 19,597 in 1982-83, a 5.3 percent increase. Overall, women hold 30.6 percent of the places in the nation's medical schools in academic year 1983-84 in contrast to 24.3 percent in 1978-79.

Underrepresented minorities (Black, American Indian, Mexican American and Mainland Puerto Rican) comprise 8.5 percent of this year's entering class, as compared to 8.4 percent last year. They comprise 8.3 percent of the total number of U.S. medical students as they did in academic years 1981-82 and 1982-83.

Concerned about the effect of declining financial assistance and the reduction in entering class size, the AAMC Executive Council in September 1982 reaffirmed the continued commitment of the AAMC and its member schools to undertake new efforts and maintain and reinforce past activities to increase the numbers and proportions of underrepresented minority group students in their classrooms.

In 1983 15,801 medical students graduated and entered residency programs for three to seven years of additional education and training. About half of the graduates of 1983 reported their career plans to the AAMC through an annual survey. Forty-two percent plan careers in the primary care specialties of internal medicine, family practice, and pediatrics. Eight percent are going to become obstetricians, and nearly half of these are women graduates. The remainder are planning to specialize in over 20 different specialties and subspecialties.

Despite the decrease in competition for admission to accredited U.S. medical schools, significant numbers of U.S. citizens who are not selected are enrolling in foreign chartered schools, most of which are located in the Caribbean or Mexico and operated for profit. These students, who hope to have a medical career in the United States by completing their training in an accredited residency program in the U.S. are in many cases unlikely to achieve their goal. This year only 49 percent of the U.S. citizens who graduated from foreign medical schools gained a position in a residency program through the National Residency Matching Program. As the number of U.S. medical graduates continues to increase, the positions available for foreign graduates in residency programs is expected to decline further.

Dr. Cooper stated that "the expansion of medical education in the United States has been criticized by others as providing more than enough physicians to meet the needs of our citizens for the forseeable future. It is unfortunate that some disappointed medical school applicants believe that by enrolling in unaccredited foreign chartered medical schools, they have attained a position of special privilege and should be accorded placement in a medical education system that has already more than met the national mandate for an increased supply of physicians."

Tables showing trends for new entrants, total first-year and total enrollment are attached.

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TABLE 1

FIRST-YEAR NEW ENTRANTS TO U.S. MEDICAL SCHOOLS + *

Racial/Ethnic Group	1980-81*				1981-82				1982-83				1983-84			
	Men	Women	Total	% of Grand Total	Men	Women	Total	% of Grand Total	Men	Women	Total	% of Grand Total	Men	Women	Total	% of Grand Total
U.S. Citizens																
White	10,138	3,813	13,951	84.1	9,760	4,135	13,895	83.5	9,535	4,160	13,695	82.7	9,299	4,266	13,565	82.3
Underrepresented Minorities																
Black	552	441	993	6.0	554	430	984	5.9	548	413	961	5.8	527	445	972	5.9
American Indian or Alaskan Native	44	22	66	0.4	46	18	64	0.4	33	21	54	.3	33	33	66	.4
Mexican American/ Chicano	165	68	233	1.4	194	83	277	1.7	191	87	278	1.7	174	91	265	1.6
Puerto Rican (Mainland)	54	37	91	0.5	56	41	97	0.6	61	33	94	.6	58	38	96	.6
(Subtotal)	(815)	(568)	(1,383)	(8.3)	(850)	(572)	(1,422)	(8.6)	(833)	(554)	(1,387)	(8.4)	(792)	(607)	(1,399)	(8.5)
Other U.S. Students																
Asian or Pacific Islander	474	208	682	4.1	493	254	747	4.5	604	306	910	5.5	627	322	949	5.8
Puerto Rican (Commonwealth)	160	70	230	1.4	169	72	241	1.4	133	84	217	1.3	153	69	222	1.3
Other Hispanic	174	74	248	1.5	174	58	232	1.4	181	82	263	1.6	165	72	237	1.4
(Subtotal)	(808)	(352)	(1,160)	(7.0)	(836)	(384)	(1,220)	(7.3)	(918)	(472)	(1,390)	(8.4)	(945)	(463)	(1,408)	(8.5)
Unidentified	14	10	24	0.2	3	3	6	0.0	5	4	9	0.0	4	0	4	0.0
Foreign	57	15	72	0.4	83	18	101	0.6	66	20	86	0.5	70	34	104	.6
Grand Total	11,832	4,758	16,590	100.0	11,532	5,112	16,644	100.0	11,357	5,210	16,567	100.0	11,110	5,370	16,480	100.0
Percent	71.3	28.7	100.0		69.3	30.7	100.0		68.6	31.4	100.0		67.4	32.6	100.0	

*Source: 1980-81, AAMC Student Record System; 1981-82 and thereafter, Fall Enrollment Surveys.

+New Entrants figures include only those students entering medical school for the very first time.

NOTE: U.S. Citizens redefined in 1981-82 and thereafter to include Permanent Residents.

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TABLE 2

FIRST-YEAR U.S. MEDICAL SCHOOL ENROLLMENT, [Men and Women]+

Gender	1979-80 (126 Schools) No.	1979-80 Percent	1980-81 (126 Schools) No.	1980-81 Percent	1981-82 (126 Schools) No.	1981-82 Percent	1982-83 (127 Schools) No.	1982-83 Percent	1983-84 (127 Schools) No.	1983-84 Percent
Men	12,217	72.2	12,220	71.1	11,951	69.2	11,792	68.3	11,497	67.0
Women	4,713	27.8	4,966	28.9	5,317	30.8	5,462	31.7	5,653	33.0
TOTAL	16,930	100.0	17,186	100.0	17,268	100.0	17,254	100.0	17,150	100.0

TABLE 3

FIRST-YEAR U.S. MEDICAL SCHOOL ENROLLMENT+ BY RACIAL/ETHNIC GROUP AND CITIZENSHIP*

Racial/Ethnic Group	1979-80 No.	1979-80 Percent	1980-81 No.	1980-81 Percent	1981-82 No.	1981-82 Percent	1982-83 No.	1982-83 Percent	1983-84 No.	1983-84 Percent
U.S. Citizens										
White	14,259	84.2	14,262	83.0	14,218	82.4	14,085	81.6	13,909	81.1
Underrepresented Minorities										
Black	1,108	6.5	1,128	6.6	1,196	6.9	1,145	6.6	1,173	6.8
American Indian or Alaskan Native	63	0.4	67	0.4	70	0.4	62	.4	75	.4
Mexican American/ Chicano	290	1.7	258	1.5	300	1.8	305	1.8	301	1.8
Puerto Rican (Mainland)	86	0.5	95	0.5	105	0.6	114	.7	109	.6
(Subtotal)	(1,547)	(9.1)	(1,548)	(9.0)	(1,671)	(9.7)	(1,626)	(9.4)	(1,658)	(9.7)
Other U.S. Students										
Asian or Pacific Islander	502	3.0	572	3.3	765	4.4	936	5.4	983	5.7
Puerto Rican (Commonwealth)	226	1.3	241	1.4	250	1.5	229	1.3	235	1.4
Other Hispanic	188	1.1	224	1.3	247	1.4	278	1.6	248	1.4
(Subtotal)	(916)	(5.4)	(1,037)	(6.0)	(1,262)	(7.3)	(1,443)	(8.4)	(1,466)	(8.5)
Unidentified	--	--	--	--	6	0.0	9	0.0	4	0.0
Foreign	208	1.3	339	2.0	111	0.6	91	0.5	(113)	(.7)
Grand Total	16,930	100.0	17,186	100.0	17,268	100.0	17,254	100.0	17,150	100.0

Source: AAMC Fall Enrollment Surveys.

+First-year enrollment includes new entrants and those students repeating, reentering or continuing the initial year.

*U.S. Citizens redefined in 1981-82 and thereafter to include Permanent Residents.

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U.S. MEDICAL SCHOOL ENROLLMENT, [1979-80 through 1983-84]

TABLE 4

TOTAL U.S. MEDICAL SCHOOL ENROLLMENT, [Men and Women]

Gender	1979-80 (126 Schools)		1980-81 (126 Schools)		1981-82 (126 Schools)		1982-83 (127 Schools)		1983-84 (127 Schools)	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Men	47,651	74.7	47,886	73.5	47,793	72.1	47,151	70.6	46,692	69.4
Women	16,149	25.3	17,248	26.5	18,505	27.9	19,597	29.4	20,635	30.6
TOTAL	63,800	100.0	65,189*	100.0	66,298	100.0	66,748	100.0	67,327	100.0

*Total includes 55 students from whom gender was not reported.

TABLE 5

TOTAL U.S. MEDICAL SCHOOL ENROLLMENT BY RACIAL/ETHNIC GROUP AND CITIZENSHIP *

Racial/Ethnic Group	1979-80		1980-81		1981-82		1982-83		1983-84	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
U.S. Citizens										
White	54,854	86.0	55,434	85.0	56,201	84.8	56,032	83.9	56,167	83.4
Underrepresented Minorities										
Black	3,627	5.8	3,708	5.7	3,884	5.9	3,869	5.8	3,892	5.8
American Indian or Alaskan Native	212	0.3	221	0.3	229	0.3	235	.4	258	.4
Mexican American/ Chicano	964	1.5	951	1.5	1,040	1.6	1,071	1.6	1,082	1.6
Puerto Rican (Mainland)	283	0.4	329	0.5	350	0.5	369	.6	368	.5
(Subtotal)	(5,086)	(8.0)	(5,209)	(8.0)	(5,503)	(8.3)	(5,544)	(8.3)	(5,600)	(8.3)
Other U.S. Students										
Asian or Pacific Islander	1,777	2.8	1,924	3.0	2,518	3.8	2,936	4.4	3,290	4.9
Puerto Rican (Commonwealth)	700	1.1	798	1.2	856	1.3	903	1.4	925	1.4
Other Hispanic	567	0.9	683	1.0	847	1.3	962	1.4	983	1.5
(Subtotal)	(3,044)	(4.8)	(3,405)	(5.2)	(4,221)	(6.4)	(4,801)	(7.2)	(5,198)	(7.7)
Unidentified	22	0.0	55	0.1	7	0.0	17	0.0	6	0.0
Foreign	794	1.2	1,086	1.7	366	0.5	354	0.5	356	.5
Grand Total	63,800	100.0	65,189	100.0	66,298	100.0	66,748	100.0	67,327	100.0

Source: AAMC Fall Enrollment Surveys

* U.S. Citizens redefined in 1981-82 and thereafter to include Permanent Residents.