Organization of Student Representatives
1987 Annual Meeting [Program I
November 6-8, 1987

WASHINGTON HILTON
Washington, DC

FRIDAY, NOVEMBER 6, 1987

3:30-4:30 p.m. **Regional Meetings**

Western - (Edison)

Central - (Military)

Northeast - (Farragut)

Southern - (State)

4:30-5:30 p.m. **Business Meeting - Part I** **(Jefferson West)**

Presiding: Vicki Darrow, M.D.
OSR Chair

Presentations: Robert L. Beran, Ph.D.
Assistant Vice President for
Student and Educational Programs

Richard Peters, M.D.
OSR Immediate Past-Chair

Andy Spooner
OSR Representative-at-Large

Synthesis and Initiation: Tom Sherman, M.D.
Northeast Region Chair

At this first business meeting, voting OSR members are asked to sit toward the front and to take a folder containing quorum forms and ballots. The OSR rep should complete quorum #1 (white). At the conclusion of the presentations, the floor will be opened for nominations for the positions of OSR chair-elect and OSR Representatives-at-Large (five).

FRIDAY, NOVEMBER 6, 1987

5:30-6:00 p.m. **New Member Orientation: Getting the Most Out of OSR** **(Jefferson West)**

Sarah Garlan Johansen
OSR Representative-at-Large
Dartmouth Medical College

Kirk Murphy, M.D.
OSR Representative-at-Large
Resident in Psychiatry
VA Medical Center
Sepulveda, CA

Wendy Pechacek
Staff Associate
Section for Student and
Educational Programs

This brief time will be spent discussing how OSR works and tips on becoming a more effective representative. New and old reps are encouraged to bring questions.

6:00 - 7:30 p.m. **Demonstrations of CONFER Computer Network** **(See Andy Spooner)**

FRIDAY, NOVEMBER 6, 1987

7:30-9:00 p.m. **Workshops**

A. Orientation to Career Decision-Making **(Farragut)**

Moderators: Mike Gonzalez-Campoy
Central Region Chair

Andy Spooner
OSR Representative-at-Large

Speakers: Emmett Manley, M.D.
Resident in Family Practice
University of Tennessee-Knoxville
Memorial Hospital

Norma Wagoner, Ph.D.
Associate Dean for Student Affairs
University of Cincinnati
College of Medicine

Franklin Williams
Coordinator
UT Family Practice Student Association
University of Tennessee-Memphis
College of Medicine

Preparing for a residency is a four year process, or so most students have come to believe. What are some of the realities and myths? It is very important to gain an overview of this process so that it does not become an overwhelming obstacle when faced with other important decisions around career choice. A handbook will be distributed for aiding students in their understanding of the complexities of the process. It will contain information on what program directors look for in residency candidates.

In addition, some recent information presented in the September, 1987 American Board of Medical Specialties Conference on "How to Select Residents" will be shared. Discussion of the timing of the various matches and the types of programs available will be reviewed. You will also receive an overview and a copy of a A Medical Student's Guide to Strolling Through the Match.

Finally, you will gain important tips from "Practical Points for a Perfect Interview" - the opportunities and pitfalls of the interview which represents the most important selection variable in the application process.

We hope that you will find many helpful suggestions as well as ideas for developing programs at your own institution.

B. Joy of Medicine **(Grant)**

Suggested Reading: pp. 4-14

Speaker: Patch Adams, M.D.
Director
Gesundheit Institute

Patch will explore many of the joys inherent in the practice of medicine--great potential in a thrilling profession. He will weave stories of this 16+ year practice to highlight this point. At least half of the time will be used in questions and answers so students can explore concerns in practice. Will be lively and inspirational.

C. Becoming an Influential Change Agent/Desert Survival Workshop **(Independence)**

Leader: D. Daniel Hunt, M.D.
Acting Associate Dean for Academic Affairs
Associate Professor, Psychiatry
University of Washington
School of Medicine

Facilitators: Cynthia Carlson
Medical Student
University of Washington

Vicki Darrow, M.D.
OSR Chair
Resident in Obstetrics/Gynecology
University of California, Irvine

Jim McQuade, M.D.
Resident in Psychiatry
University of California, Irvine

Each of you are working and will be working in complicated systems that require on-going change to remain responsive to change in the environment. It is important to prepare yourself now to be as effective an agent of change as possible. Understanding how you as an individual tend to prioritize "task-oriented interaction" versus "people-oriented interaction" can help in knowing how you approach problems that need change. This workshop will assist you in identifying your particular style of problem solving.

FRIDAY, NOVEMBER 6, 1987

D. Issues in Women Physicians' Development **(Hamilton)**

Moderator: Janet Bickel
Staff Associate
Division of Institutional Planning and Development
Association of American Medical Colleges

Speakers: Ellen E. Wilson, M.D.
Third Year Resident
Obstetrics-Gynecology
George Washington University Health Sciences Center

Deborah Geer, M.D.
Clinical Instructor of Surgery,
Uniform Services University School of Health Sciences
and Assistant Chief of General Surgery,
Kimbrough Army

Linda Goldstein, M.D.
Pediatrician
Chevy Chase, Maryland

Each physician will summarize her own history, expanding upon issues and strategies that have been important in her development. The goal of the presentations will be to stimulate those in attendance to raise questions and concerns they may have about their own personal, professional and career development and to examine these with the input of the other participants.

E. Communicating with Patients **(Jackson)**

Suggested Reading: pp. 15-29

Moderator: Joanne Fruth, M.D.
OSR Representative-at-Large

Speaker: Noel Chrisman, Ph.D., M.P.H.
Professor
Community Health Care Systems
University of Washington
School of Nursing

The goal of this session is to introduce new questioning and listening skills to participants. We will discuss cases and their outcomes, relating these to practices that promote and inhibit communication with patients. My premise is that sickness is as much cultural as it is biomedical. A culture-sensitive approach includes reducing ethnocentrism, using the illness-disease distinction, being familiar with prevalent types of American illness beliefs, and the ability to negotiate.

FRIDAY, NOVEMBER 6, 1987

9:00 p.m. - 10:30 p.m. **OSR Reception** **(Map)**

See Flyers for Details

SATURDAY, NOVEMBER 7, 1987

9:00 - 11:30 a.m. **PLENARY SESSION** **(Jefferson West)**

Looking Ahead: Perceptions of a Physician's Role in Society

Moderator: Vicki Darrow, M.D.
OSR Chair

Panel: Noel Chrisman, Ph.D., M.P.H.
Professor
Community Health Care Systems
University of Washington
School of Nursing

Charles Odegaard, M.D.
President Emeritus
Professor Emeritus of Biomedical
History and Higher Education
University of Washington

Victor W. Sidel, M.D.
Distinguished University
Professor of Social Medicine
Montefiore Medical Center and
Albert Einstein College of Medicine

During this session, topics will include: a perspective on the general issues of social responsibility as well as its history in medicine, e.g., free clinics and indigent care; a discussion of the many cultural backgrounds of the patients we care for and the need to address that diversity during care; and the importance of including the humanities in medical education--with the premise that human values/humanities during training can improve the physician-patient relationship and, ultimately, society's perceptions of physicians as a group. Please bring concerns and questions for discussion.

SATURDAY, NOVEMBER 7, 1987

1:30 - 4:30 p.m. **Discussion Groups**

A. Health Care for the Indigent **(Caucus)**

Suggested Reading: pp. 30-34

Moderator: Tom Sherman, M.D.
Northeast Region Chair

Discussants: David Hilfiker, M.D.
Family Practice Physician
Community of Hope Health Service

Victor W. Sidel, M.D.
Distinguished University
Professor of Social Medicine
Montefiore Medical Center and
Albert Einstein College of Medicine

At least 37 million people in the United States are without health insurance. There is a bill in the Senate Labor and Human Resources Committee that mandates employer-provided health insurance. However, approximately half of these uninsured are also unemployed, representing a population disproportionately served by public, inner-city hospitals. Care is difficult to obtain without insurance and even more difficult without an income. In 1982, only 37.5 percent of the people with incomes under the federal poverty standard were covered by Medicaid. There is legislation recently proposed by Rep. Pete Stark (D-CA) that would provide supplemental government reimbursement to hospitals with a disproportionate share of indigent, or uncompensated, care through an excise tax on all employers.

Clearly these measures, enacted outside of the medical community, represent only a partial and inadequate response to a growing problem in our own "house". We have the means to provide input into this vital issue, through the OSR and AAMC as well as through our local medical centers. We should also have a vital interest in the outcome of these congressional and other efforts to close a widening disparity of access to care. This session will involve two experts in the field. Dr. Sidel is Distinguished University Professor of Social Medicine at Albert Einstein in New York City. Dr. Hilfiker is a family practice physician at the Community of Hope Health Service in Washington, D.C. Their insight should provide invaluable perspective with which we might approach the problem.

B. The Current Debate on Education and Training of Physicians: Supply, Demand and Opportunity **(Map)**

Moderator: Vicki Darrow, M.D.
OSR Chair

Discussants: Kim Dunn
OSR Chair-elect

Sarah Johansen
OSR Representative-at-Large

Deborah M. Prout
Director
Department of Public Policy
American College of Physicians

C. Learn to Love the Questions: Clinical Lessons from Creative Literature **(Lincoln West)**

Moderator: Janet Bickel
Staff Associate
Division of Institutional Planning and Development
Association of American Medical Colleges

Discussants: Lou Borgenicht, M.D.
Pediatrician
Salt Lake City

Kathryn Hunter, Ph.D.
Associate Professor, Humanities in Medicine
University of Rochester School of Medicine

Delese Wear, Ph.D.
Coordinator, Human Values in Medicine
Northeastern Ohio Universities
College of Medicine

This session will provide ideas, examples and a rationale for looking to creative literature as a resource in the development of clinical skills. With the help of two medical students and a physician from NEOUCOM, Dr. Wear will describe the Literature and Medicine Clinical Reading Groups which have been going on in their affiliated hospitals with amazing success. After sketching the University of Rochester's medical humanities offerings, Dr. Hunter will offer observations about program characteristics and literary works that medical students have found most valuable in their clinical development. A former medical school faculty member, Dr. Borgenicht will provide reflections from his perspective as a pediatric fisherman and will stimulate audience participation by asking provocative questions about communicating with patients. Come prepared to examine issues in your clinical skill development.

SATURDAY, NOVEMBER 7, 1987

D. Transition into Residency and Practice **(Jefferson West)**

Suggested Reading: pp. 35-41

Moderator: Joanne Fruth, M.D.
OSR Representative-at-Large

Discussants: Pamelyn Close, M.D.
Hematology/Oncology Fellow
Children's Hospital of Philadelphia

David Nash, M.D., M.B.A.
Deputy Editor
Annals of Internal Medicine

Professional development in the transition into residency and beyond receives varying attention in current medical training. Early in the residency period, opportunities to identify future practice partners and decisions regarding practice type and location may be overlooked because the new physician is not receptive to these opportunities. Up-to-date information regarding current practice trends and preparedness for the emotional challenges facing the new resident can enhance the transition from medical student to practitioner. This discussion group will address these issues from the perspective of an intern, resident-fellow, and faculty practitioner who is also an authority on practice trends in the United States. Ample time will be allowed for information exchange and audience participation.

5:00 - 6:00 p.m. Chair-elect Campaign Speeches **(Jefferson West)**

Following their presentations, candidates will respond to questions from the floor.

6:00 - 10:00 p.m. Demonstration of CONFER Computer Network **(See Andy Spooner)**

7:30 - 9:30 p.m. Evening Programs

A. Service **(Jefferson West)**

Moderator: Sarah Garlan Johansen
OSR Representative-at-Large

Speaker: Daniel W. Morrissey, O.P.
Consultant to the Vice President
for Health Sciences
Columbia University

SATURDAY, NOVEMBER 7, 1987

B. Life in the Medicine Lane **(Caucas)**

Moderator: Vicki Darrow, M.D.
OSR Chair

Speakers: Barry Rosen, M.D.
Medical Director
Drug & Alcohol Rehabilitative Service
Sequoia Hospital

Sally Rubenstone, M.D.
Chief Medical Resident
Kaiser Hospital - Santa Clara

SUNDAY, NOVEMBER 8, 1987

8:30 - 10:00 am Workshops

A. Self-Directed Learning **(Grant)**

Speakers: Amy Justice
Medical Student
Yale University
School of Medicine

George Askew
Medical Student
Case Western Reserve University
School of Medicine

Presenters will discuss the tutoring/advising models developed at their schools and how to begin one at yours.

B. Initiating Curriculum Changes at Medical Schools **(Hamilton)**

Moderator: Tom Sherman, M.D.
Northeast Region Chair

Speaker: Deborah Capko
Medical Student
UMDNJ-New Jersey Medical

At the Northeast OSR Spring meeting students realized that there were alot of ideas and programs at other medical schools which would benefit their own schools. However, there was also a common problem--how to intiate those changes.

This session will be composed of three parts. First, a dean will give advice on how to be successful in gaining the cooperation of your administration. Second, in small group discussions, participants will work to solve currently existing problems at various medical schools. The session will conclude with

a general summary of the small groups and how the OSR (in Washington and representatives at other schools) can help to initiate changes.

An important part of the session is preparation. A survey will soon be sent asking questions about current curriculum problems and changes at your medical school. Results will be used during the small group discussions.

C. Influencing the Legislative Process **(Independence)**

Moderator: Mary Vistica, M.D.
Western Region Chair

Speaker: Sarah Carr
Legislative Analyst
Association of American Medical Colleges

This session will focus on how current legislation is affecting medical education at the institutional and personal levels. Topics for discussion will include: current budget issues and how they will affect the schools; the increasing levels of student indebtedness and its effects on specialty choice and geographic maldistribution of physicians; the issue of GSL/SLS deferments during residency, and the upcoming reauthorization of Title VII. Staffers from Capitol Hill will answer questions and provide students with ideas on how to influence legislation.

D. Preventive Medicine in the Clinical Specialties **(Jackson)**

Co-sponsored by the Association of Teachers of Preventive Medicine

Suggested Reading: pp. 42-46

Moderators: Daniel Blumenthal, M.D.
Chairman, Department of Community Health and Preventive Medicine
Morehouse School of Medicine

Michael Pratt, M.D.
Resident in Family Practice
Mayo Clinic

Panelists: Joseph Barbaccia, M.D.
Professor and Vice Chairman
Department of Family andCommunity Medicine
University of California, San Francisco

Robert C. Cefalo, M.D.
Chairman, Division of Maternal and Fetal Medicine
University of North Carolina at Chapel Hill

Alan Cross, M.D.
Associate Professor
Department of Social and Administrative Medicine
University of North Carolina at Chapel Hill

Richard Owen, M.D., M.P.H.
Consultant in Internal Medicine
Mayo Clinic
and Assistant Professor of
Preventive Medicine
Mayo Medical

This overview of the importance of incorporating preventive medicine in the clinical specialties will provide many examples of this practice in action--Dr. Barbaccia in Family Practice, Dr. Cefalo in Obstetrics/Gynecology, Dr. Cross in Pediatrics, and Dr. Owen in Internal Medicine. There will be ample time for discussion with participants.

E. Synthesis & Initiation: Turning Ideas Into Reality (Kalorama)

Leader: Tom Sherman, M.D.
Northeast Region Chair

Ever noticed a real problem, had a good idea, or really felt you could change for the better the way something is done at your school? In this session you will have the chance to present your ideas and hear how other students have managed to implement programs successfully at their schools or in their communities. We will brainstorm, sharing our thoughts on common problems, and use the themes and information from the conference to construct basic mechanisms for change at our schools and in our communities. Here is a chance to apply the enthusiasm and information you have accumulated over the past two days of the meeting!

SUNDAY, NOVEMBER 8, 1987

10:30 - 12:00 p.m. **Regional Meetings**

Western - (Kalorama)

Central - (Independence)

Northeast - (Hamilton)

Southern - (Jackson)

1:30 - 4:00 p.m. **Business Meeting, Part II** **(Lincoln West)**

A packet of curriculum vitae for those OSR members who are running for office will be distributed at 1:15 p.m. These candidates will give very brief presentations, followed by voting--first for Chair-elect, then for Representatives-at-Large.

Other Programs of Special Interest to OSR Members:

SUNDAY

4:30-6:00 p.m. — AAMC Plenary

Presiding: John W. Colloton
Director and Assistant to the President
of Statewide Health Services
University of Iowa Hospitals and Clinics

Presentation of the AAMC Award for Distinguished Research and Flexner Award

Chairman's Address: Edward J. Stemmler, M.D.
Executive Vice President and Dean
University of Pennsylvania
School of Medicine

President's Address: Robert G. Petersdorf, M.D.
AAMC President

MONDAY

7:30-9:00 a.m. — Women in Medicine Breakfast Program — Conservatory

($9.00 charge to be paid in advance)

Discussion Groups:

*Promoting Academic Medicine as a Career to Minorities and Women

*Concerns of the Single Woman in Medicine

*Maternity/Parenting Leave Policies

*Taking Better Care of Ourselves: Handling Stress and Anger at Work

*Dealing with Role Conflicts

9:00-11:30 a.m. — AAMC Plenary

Presiding: Edward J. Stemmler, M.D.
AAMC Chairman

"The Rising Physician Supply: Some Implications"
Alvin R. Tarlov, M.D.
President, Henry J. Kaiser Family Foundation

"Supply and Demand: Lessons from Dental Medicine?"
D. Walter Cohen, D.D.S.
President, Medical College of Pennsylvania

"On the Perennial Problem of America's Physician Shortage"
Uwe E. Reinhardt, Ph.D.
Professor of Economics and Public Affairs
Woodrow Wilson School of Public and International Affairs

11:30-1:00 p.m. and 2:00-4:30 p.m.	Innovations in Medical Education Exhibits	Exhibit Hall
2:30-4:30 p.m.	COTH General Session	
	Presiding: J. Robert Buchanan, M.D. COTH Chairman-Elect	
	"Projecting Hospital Use by AIDS Patients" Michael H. Alderman, M.D. Chairman, Epidemiology and Social Medicine Albert Einstein College of Medicine	
	"The Emotional Impact of AIDS on Residents" R. Nathan Link, M.D.	
4:30-6:00	Women in Medicine Career Development	Military
	Moderator: Betsy Bennett, M.D. Assistant Dean of Student Affairs Assistant Professor of Pathology University of South Alabama College of Medicine	
	Panelists: Nancy Gary, M.D. Professor of Medicine UMDNJ-Robert Wood Johnson Medical School	
	Amber Jones Vice President for Academic Planning and Development Albany Medical College	
	Carol Nadelson, M.D. Director, Training and Education Department of Psychiatry Tufts University School of Medicine	
5:00-6:00 p.m.	GSA Plenary	Ballroom Center
	Institutional Survival Versus Social Responsibility: Finances as a Driving Force	
	Edward N. Brandt, Jr., M.D. Chancellor University of Maryland	
6:30-8:30 p.m.	GSA-Minority Affairs Section Session	Georgetown West
	Doctor/Patient Relationship as a Curriculum Issue	
	Moderator: Jane Thomas, Ph.D. Wayne State University School of Medicine	

Panelists: Philip Bashook, Ed.D.
American Psychiatric Association

Raquel Bauman, Ed.D.
University of Massachusetts
School of Medicine

John Yergan, M.D.
University of Washington
School of Medicine

TUESDAY

9:30-10:00 a.m. Honorable Edward M. Kennedy
United States Senate

10:30-12 noon GME/GSA Plenary Ballroom East

NBME III: Results of the Field Test of Computer-Based Testing-Plans for Future Development and Implementation

Moderator: Gerald H. Escovitz, M.D.
Medical College of Pennsylvania

Speaker: Robert L. Volle, Ph.D.
President, National Board of Medical Examiners

Reactors: Clayton Ballantine
University of Louisville
School of Medicine

Fredric Burg, M.D.
University of Pennsylvania
School of Medicine

Henry M. Seidel, M.D.
Johns Hopkins University
School of Medicine

12:00-1:00 p.m. IME Exhibits Exhibit Hall

CULTURE SENSITIVE PATIENT CARE

NOEL J CHRISMAN, Ph.D., M.P.H.
University of Washington

Looking Ahead: The Physician's Role in Attending to Patients' Cultural Differences.

During the last three decades, American society has been replacing its "melting pot" model of the integration of multiple cultural groups with a "fruit salad" model. A consequence of the melting pot model was that all people were to be treated the same--and usually this meant being treated like white Anglo-Saxon Protestants. Now, physicians and other health practitioners need to adjust their practice styles to actively take their patients' cultural perspectives into account during patient care. Active attention requires the modification of many current practices; the addition of a few. But most important, including cultural variation in your practice requires a positive attitude toward a challenging new style of medicine: Culture-Sensitive Care.

Findings from a study of 101 patients in a Family Medical Center include:

1. Patients have their own beliefs about illness that do not always coincide with physician beliefs, but that make a difference in their self care.

2. Patients comply with what their physicians suggest, but also treat themselves.

3. The top three reasons patients gave for their satisfaction were: the doctor gave me information (71%); the doctor spent time with me and did not appear hurried (58%); the doctor listened to what I had to say (52%).

Getting along with patients requires understanding how culture affects their lives as well as understanding their sickness; use CULTURE SENSITIVE PATIENT CARE

Culture is a learned, shared, symbolically transmitted design for living.

Beliefs are propositions accepted as true.

Values are standards for evaluating beliefs and behaviors

Principles of Culture Sensitive Care: KNOWLEDGE, MUTUAL RESPECT, NEGOTIATION.

To achieve these: LISTEN

Ethnocentrism: The belief that one's own culture is the only right one.

Cultural Relativism: To try to understand people's beliefs and behaviors from their culture's point of view.

A fundamental approach in culture sensitive care is using the ILLNESS-DISEASE DISTINCTION

Disease: a professional view of sickness; in the U.S., a pathological process.

Illness: the patient/family description, experience, and/or explanation of the sickness.

Explanatory Model: description of the sickness that includes onset, cause, pathophysiology, course, and treatment.

1. What do you call your sickness?
2. When did it start? What else was going on then?
3. Why do you think it started then? What caused it?
4. How does the sickness work in your body?
5. What have you been doing for your sickness? What should be done now?
6. How long will your sickness last?

ILLNESS BELIEF SYSTEMS are useful for categorizing explanatory models.

Germ Theory, Equilibrium (Humoral Pathology, Harmony), Sorcery/Witchcraft, God- and Spirit- Caused, Symbolic/Metaphorical

Levels of Cause

Proximate Cause: how it works.

Ultimate Cause: answers to the questions Why me? Why Now?

Negotiation is recommended when patient and practitioner therapies conflict or contrast. (In fact, this approach is useful in all patient encounters.)

1. Careful, culturally relativistic listening to the patient/family view.

2. Clear exposition of the practitioner view, using language appropriate to the patient/family.

3. Compare the two views, explaining similarities and differences, indicating disagreement with the patient perspective (when appropriate), but not indicating disvalue of that perspective.

4. Compromise, using the Hippocratic principle of avoiding biomedical harm. Remember, when the scientific evaluation of a non-biomedical therapy indicates harm and the patient demands to continue it, a choice based on professional ethics must be made by the clinician about whether to remain on the case.

SUMMARY

REDUCE ETHNOCENTRISM

USE THE ILLNESS-DISEASE DISTINCTION

VALUE PATIENT RESPONSES

A DOCTOR'S VIEW OF MODERN MEDICINE

by David Hilfiker

Private medicine is abandoning the poor. As a family doctor practicing in the inner city of Washington, I am embarrassed by my profession's increasing refusal to care for the indigent; I am angry that the poor are shuttled to inferior public clinics and hospitals for their medical care. Before coming to Washington, I practiced for seven years in a standard fee-for-service clinic in rural Minnesota. Patients there were charged on a sliding scale according to their income. As far as I can remember, none of my specialist consultants ever turned away a patient of mine who lacked insurance coverage. In our isolated rural environment, I was simply not aware that many physicians would refuse to see patients who could not afford to pay the full fee.

Two and a half years ago, however, I moved to Washington to work in two small church-sponsored health services which serve the inner-city poor. At our clinics, which were established to care for those with no other access to health care, we are discovering that thousands of Washington residents have essentially no access to private medical care. Almost every day my patients tell me stories of having been refused care by physicians all over the city. Our informal telephone survey indicates that less than 10 percent of the private physicians in the city have a sliding fee scale or offer the opportunity to defer payments. More than half the physicians even turn down Medicaid patients, for whom they would be guaranteed substantial, if reduced, fees.

More than 30 million Americans lack any kind of medical insurance. Millions of those living in indisputable poverty do not receive Medicaid either because they do not meet the restrictive requirements (it is not enough just to be poor) or because the bureaucratic process is simply too daunting. These poor are sicker and die earlier than the affluent. And the health problems among the poorest of the poor -- the homeless -- remind one of the third world: active tuberculosis, hernias as big as footballs, untreated fractures and all manner of eminently treatable skin diseases. The statistics on the health of the poor are an embarrassing contradiction to the affluence of our nation.

At private hospital emergency rooms all over this city, it is now standard practice to ship indigent patients who need hospitalization to the District of Columbia General Hospital, the city's only public general hospital. Although the guidelines specify that the patients must be medically stable and able to withstand the transfer, the inevitable delay in securing appropriate treatment has occasionally caused serious harm. These transfers of poor patients from private hospitals to public ones continue to occur despite the fact that the national commission which accredits all hospitals mandates that no patient should be transferred arbitrarily if the hospital he initially visited has the same means for adequate care of his problem. The Arizona Supreme Court has recently confirmed the principle, established in an earlier case, that a private institution has the same legal obligation as a public hospital to render all needed care to emergency patients.

With the single exception of Howard University Hospital, a predominantly black hospital with a long tradition of service to the poor, I know of no Washington-area private hospital that routinely accepts indigent nonemergency patients for admission. There are, to be sure, some hopeful exceptions. Several hospitals do have programs targeted for a special segment of the poor -- pregnant refugee women, for example; one hospital accepts patients with coverage by the D.C. Medical Charities Program, a low-level form of governmental insurance that pays less than $80 a day toward private hospital bills. Still, except for Howard, not a single private hospital in the city admits indigent patients without qualifying criteria. As a private physician, I cannot even admit patients to the private hospital with which I am affiliated unless they have medical coverage or can pay the bulk of the expected fee in advance. What is available for the poor are long waits in the emergency rooms and outpatient clinics of public hospitals, inconsistent care by a succession of doctors-in-training and impersonal service that eventually discourages many from even seeking medical help.

A teen-ager came into our clinic for a brief appointment with Dr. Janelle Goetcheus, one of my partners. As she was leaving, she turned to Janelle and said, "I like this place. How can I have you as my doctor?" Janelle looked at her, surprised. "Just by your wanting me to be," she answered. For a moment the young woman seemed confused. Then a smile lit up her face. "You mean I can tell people I have my own private doctor?" A "private doctor" was, for this young woman of poverty, something almost too wonderful to hope for.

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There are, of course, many complex factors that have precipitated private medicine's abandonment of the poor. The urbanization and anonymity of the poor, the increasingly technological nature of medicine and the bureaucratic capriciousness of public medical assistance -- all these serve to make private physicians feel less responsible for the medical needs of those who cannot afford the going rate.

But the cause that is probably most obvious to lay public is singularly invisible to the medical community: Medicine is less and less rooted in service and more and more based in money. With many wonderful exceptions all over the country, American physicians as a whole have been turned away from the ideals of service by an idolatry of money. Physicians are too seldom servants and too often entrepreneurs. A profitable practice has become primary. The change has been so dramatic and so far-reaching that most of us do not even recognize that a transformation has taken place, that there might be an alternative. We simply take it for granted that economic factors will be primary even for the physician.

I do not mean merely to accuse my profession of greediness, though greed exists among doctors as among any other group. Rather, I would suggest that we physicians have been seduced by money; we have been bound by it. Money has become the measure of what we do, the yardstick of our work. Just as if we were in any other business, we physicians have capitulated to the use of economic worth as the determinant of value. In a consumer society such as ours, we doctors are not alone in our idolatry, but our seduction is such a major change from the roots of our profession that it should not go unnoticed.

According to the American Medical Association, the average net income for American physicians is approximately $103,400 a year for 47 weeks of work averaging 56.8 hours each. The usual physician's fee for a physical examination in Washington is $75 to $100, excluding laboratory and X-ray work. Depending on specialty, size of office, efficiency and other factors, about half of the fee is returned to the physician directly; the rest is used for overhead expenses such as office space, ancillary help and malpractice insurance. A thousand dollars is not an unusual surgeon's fee for an hour's surgery plus follow-up visits totaling less than an hour's time. Physicians have become very well-paid servants, indeed.

While we physicians have been unable or unwilling to recognize this increasing monetization of our work, society seems to have perceived it clearly and responded in kind. There are certainly many reasons for the drastic increase in malpractice judgments, but one of them is that patients are angry over the high fees physicians charge. Insurance companies recognize that patients generally sue physicians who are perceived as unsympathetic. As physicians have become wealthier, malpractice suits have risen alarmingly, and the insurance premiums have kept pace. Malpractice insurance for some specialties is now well over $50,000 a year.

Recognizing the wealth of physicians, the Government has in the last 10 to 15 years reduced financial support for medical education, and medical students must now pay a much larger share of the costs of their education. The tuition alone for one year of medical education at George Washington University Medical School here is $18,500, with relatively few grants or low-interest loans available. When I started medical school in 1970, yearly tuition at the state university was a little over $1,000, and I was able to pay my own way through school without difficulty. When I earned by degree, I had accumulated low-interest Federal loans totaling about $5,000, all of which was forgiven after I had practiced for three years in a rural area where medical services were in short supply. Today's students may find themselves finishing medical school with conventional bank loans of more than $100,000. A young person has to be courageous indeed to accrue debts of that magnitude before entering a profession. Debts of $100,000 and insurance premiums that can run as high as $80,000 are threatening sums which reinforce the "bottom line" mentality among physicians.

As the medical ethicist Albert R. Jonsen has pointed out, there has always been a tension between the Greek Hippocratic tradition and the monastic medical tradition. For the ancient Greeks, "medicine is a skill so rare that it can be sold at great price," Jonsen wrote. "It is acquired with effort, and it promises rewards." In the monastic tradition, on the other hand, monks and nuns were the healers, and "the imperatives of self-sacrifice under which they lived were extended to their duties toward the sick and dying." So the conflict is not new. What is new is the degree to which medicine has accepted the business, corporate model of measuring itself. What is new, too, I think, is the abandonment of the monastic model as idealistic nonsense.

We physicians have not, I think, deliberately chosen to abandon the poor; rather, we have been blinded to our calling by the materialism of our culture and by the way medicine is structured. Many of us entered medicine out of deep altruism, wanting to be of service, only to discover that the daily crush of

dozens of sick and needy souls left us exhausted. Under such circumstances, we found ways to detach ourselves from the emotional turmoil of the sick. We may have become physicians desiring to enter deeply into our patients' lives, but we soon discovered that the long lines of patients waiting to be seen encouraged us to be more "efficient" and "cost effective." We discovered that the economic pressure to see 30 or more patients a day did not allow for the kinds of relationships we had envisioned. We learned, too, that our positions of expertise, power and prestige thrust us into positions of authority from which it was difficult to escape.

The structure of day-to-day medical practice alters one's perspectives. In 10 years, I have become aware of the pressures which have subtly encouraged me to measure my work according to its economic productivity and have thus distorted the physician-patient relationship. Doctors have always been busy, I suppose, but the increasing technical intensity and busyness of medical practice has led to a preoccupation with better "management" of the office. This has generally led to the hiring of additional nurses, technicians and assistants: the physician suddenly finds himself the administrator of a large staff, a task he may never have expected and for which he was probably never prepared. Many third-party payers -- insurance companies, Medicaid, Medicare and so forth -- will pay only for the physician's actual, direct services, and will not pay for any tasks performed by nurses or other personnel, so the physician scurries around from patient to patient, trying to do enough to pay for the office and the staff. Very soon, a business approach seems necessary just to keep afloat, and the physician has already become an entrepreneur.

More and more medical care today consists of highly technological procedures offered to the patient -- computerized X-rays, the sliding of various catheters and tubes through the body to take pictures and biopsies, specialized laboratory tests, transplants, transfusions of highly refined blood products. All are extremely expensive, and it is easy to see them as products rather than as human services. Medicine has also become increasingly specialized. The radiologist interprets the computerized X-ray, the cardiologist performs the coronary angiogram, the anesthesiologist puts the patient to sleep, the cardiovascular surgeon bypasses the heart's arteries, a second cardiologist manages the follow-up. It is tempting for the individual physician to see his or her work as simply the performance of a very difficult and demanding task -- a task involving a product on a kind of assembly line -- rather than the healing of a person. Like other highly trained technicians, the physician wants to be well remunerated. Whatever remains of the ideal of servant-hood becomes buried under technology and specialization.

The entrance of corporate medicine into health care has exacerbated all these tendencies. Physicians are now frequently employees of a corporation which is explicitly profit-oriented. Efficiency is now not only important but mandated from above. If the physicians, as healers, do not want to measure their work by its economic production, their employers certainly do, and the attitude filters inevitably down. When the corporate body dictates that the medical care needs to become more efficient in order to increase profitability, there may be discussion about how that goal may best be attained, but ultimately there is little argument about the goal itself.

The fee schedule for medical visits encourages an economic model for patient-physician interactions. In most offices, there are set charges for different kinds of visits -- brief, intermediate, extended and complete evaluation -- but there are no firm guidelines to determine the fees set by an office for a category. The fee for an intermediate visit, the most common routine visit, may vary from $15 to $50, depending on the office. But there are also no clear criteria for what constitutes what kind of visit, and there is plenty of leeway (by changing the category) for adjusting charges, depending on the patient's financial status, the mood of the doctor or the tenor of the consultation.

The realities of medical economics encourage doctors to do less and less listening to, thinking about, sympathizing with and counseling of patients -- what doctors call "cognitive services." Instead, the doctor is encouraged to act, to employ procedures. A procedure is anything the physician does to a patient -- suturing a laceration, withdrawing fluid from a swollen joint, performing a proctoscopy, removing an appendix. Charges for procedures are a labyrinth of arbitrary rates which are almost independent of the time involved, but they are universally higher than fees for talking with the patient.

In my clinic in Minnesota I could charge, perhaps, $30 for half an hour of counseling a patient about how to manage the discomfort of arthritis. But the fee for the 10-minute procedure of slipping a needle into a joint to remove some fluid would be upwards of $50. I could charge up to $60 an hour for time talking with a patient about his severe emotional problems, but if I entered the surgery suite and performed an appendectomy during the same hour, I could charge well over $400. Time spent performing procedures could be charged anywhere from three to 10 times the rate charged for the cognitive services.

The rationale behind these huge differentials is supposed to be the difference in skill and "intensity" involved, a rationale which makes no sense at all to anyone who has first spent an hour counseling a person with severe emotional problems and then earned the identical fee in 10 minutes by going into the next room to treat a wound. In fact, the fee schedule is fixed around what third-party payers historically have been willing to pay for particular services; the individual physician who wished to charge on a more rational basis would simply be refused. The current hodgepodge of fees is incomprehensible to anyone trying to understand the system rationally, but it does provide a strong incentive to orient one's practice around the higher-paying procedures.

None of these pressures has caused overnight changes in physician behavior, of course, but I am aware from my own experience how a doctor's perceptions gradually evolve as a result of the economic incentives. I remember realizing one morning how deeply I had changed. It was toward the end of my stay in Minnesota and before I began work for a salary. An aged patient had come in to my office and was talking about her aching feet. She not only had several very real physical problems but she was also very lonely and quite hypochondriacal. She visited me about once a month, mostly just to complain about how people ignored her and about how lousy she felt. This month, it was her feet, swollen and aching. She lifted up her dress so I could see the feet bulging out of the shoes. It was true, the feet were swollen, but they hadn't changed perceptibly in the three years I'd been seeing this patient. I had previously tried, without much success, to explain that her obesity and sedentary life style were the primary causes of the swelling, and that I didn't have any medicines that would help her.

As she continued to tell me how tired she was, I realized I wasn't listening. I was angry. What she needed was someone to sympathize with her, gently encourage her, and to make some simple suggestions that might alleviate her suffering. I knew from past experience that that kind of listening and empathetic presence would require at least half an hour, but I would only be able to charge $20 for an intermediate call, Medicare would discount the charge significantly, and my half, after overhead, would be, maybe, $8. I also knew that if I just stood up, cut the woman off by giving her a prescription for a pain medicine and scheduled her for next month, I could charge the same $20 and move into the next room where another patient was waiting with a small laceration from which I would earn about $30 in perhaps 10 minutes.

As soon as I recognized what I was angry about, I was ashamed. But the truth of my feelings was nonetheless real. Over the years, I found myself valuing brief interviews over real listening, aspiration of a joint over taking a good history, removal of an appendix over counseling a distraught teen-ager. Now I was actually angry at this old woman for taking up my time with something so economically unprofitable as listening to her story. I was looking at my interactions with patients more and more as business transactions.

There is no code in the fee book for comforting the grieving family of a patient who has just died; it is difficult to charge a panicked parent for middle-of-the-night telephone reassurance. The very fact that money has become the basis of the physician-patient interaction often inhibits a patient from raising "extraneous" issues which may be vitally important to health; it may even inhibit a patient from coming to see a doctor in the first place.

The monetization of medicine is bad enough for the patient who can afford to pay the going rate. For the average patient, there is at least the possibility of seeing a physician. It is even possible to argue that, to some extent, the third-party payers improve matters. They remove considerations of money from the immediate transaction and thus make it possible for physician and patient to interact without being very conscious of the business nature of the relationship. Once into the interaction of such a visit, I can frequently forget the economic nature of my work and be the servant-physician I want to be.

But the business model for medicine breaks down completely when applied to the care of the poor. If we physicians have consciously or unconsciously begun to see ourselves as entrepreneurs, how can we reconcile the need to serve the indigent where little or no remuneration is possible? We are too easily led away from the calling of our profession by the structures we have created.

At some deep level, I think, we physicians know something is wrong. We are invested with enormous trust and confidence predicated ultimately upon our role as healers who place the patient above our own personal needs. The monetization of medicine strikes at the heart of this trust. As patients gradually recognize that their physician is getting rich from the services rendered, the very core of the relationship is shattered. We physicians must recognize that there is a contradiction between a vocation of service and the inordinate earnings we now command. Though we physicians may deny it even to ourselves, we know it is true.

I do not know if it is possible to begin the return to a medicine based in service. Such a return would not have to mean ascetic monks and nuns delivering care without remuneration -- my own yearly salary of $22,000 plus housing is hardly sacrificial. But it would mean a personal and professional commitment to medicine as a vocation of healing everyone who is sick, including the poor. It would mean that physicians base their income on their own need rather than on what the market can bear. It would mean that the truly indigent would be cared for free of charge and that Medicaid -- even with all its bureaucratic indignities -- be accepted gratefully. It would mean that the poor be charged on a sliding scale based on their ability to pay.

This is already happening in many small nonprofit clinics around the country that are serving the poor; physicians in many of these places are paid amounts equivalent to what other "normal" people earn.

The objection from physicians, of course, is that we are a profession which, by virture of its long training, intense hours, dedication to patients and self-sacrifice should be well compensated. I would agree that we should be compensated well enough to assure our basic comfort and security, but when we believe that our earnings measure our worth and our dedication, we have accepted the wrong measuring stick. We have stepped away from the basis of our profession. And as we continue to follow this course, ultimately we will abandon the poor.

OSR PROGRAM EVALUATION

Please evaluate the following sessions:

	Poor 1		Avg. 3		Excellent 5	Did not attend
FRIDAY, NOVEMBER 6						
WORKSHOPS:						
1. Career Decision-Making Manley, Wagoner, Williams						
2. Joy of Medicine Adams						
3. Change Agent/Desert Survival Hunt et. al						
4. Women Physicians' Development... Bickel, Wilson						
5. Communicating with Patients Chrisman						
SATURDAY, NOVEMBER 7						
PLENARY:						
Perceptions of a Physician's Role... Chrisman, Sidel, Odegaard						
DISCUSSION GROUPS:						
1. Health Care for the Indigent Hilfiker, Sidel						
2. Debate on Physician Supply/Demand Dunn, Johansen, Prout						
3. Clinical Lessons from Creative Lit... Borgenicht, Hunter, Wear						
4. Transition into Residency ... Close, Nash						
EVENING PROGRAMS:						
1. Service Morrissey						
2. Life in the Medicine Lane Rosen, Rubenstone						
WORKSHOPS:						
1. Self-Directed Learning Justice						
2. Changing the Curriculum Capko, Sherman						
3. Influencing Legislation Vistica, Carr						

	1		3		5	Did not Attend
4. Incorporating Preventive Medicine... Blumenthal, Pratt, Cefalo, Barbaccia Cross, Owen						
GENERAL:						
Business Meetings						
Regional Meetings (Region:_____)						
Handouts/Agenda						
Information Booth (Friday)						
OSR NETWORK						

Comments/Suggestions for next year (include your name and address if you would like to help with program planning:

What do you think are the most important issues for the OSR Administrative Board to address next year, e.g., promotion of problem-based learning?

1.

2.

3.

Do you have suggestions for implementing/pursuing any of the above, e.g., resource persons?

Any suggestions for improving OSR?

Organization of Student Representatives
Business Meeting Agenda
and
Written Information Items

Friday, November 6 - 4:30 p.m.
[Washington Hilton & Hotel
Washington DC]

I. Call to Order

II. Remarks
A. Robert G. Petersdorf, M.D., AAMC President

III. Reports
A. Vicki Darrow, M.D., OSR Chair
B. Robert L. Beran, Ph.D., Assistant Vice President for Student and Educational Programs, AAMC
C. Andy Spooner, OSR Representative-at-Large, on CONFER Network for Students
D. Richard M. Peters, M.D., OSR Immediate Past-Chair
E. Thomas Sherman, M.D., OSR Northeast Region Chair - Synthesis and Initiation

IV. Determination of Quorum

V. Action Items
A. Approval of minutes of 1986 Business Meeting. 1

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

VI. Recess

VII. Recall to Order - Sunday, November 8 - 1:30 p.m.

VIII. Determination of Quorum

IX. Action Item
A. Election of Chair-Elect and Representative-at-Large

X. Discussion Item
A. Revision of the Universal Application Form for the National Resident Matching Program. 7

XI. Remarks
A. Leaders of Other Medical Student Groups

B. Kim Dunn, OSR Chair-Elect

XII. Old Business

XIII. New Business

XIV. Adjournment

WRITTEN INFORMATION ITEMS

ANNUAL BUSINESS MEETING MINUTES
OF
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES
October 24 & 26, 1986
New Orleans Hilton Hotel
New Orleans, Louisiana

I. Remarks from OSR Chairperson

Dr. Richard Peters called the meeting to order at 4:45 and welcomed everyone. He described the disillusionment accompanying his first months as house officer and how this has reinforced his commitment to working for change via the AAMC. Dr. Peters charged the students that, unless they strive for fundamental changes, they are destined to mimic their predecessors' inarticulateness in response to the medical profession's loss of credence. While medical education is micro-focused, medicine is practiced in a macro-world about which students learn little; he therefore urged OSR members to seek a wider world view. He also asked students to push their curricula in a problem-solving direction rather than continuing in a fact-memorization mode. Next, Dr. Peters encouraged very active participation in the annual meeting programs and consideration of running for OSR office. He closed by introducing key AAMC/OSR staff and the other members of the OSR Administrative Board.

II. Report on Survey of Preventive Medicine Courses

Ms. Joanne Fruth, OSR Central Region Chair, described a survey undertaken in conjunction with the Association of Teachers of Preventive Medicine (ATPM) which was mailed to OSR members in July. It asked OSR members to identify teaching approaches in health promotion and disease prevention that they would recommend as "good" or "outstanding". While ATPM is building a database on courses, she stressed the importance of adding to this students' perceptions of the most valuable approaches. Ms. Fruth also noted that she didn't realize until she started her fourth year how essential it is to be able to write excercise and diet prescriptions, for example. Since the response rate to the survey was low, she said that OSR members are now being given a second chance to submit information from their schools.

III. Remarks from Division of Student Programs (DSP) Director

Dr. Robert Beran explained that OSR is staffed by the DSP which attempts to be responsive to students' concerns on all fronts. He summarized some of the activities of the DSP and Group on Student Affairs (GSA). A major Division focus this past year has been the creation of MEDLOANS, a coordinated borrowing program which AAMC hopes will make the process of getting loans and paying them back a little easier for medical students. He said that the GSA Steering Committee had been so overwhelmed by issues of importance that in addition to its Committee on Student Financial Assistance, it now has a Committee on Admissions and a Committee on Student Affairs; each of these has

student representation. He urged the OSR to enjoy the meeting and to work hard.

IV. Federal Legislation Update

Mr. David Baime, AAMC Legislative Analyst, remarked that AAMC chooses to rely on its constituents to carry the ball to legislators after staff compile pertinent summaries of pending issues. While the summaries may sometime seem lengthy, issues are unavoidably complex. Mr. Baime reminded students to call AAMC staff with their questions, their needs and their experiences and to remember that OSR gives students a big opportunity to influence the legislative process. Next, he summarized the Higher Education Amendments of 1986 which represent big improvements in the Guaranteed Student Loan Program, the ALAS/PLUS Program which is renamed Supplemental Loans for Students (SLS) and Loans for Parents, and in loan consolidation (a handout provided a full summary). Mr. Baime also gave an overview of how the new tax law will affect students, especially the phase-out of the loan interest deduction. Mr. Baime answered a number of questions from the floor.

V. Remarks from the Immediate-Past-OSR-Chairperson

Dr. Ricardo Sanchez summarized some of what he has learned and worked on over the last three years. He noted that he assumes that OSR members have come to medicine not out of a sense of personal gain but out of a desire to help people and that they are also part of an elite who see more to medicine than memorizing the Krebs cycle. He said that OSR is full of pioneers--the first generation of medical students to get involved early in their development in the big picture of medicine. If OSR members continue to pursue their education in health policy, by the time they're professionally established, they will know a great deal more than present faculty members. Dr. Sanchez conceded that everyone is faced with a terra incognita of ethical and cost questions far outnumbering answers. He said that a lot is to be learned, for instance, from the AAMC President's pink and blue memos about what can be done and what gets accomplished. He urged students to pick an issue and contribute something important. This does not require superhuman effort, but does require conviction, energy and perspective on who is involved. What is learned in the process of working for change becomes a valuable tool, useful for years to come. He cautioned students about the risk of losing perspective and advised continually asking the questions--is it in the interest of health care and medical education? With regard to deciding whether to run for OSR office, he mentioned the enormous opportunity to advance important causes for peers across the country but the potential damage if office is sought for personal gain.

VI. Nominations for OSR Office

The following OSR members were nominated:

Chairperson-Elect:	Rebecca Fox, Kansas
	Monica Vogt, Baylor

Representative-at-Large:	Debra Weiner, U. Southern California
	Joanne Fruth, Medical College of Ohio
	Mitchell Goldstein, Miami
	Mark Blumenthal, Rutgers
	Robert Emmons, Cincinnati
	Dan Shapiro, Emory
	Sarah Johansen, Dartmouth

VII. The meeting recessed at 5:35.

VIII. Ms. Vicki Darrow, incoming OSR Chairperson, re-called the meeting to order at 1:45 pm on October 26 and awarded tokens of OSR's appreciation to Dr. Peters and Ms. Bickel for their service. She explained that, due to her participation in the concurrent AAMC Special General Session, she was unable to remain at the Business Meeting but that she looked forward to serving OSR as its leader.

IX. Additional Nominations

The following OSR members were also nominated:

Chairperson-Elect	Clay Balentine, Louisville
	Kim Dunn, Texas-Houston
	Ken Misch, Nevada
	Robert Emmons, Cincinnati
	Mitchell Goldstein, Miami
Representative-at-Large:	Renee Caswell, Colorado
	Kirk Murphy, Hanemann
	Tom Sherman, Connecticut
	Yvonne Brouard, Pittsburgh
	Andy Spooner, Tennessee

X. Remarks from AAMC President

Dr. Robert Petersdorf said that he was encouraged by the OSR's democratic process. He reiterated the importance of the Special Session on the Transition from Medical School to Residency at which Ms. Darrow was speaking and expressed the hope that the Transition Committee's recommendations would be adopted. After being on the job for only two months, he said that he had only first impressions to report. He mentioned that the AAMC seems so thinly staffed that not enough strategic planning can occur and that some areas may require reorganization. He raised the possibility of giving representation within the AAMC to housestaff as well as to graduate students and postdoctoral fellows. Dr. Petersdorf described the survey which has gone out to all parts of the AAMC constituency asking for opinions on the AAMC's mission, organization and services. The results will form a starting point for consideration of changes, and OSR's input is really wanted. A mechanism for achieving change is needed, however painful the changes may be. How well AAMC changes will be determined by its constituents. He stated that, while it's never been more challenging to be a medical student, it's never been more important for students to have such an opportunity as AAMC provides to extend one's medical

education and to help shape medical education. Dr. Petersdorf closed with the hope that students would return to their campuses refreshed and ready to work with their faculty and deans.

XI. Remarks from Leaders of Other Groups

A. Dr. Pat Lyden, Chair of AMA-Resident Physicians Section (RPS), likened the AMA to an oceanliner headed in one direction but gave examples of its changing little by little, e.g., its recent strong stance against smoking. He warned that, while problems with graduate medical education financing may mean nothing to students now, these problems will soon become realities as they find themselves having to pay for their own malpractice insurance, etc. Dr. Lyden praised the expertise and commitment he has discovered in OSR members and invited them to bring this to RPS when their time as medical students is over.

B. Dr. Christine Cassel, Chair-Elect of Physicians for Social Responsibility (PRS), summarized her commitment to increasing medical education's focus on humanities, occupational health and geriatrics and to better studies of aging and health care delivery. She stressed the importance of OSR in implementing respectable changes such as these and of groups of students at all schools in influencing their curricula. Dr. Cassel noted that when she was on the U. of Oregon's faculty, students decided that nuclear war threats were the most important public health issue, and together they translated skeptical questioning into practical plans and then into an elective. After publication of a description of this elective in the New England Journal of Medicine, she received 250 requests for more information; these requests came from all over the world. She pointed to other evidence of the importance of educating each other, the public, and legislators about the psychological barriers regarding nuclear destruction and about the necessity of prevention. Physicians must accept the job of translating scientific information into language for laypersons along these lines. She urged students to seek more information about PSR's curriculum project which is looking at changing the physician's oath at medical school graduation and at increasing global awareness about nuclear arms (contact Damon Moglen at PSR's national office in Washington, D.C., 202/ 929-5750).

C. Ms. Lynn Pappas, Vice-Chair of AMA-Medical Student Section (MSS), said that this was her first time at an OSR meeting and that she applauds OSR for its goals and spirit. She reiterated some of Dr. Rick Peters' comments about the need for cooperation among medical student groups. She said that while AMA has a bad name among a lot of students, she belongs because students must take any avenue as an opportunity to work for change. She said that it's impossible to know how many of the 38,000 student members joined just to get J.A.M.A but that AMA-MSS meetings are important forums where a great deal is accomplished. She mentioned the new Young Physicians Section; previously there was no avenue for those just finishing their training. She urged students not to see the AMA as a closed door just because of its conservatism and invited everyone to the Interim Meeting in December in Las Vegas.

D. Ms. Preston Reynolds, President-Elect of the American Medical Student Association, thanked OSR for its tremendous program. She said that AMSA has chapters at almost all schools and now has 16 task forces. She summarized AMSA's new loan program and a recent AMSA publication titled "The Corporatization of Medicine" which she recommended to OSR students. AMSA's convention is March 18-23 in New Orleans. Ms. Reynolds said that OSR representatives' commitment to change assures them of being future leaders and that it's rewarding to see so many students working toward the same important goals.

E. Mr. David Zucker, Stanford medical student, described the January conference he and other students are creating at Stanford on taking responsibility for health policy and how medical students can create change. He thanked OSR for the inspiration he received at this meeting. He said the Stanford conference grew out of students' concern about a lack of health policy issues raised during their education and thus will feature physicians who have been active in this area sharing their personal experiences. He welcomed OSR's contributions and attendance.

F. Ms. Shiela Rege, American Medical Women's Association student leader and OSR representative from U. of California-Los Angeles, gave examples of women's groups getting stronger at her school and other schools and of how AMWA operates. She said that women's groups need the support of men too and offered information about AMWA to anyone interested.

XII. Elections

The OSR elected Kim Dunn to the office of Chairperson-Elect.

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

Clay Balentine
Robert Emmons
Monica Vogt
Rebecca Fox

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

Kirk Murphy
Joanne Fruth
Mark Blumenthal
Sarah Johansen
Andy Spooner

XIII. Closing Remarks

Dr. Ricardo Sanchez urged the students to look to their right and left to see the next generation of prominent men and women in medicine. He likened medicine to a sick patient who doesn't need another committee for each new problem but rather needs physicians

who are willing to collaborate and who do not drop the ball no matter how complex the case. He said that the collegial nature of the AAMC makes it the ideal medium and tool for improving medical education. Dr. Sanchez adjourned the meeting at 4:00 p.m.

GRADUATE MEDICAL EDUCATION
APPLICATION FOR RESIDENCY

PROVIDED BY

NATIONAL RESIDENT MATCHING PROGRAM

DEVELOPED BY

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INSTRUCTIONS – PLEASE READ CAREFULLY

The application materials include an Application Form and Program Designation/Acknowledgement Cards, which are to be used for residency programs regardless of their NRMP participation.

1. *APPLICATION FORM.* The Application Form is a 4-page document.

Pages 1 and 2 (with the exception of item 3, page 1) may be completed once and copied for distribution to more than one prog or they may be completed individually for each application.

Pages 3 and 4 may be completed once and copied for distribution to all programs where an application is filed.

For each application the pages should be assembled in sequence and stapled together in the upper left corner. THE APPLICATION FORM IS COMPLETE ONLY IF IT INCLUDES ALL FOUR PAGES AND THE APPLICANT'S ORIGINAL SIGNATURE (NOT COPIED) ON PAGES 2 AND 4. Do not include this instruction sheet.

2. *PROGRAM DESIGNATION/ACKNOWLEDGEMENT CARDS.* It is essential that original Program Designation and Acknowledgement Cards be completed for each application. DO NOT SEPARATE THESE TWO CARDS.

A. *PROGRAM DESIGNATION CARD.* Side 1: Enter your name and social security number. Designate the institution (hospital) and program (including NRMP code) to which the application is sent. Information on this card should correspond exactly with that appearing on page 1 of the Application Form. Be sure to designate the beginning year. Side 2: Provision of information on age, sex, and racial/ethnic group, which is requested for reporting purposes, is optional.

B. *ACKNOWLEDGEMENT CARD.* Enter your name and current mailing address on the lines provided. BE SURE TO PLACE A STAMP ON THE CARD. This card will be returned to you by each program to which you apply to acknowledge receipt of your application materials.

ATTACH THE COMPLETED PROGRAM DESIGNATION AND ACKNOWLEDGEMENT CARDS (JOINED BY PERFORATION TO EACH OTHER) TO THE UPPER LEFT FRONT OF THE COMPLETED APPLICATION FORM. Space is provided for this purpose on the Program Designation Card.

A complete application for a first-year graduate medical education program includes:

1. A 4-page Application Form, with original signatures on pages 2 and 4;
2. Program Designation and Acknowledgement Cards, attached to each other and to the front of the Application Form.

Application materials should be mailed without folding the Program Designation/Acknowledgement Cards.

Please TYPE or PRINT LEGIBLY throughout. If application is duplicated, be sure that copies are clear and legible.

PERSONAL STATEMENT (item 4, page 1): Most program directors want to know about your professional interests, achievem and plans for the future, including the number of years of graduate medical education you intend to pursue, your ultimate goal specialty, and your anticipated geographic location. Reference should be made to research experience and training, special projects or scientific work you have engaged in, and any notable professional accomplishments you have achieved. Bibliographic references should be provided for all published papers. You may also wish to describe your personal interests, activities, and circumstances, including your family and household.

REFERENCES (item 5, page 2): Virtually all hospital programs require the Dean's letter as a standard reference. It is the applicant's responsibility to ensure that this and all other letters of evaluation are received by each hospital program to which application is made. Most programs require a minimum of three evaluations; space is provided for a maximum of five, including the Dean's letter. References should be faculty members who know you well and are in a position to comment upon your suitability for the position you seek.

PHOTOGRAPH (page 3): Because of the number of applicants interviewed by each program, most program directors require a photograph in order to identify individuals with whom they have spoken during the selection process. Space is provided for the optional attachment of a recent 2" x 2" photograph, should you wish to submit one with this application. If you do not submit one at this time, many program directors will require that you do so at the time of the interview.

PERMANENT ADDRESS AND TELEPHONE NUMBER (items 12 and 13, page 3): Enter the name, address, and telephone number of an individual through whom you can always be contacted (parent, close friend or relative, etc.)

MONTH/YEAR OF MATRICULATION AT MEDICAL SCHOOL AND MONTH/YEAR OF (ANTICIPATED) GRADUATION (under item 17, page 3). If your medical education was interrupted for any reason, you should explain this circumstance in the Personal Statement.

ELECTIVES COMPLETED/PLANNED (under item 17, page 3); List all electives completed and all senior electives planned. Electives planned should be so designated by a "P" following course title: for example, "Cardiology (P)".

HONORS/AWARDS (under item 17, page 3): Specify basis for awards listed (i.e., academic performance, special accomplishments, leadership, research, community service, etc.) Include membership in honor societies, such as AOA.

INTERVIEW SCHEDULING (item 23, page 4): Indicate the general time period or specific date(s) that you are able to appear for an interview.

IT IS THE APPLICANT'S RESPONSIBILITY TO ARRANGE TO SUBMIT ANY SUPPLEMENTARY MATERIALS (TRANSC LETTERS OF EVALUATION, ETC.) REQUIRED BY A PARTICULAR PROGRAM.

APPLICATION FOR RESIDENCY – PAGE 1

BEGINNING IN _____
(year)

(Type or Print; black ink is preferred)

1. NAME (LAST) (FIRST) (MIDDLE)	2. SOCIAL SECURITY NUMBER

3. I AM APPLYING TO THE FOLLOWING GRADUATE PROGRAM: (DESIGNATION OF PROGRAM AND PROGRAM NRMP CODE)

(NAME OF HOSPITAL) (CITY/STATE)

4. PERSONAL STATEMENT (SEE INSTRUCTIONS. USE ADDITIONAL SHEET, IF NECESSARY.)

NAME: _____ (LAST) (FIRST) (MIDDLE)

Note to Teaching Hospitals and Graduate Programs: This application form is provided by the National Resident Matching Program to students enrolled in the constituent medical schools of the Association of American Medical Colleges. It may be used for all programs regardless of their participation in the Matching Program. It is intended to provide the information commonly requested from applicants. **Hospitals and programs are free to request supplementary information as needed.** Comments on this form should be directed to the Division of Student Programs, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C., 20036.

APPLICATION FOR RESIDENCY – PAGE 2

5. IN ADDITION TO A LETTER FROM THE OFFICE OF THE DEAN OF THE MEDICAL SCHOOL FROM WHICH I WILL GRADUATE, THE FOLLOWING INDIVIDUALS, WHO KNOW MY QUALIFICATIONS WELL, HAVE BEEN ASKED TO WRITE REFERENCES FOR ME:

A. NAME AND TITLE

INSTITUTION

ADDRESS

B. NAME AND TITLE

INSTITUTION

ADDRESS

C. NAME AND TITLE

INSTITUTION

ADDRESS

D. NAME AND TITLE

INSTITUTION

ADDRESS

(CHECK ONE)

☐ I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

☐ I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

SIGNATURE _____ DATE _____

NAME OF APPLICANT – TYPE OR PRINT _____

NOTE: THE SIGNATURE AND DATE ON THIS STATEMENT MUST BE ORIGINAL.

APPLICATION FOR RESIDENCY – PAGE 3

6. NAME (LAST) (FIRST) (MIDDLE)

7. SOCIAL SECURITY NUMBER

8. SHALL PARTICIPATE IN NRMP MATCH ☐ YES ☐ NO

9. NRMP NUMBER

10. PRESENT ADDRESS (STREET) (CITY) (STATE) (ZIP)

11. PRESENT PHONE NOS.
DAY ( ) EVENING ( )

12. PERMANENT ADDRESS: (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)
C/O
(STREET) (CITY) (STATE) (ZIP)

13. PERMANENT PHONE NO.
( )

14. NUMBER OF DEPENDENTS

15. CITIZENSHIP
☐ U.S.
☐ OTHER ( )

16. VISA STATUS (IF APPLICABLE)
☐ PERMANENT
☐ TEMPORARY (SPECIFY: ☐ J-1 ☐ H-1)

OPTIONAL
(SEE INSTRUCTIONS)
ATTACH RECENT PHOTOGRAPH
(2" X 2")

17. MEDICAL EDUCATION

MEDICAL SCHOOL(S) (NAME) (CITY) (STATE)

MONTH/YEAR OF MATRICULATION AT MEDICAL SCHOOL

MONTH/YEAR OF (ANTICIPATED) GRADUATION

ELECTIVES COMPLETED/PLANNED (COURSES FOLLOWED BY "P" ARE SENIOR ELECTIVES PLANNED)

HONORS/AWARDS

18. AT THE TIME I BEGIN THE GRADUATE MEDICAL EDUCATION PROGRAM FOR WHICH I AM NOW APPLYING, I WILL HAVE TAKEN THE EXAMINATIONS CHECKED BELOW:

☐ NBME, PART I ☐ NBME, PART II ☐ FEDERATION LICENSING EXAMINATION (FLEX)

19. I HAVE ALREADY PASSED THE EXAMINATIONS CHECKED BELOW ON THE DATES INDICATED:

☐ NBME, PART I: (DATE) ☐ NBME, PART II: (DATE)

☐ FLEX: (DATE) (STATE(S) OF LICENSURE)

APPLICATION FOR RESIDENCY — PAGE 4

20. UNDERGRADUATE EDUCATION

UNDERGRADUATE COLLEGE(S)	DATES ATTENDED FROM (MO./YR.)	DATES ATTENDED TO (MO./YR.)	MAJOR	DEGREE (IF ANY)
NAME A.				
CITY STATE				
NAME B.				
CITY STATE				
NAME C.				
CITY STATE				

21. GRADUATE EDUCATION

GRADUATE SCHOOL(S)	DATES ATTENDED FROM (MO./YR.)	DATES ATTENDED TO (MO./YR.)	AREA OF STUDY	GRADUATE DEGREE (IF ANY)
NAME A.				
CITY STATE				
NAME B.				
CITY STATE				

22. SERVICE OBLIGATIONS (NATIONAL HEALTH SERVICE CORPS, ARMED FORCES SCHOLARSHIP, STATE PROGRAMS, ETC.)

☐ I AM NOT REQUIRED TO FULFILL ANY SERVICE OBLIGATIONS

☐ I AM COMMITTED TO FULFILL A SERVICE OBLIGATION BEGINNING _____ (MO./YR.)

NUMBER OF YEARS COMMITTED _____

23. INTERVIEW SCHEDULING

☐ THE FOLLOWING GENERAL TIME PERIOD(S) IS MOST CONVENIENT FOR ME:

FROM: TO:

☐ I AM ABLE TO SCHEDULE AN INTERVIEW ON THE FOLLOWING SPECIFIC DATE(S):

☐ I AM NOT ABLE TO COME FOR AN INTERVIEW

I HAVE READ AND I UNDERSTAND THE INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION. I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE: I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION.

SIGNATURE OF APPLICANT: _____ DATE: _____

NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL.

OSR MEMBER RESPONSIBILITIES *

Each OSR Representative is the link between his or her school and the OSR and AAMC, and, as such, is responsible for disseminating to other students the information received. While the Administrative Board of the OSR does much of the work, each Representative must also assume an active role in improving OSR's quality, both locally and nationally. In addition to administrative responsibilities, Representatives have the opportunity to build their leadership capabilities and to expand their participation in their own institution, in national issues and in the AAMC.

Each Representative's role will be individually and institutionally shaped, but certain duties come with the position, as outlined below:

A. General Administrative
   1. Distributing OSR Report to all students (help from the student affairs office may be sought).
   2. Sharing information and publications which the official representative receives (e.g., President's Weekly Report), with junior OSR members, other student leaders and faculty and deans, as appropriate. Common avenues for sharing information with the whole student body include a central bulletin board or an OSR file in the library.
   3. Working to achieve continuity of representation and revisions in the OSR member selection process, as needed. Following are examples from three schools.

B. Meetings
   1. The Representative will maintain the necessary contact with the student council or dean's office so that both spring regional and fall national meetings can be attended. Representatives are encouraged to seek funding also for junior members and successors.
   2. Following meetings, representatives should submit a report to the student affairs dean and student council president summarizing highlights of special relevance to the school.

C. Legislative Affairs
   1. The Representative should contact Congressmen as requested via memos from the AAMC President and should respond in a timely manner when asked by the AAMC to conduct a student letter-writing campaign.

*Developed and approved by OSR Administrative Board

EXAMPLES OF OSR MEMBER SELECTION METHODS RECOMMENDED BY STUDENTS

University of Southern California

The OSR representative is elected from the first-year class at the end of the year to serve the next two years. As a sophomore and OSR alternate, the OSR representative's responsibility is to chair five meetings/year of a coordinating committee composed of all students serving on any school curriculum committee and of other interested students. (students involved in political, ethical and service oriented clubs are strongly urged to attend). The role of the OSR alternate is to facilitate program development by coordinating medical student efforts. As a junior, the student serves as the official OSR representative, whose responsibilities are: a) maintain contact with other OSR members on a regional and national level; b) assist the OSR alternate with the coordination committee and act as the student voice to faculty and deans regarding issues of student concern. This arrangement helps make the OSR a productive organization at the school, helps keep students informed regarding national issues, and maintains continuity from year to year.

University of Colorado

The goal at Colorado is to have one person representing the clinical years and another representing the basic science years. When he or she becomes a junior, the current OSR representative contacts the 1st year students about OSR and the issues that OSR deals with on a national level. The students who express interest are then given more details and asked to write a speech and present it to the medical student council. A discussion then follows, and the council decides who the representatives will be. OSR members are expected to remain active until graduation.

Univer[illegible] of Texas-Houston

Each medical school class selects one person to represent that class until graduation. The freshman is selected in time to attend the OSR Spring Regional Meeting. The process is as follows: 1) First-year students' mailboxes are stuffed with description of the OSR position; 2) Interested freshmen meet with current OSR representatives and class officers; 3) Class officers interview students and select one. Therefore, there are three OSR representatives who attend both regional and national meetings: in the Spring - MSI, II, III; National - MSII, III, IV. Who votes is left for the individual OSR representatives to decide among themselves.

OPENINGS ON COMMITTEES FOR STUDENTS

An important way in which student perspectives are brought to bear on issues facing medical educators is through participation on national committees. The committees described below are those for which the OSR Administrative Board will be making nominations during 1987-88. One does not need to be an OSR member to apply for these positions. So please encourage all students who are interested at your school to apply.

Interested students should either complete the attached self-descriptive sheet or submit a curriculum vitae to Wendy Pechacek by November 5 (March 30 for the LCME opening). At the conclusion of the Annual Meeting (November 6-8) the OSR Administrative Board will consider applications received and make recommendations to the AAMC Chair. Students who serve on these committees are responsible for keeping in touch with the OSR Chair on actions and proceedings. This includes summarizing meetings attended in a letter or report for the OSR record.

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

   This committee is composed of financial aid administrators who monitor legislation affecting provision of financial aid to medical students. They also develop publications and programs to assist other financial aid officers in their work. COSFA meets in Washington, D.C. usually in early February, June, and in conjunction with the AAMC Annual Meeting in the fall. AAMC can cover travel to the February and June meetings. Term begins June 1988 and ends with student's graduation from medical school.

2. GSA Committee on Student Affairs:

   Makes recommendations to the GSA Steering Committee regarding issues such as: transition from medical school to residency, student advising, student health, and the problem student. AAMC does not fund travel for this committee. See #1 for description of term.

3. GSA Committee on Admissions:

   Makes recommendations to the GSA Steering Committee in the area of medical school admissions including decreasing the amount of acceptance activity during the summer preceeding matriculation, simplifying medical school prerequisites, and reaffirming affirmative action goals. AAMC does not fund travel for this committee. See #1 for description of terms.

4. 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.

5. Liaison Committee on Medical Education (LCME):

The joint AAMC/AMA Committee is responsible for certifying the quality of American medical schools. It has established the following criteria for the appointment of a student member: a) have commenced the clinical phase of training by July 1988, b) be in good academic standing, c) warrant the judgment that the responsibilities to the LCME would be capably executed. Demonstrated interest in academic medicine and participation on academic affairs committees are also important. This one-year term begins June 1988. The appointment entails extensive reading and attendance at four meetings per year. Contact AAMC Section for Accreditation (202/828-0670) for additional information.

6. National Resident Matching Program (NRMP) Board of Directors:

This Board consists of seventeen persons representing ten organizations and meets once a year in Chicago. The person selected will attend his/her first meeting as an observer in May 1988; the official terms then extend for three years. Applicants must be juniors during 1987-88 and should have demonstrated interest in career and specialty choice concerns of medical students.

7. Association of Teachers of Preventive Medicine Board of Directors:

The liaison representative for this group serves as the primary link between ATPM and the organization he or she is named to represent and will serve as advisor to the Board in its development of policies. The spring meeting is held in Atlanta and the fall meeting is in conjunction with the American Public Health Association; ATPM will fund travel to one meeting. Term begins Spring 1988.

aamc association of american medical colleges

Name:_____ School:_____ Class of: _____

Address: _____

_____

Phone: Day: ( )_____ Evening: ( )_____

Committee or Medical Education Area of Interest:

Education: Degree Institution Date

Research or Extracurricular Activities:

Other Qualifications:

Name of dean who will supply a supporting letter: _____

RETURN TO WENDY PECHACEK, AAMC SECTION FOR STUDENT AND EDUCATIONAL PROGRAMS,
1 Dupont Circle, Suite 200, Washington, DC 20036 by NOVEMBER 5, 1987.

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

SCHOOLS WITH UPCOMING LCME SITE VISITS SCHEDULED FOR 1988-89 ACADEMIC YEAR

University of South Alabama
University of California, San Francisco
University of California, Irvine
University of California, San Diego
University of Connecticut
Georgetown University
University of Kentucky
Tulane University
Boston University
Mayo Medical School
University of Missouri, Kansas City
University of New Mexico
Albany Medical College
Columbia College of Physicians and Surgeons
Cornell University
SUNY-Buffalo
SUNY-Stony Brook
SUNY-Syracuse
Northeastern Ohio
Oral Roberts University
University of Oklahoma
University of Oregon
University of Pittsburgh
Medical University of South Carolina
University of South Dakota
East Tennessee State University
University of Texas, San Antonio
University of Texas, Southwestern
Marshall University
Medical College of Wisconsin
University of Wisconsin

A copy of "The Role of Students in the Accreditation of U.S. Medical Education Programs" will be distributed at the annual business meeting; if your school is listed here, be sure to obtain this booklet. The earlier that planning can occur for student participation in the accreditation process, the better. Please call the AAMC Section for Accreditation (202/828-0670) with questions. Taking a leadership role in this process is an OSR member responsibility.

ACRONYMS USED FREQUENTLY IN AND AROUND THE AAMC

Internal AAMC

CAS - Council of Academic Societies
COD - Council of Deans
COTH - Council of Teaching Hospitals
OSR - Organization of Student Representatives

GBA - Group on Business Affairs
GIP - Group on Institutional Planning
GME - Group on Medical Education
GPA - Group on Public Affairs
GSA - Group on Student Affairs

AMCAS- American Medical College Application Service
MCAT - Medical College Admission Test
MSKP - Medical Science Knowledge Profile

CFMA and the "Liaison Committees"

CFMA - Council for Medical Affairs: AAMC is one of five members, along with the American Medical Association (AMA), American Hospital Association (AHA), American Board of Medical Specialties (ABMS), and Council of Medical Specialty Societies (CMSS). CFMA serves as a forum for discussion on all aspects of medical education.

LCME - Liaison Committee on Medical Education: There are two parent organizations: AAMC and AMA; Secretariat and Chairmanship rotate annually. Responsibility for accreditation of undergraduate medical schools.

ACGME - Accreditation Council for Graduate Medical Education: Same five parents as CFMA. Chairmanship rotates annually. Staffing services provided by AMA. Responsible for accreditation of graduate medical education programs.

ACCME - Accreditation Council for Continuing Medical Education: Same five parents as AFMA, plus Federation of State Medical Boards (FSMB) and Association for Hospital Medical Education (AHME). Staffing for ACCME provided by CMSS.

Educational organizations with whom the AAMC interacts

Representatives are asked to AAMC Executive Council meetings; various reciprocal arrangements exist.

AAHC - Association of Academic Health Centers: Organization members are Vice Presidents for Health Affairs at academic medical centers.

ACE - American Council on Education: Members are some 1,200+ institutions of higher education and 165 national and regional associations and organizations.

AAU - Association of American Universities: Approximately 50 of the preeminent public and private institutions of higher education.

NASULGC- National Association of State Universities and Land-grant Colleges: Membership is approximately 150 major public (land-grant) universities and colleges.

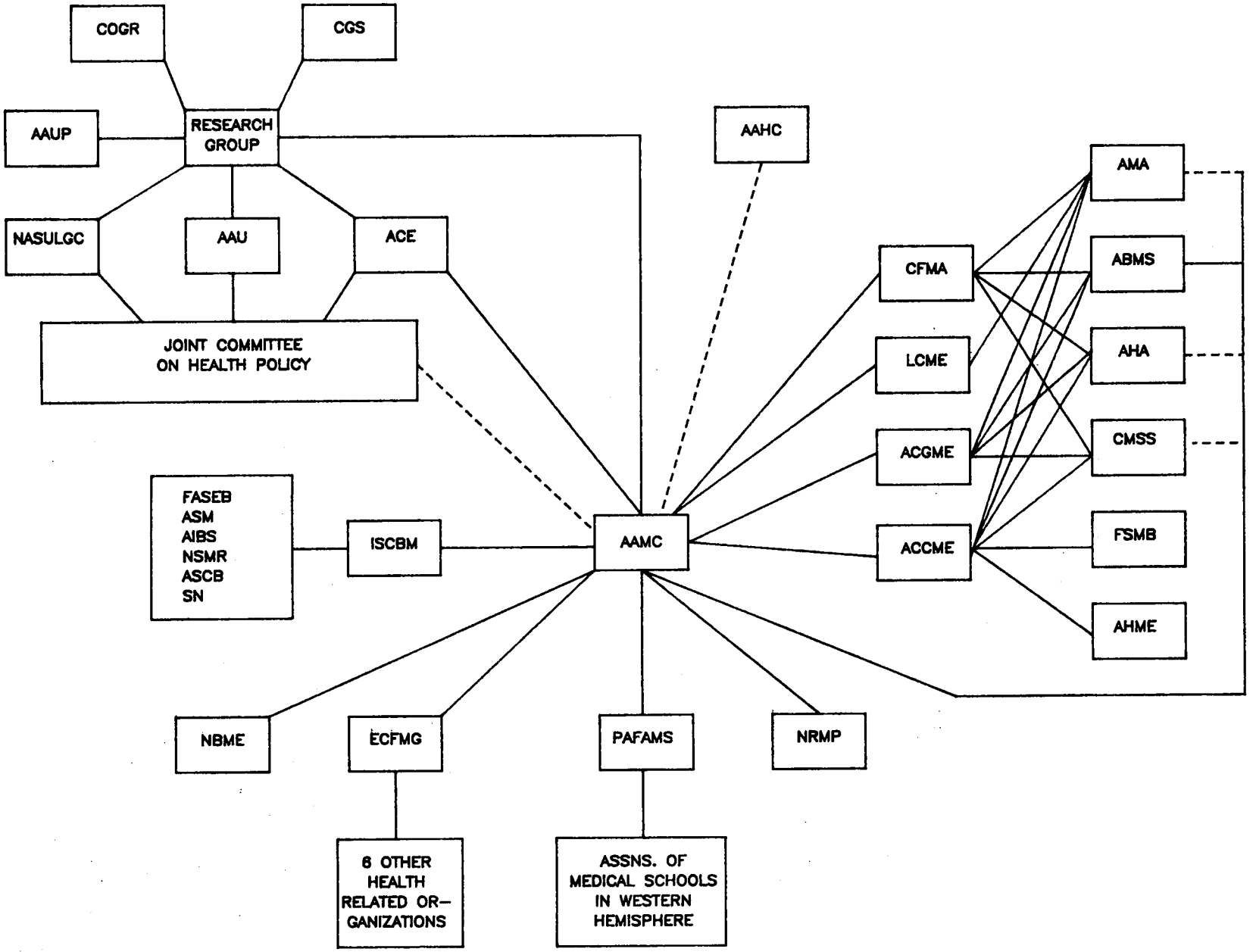
Health organizations with whom the AAMC interacts

NBME - National Board of Medical Examiners: AAMC is a member organization and appoints two members to the Board. NBME is responsible for the three part examination that leads to licensure of physicians.

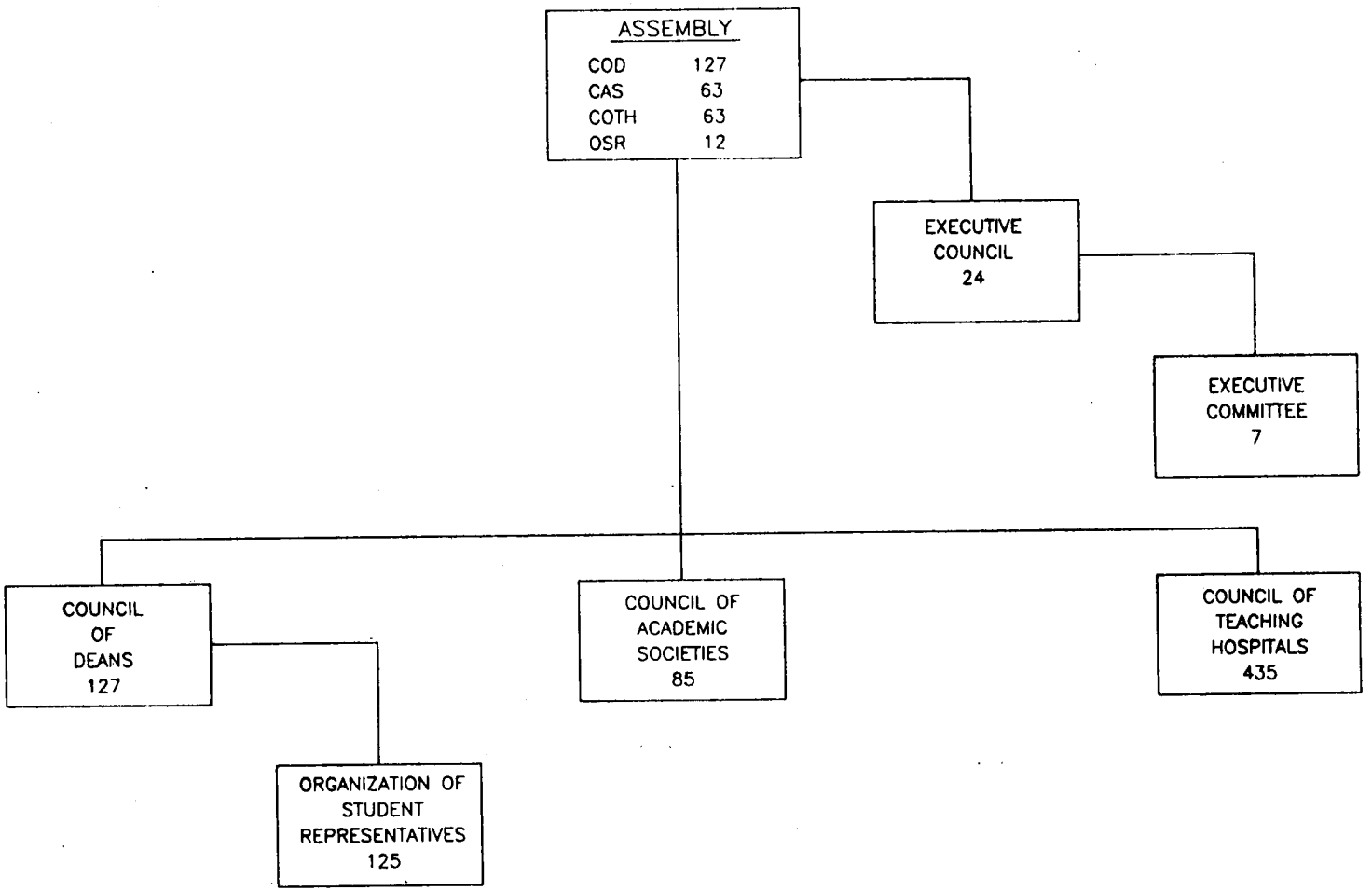
ECFMG - Educational Commission for Foreign Medical Graduates: AAMC is a member organization and appoints two members to the Commission. ECFMG is responsible for evaluating the qualifications of foreign medical graduates seeking admission to the U.S. for graduate medical education.

PAFAMS- Panamerican Federation of Associations of Medical Schools: AAMC was a founding organization. All organizations similar to AAMC throughout the Western Hemisphere belong to PAFAMS.

ISCBM - Intersociety Council for Biology and Medicine: Composed of AAMC, American Society for Microbiology, American Institute for Biological Sciences, National Society for Medical Research, and Federation of American Societies for Experimental Biology (FASEB).



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
GOVERNING STRUCTURE



Executive Committee:
Chairman: *Edward J. Stemmler, M.D., University of Pennsylvania School of Medicine*
Chairman–Elect: *John W. Colloton, University of Iowa Hospitals and Clinics*
Immediate Past Chairman: *Virginia V. Weldon, M.D., Washington University*
Chairman, COD: *Louis J. Kettel, M.D., University of Arizona College of Medicine*
Chairman, CAS: *Frank D. Moody, M.D., University of Texas, Houston, Medical School*
Chairman, COTH: *Spencer Foreman, M.D., Montefiore Medical Center*
President: Robert G. Petersdorf, M.D.

1987 OSR MEETING DATES

OSR Administrative Board:

February 24-25

June 22-23

September 7-8

OSR/GSA Regional Meetings:

Northeast	April 13-15	Montreal
Central	April 17-20	Chicago
Western	April 24-27	Asilomar
Southern	April 27-29	Memphis

AAMC Annual Meeting:

Chicago, IL	November 11 - 17

Annual Business Meeting Minutes
Association of American Medical Colleges
Organization of Student Representatives

November 6 and 8, 1987
Washington Hilton and Towers
Washington, D.C.

I. Remarks from OSR Chair

Dr. Vicki Darrow called the meeting to order at 4:40 p.m. and welcomed everyone to the meeting. She reviewed the agenda for this half of the business meeting, then introduced Dr. Robert G. Petersdorf.

II. Remarks from AAMC President

Dr. Petersdorf greeted the OSR and presented a detailed overview of the structure, and current initiatives of the AAMC membership and staff.

III. Remarks from Assistant Vice President for Student and Educational Programs

Dr. Robert Beran also greeted the group and noted that his section staffs the OSR. He updated the group on the progress of the transition report, including the November 1 release date for dean's letters. He also announced a new component to the AAMC MEDLOANS program whereby students can, for no charge, refinance ALAS loans currently at 12% or 14% interest to a variable rate SLS loan (currently 10.27%) with a 12% cap. He encouraged students to ask questions of staff on any issues of concern to them.

IV. Nominations for OSR Offices

The following OSR members were nominated:

Chair-elect:	Clayton Ballantine, Louisville Sarah Johansen, Dartmouth
Representative-At-Large:	Michael Stuntz, Arizona Andy Spooner, Tennessee Susan Toth, Miami

V. Remarks from the Immediate Past Chair

Dr. Rick Peters urged students to always remember why they are going into medicine. He spoke of residents who have forgotten why and are now driven by other agendas. He shared his feeling that being in medicine is a choice that each person makes. Therefore, although we do make sacrifices, we need to remember that we chose to do this, rather than expecting that we deserve some undefined extra reward because we went through it. He expressed the belief

that if students always remember what idealism led them to the field, they will be able to find what they were looking for.

VI. More Remarks from the OSR Chair

Dr. Vicki Darrow reviewed the accomplishments of the Ad Board, and therefore of the OSR, over the past year. She then introduced the Ad Board, as well as the new regional chairs: Jeralyn Bernier, Brown; Julie Drier, U of Minnesota-Minneapolis; Cynthia Carlson, U of Washington; Dan Shapiro, Emory.

Dr. Darrow pointed out the new OSR publication Progress Notes, and asked for feedback on it from the group. She also noted that a new question has been added to the 1988 Graduation Questionnaire which will gather data about discriminatory questions which may be being asked during residency interviews.

VII. CONFER Computer Network

Andy Spooner, OSR Representative-At-Large, introduced the group to his computer and to the CONFERencing computer network. He encouraged students to attend demonstrations of the system throughout the weekend and to GET INVOLVED.

VIII. Synthesis and Initiation

Dr. Tom Sherman, Northeast Region Chair, introduced the concept of synthesis and initiation. He asked students to listen and to be active during the meeting. He requested that they "store" questions and ideas about how to relate what they learned over this weekend to their own school and program.

Students could attend the session entitled, "Synthesis and Initiation" on Sunday morning to process and exchange this material/information.

IX. The meeting recessed at 5:50 p.m.

X. Dr. Vicki Darrow recalled the meeting to order at 1:45 p.m. on Sunday, November 8 and, re-opened nominations for national officers.

XI. Additional Nominations

Chair-elect: Michael Gonzalez-Campoy, Mayo

Representative-At-Large: Deborah Capko, UMDNJ-New Jersey Med
Kevin Flanigan, Rush
Maribel Garcia-Soto, UCSF
Sandra Groeber, Penn State
Laleh Koochek, UNC
Brian McGrory, Columbia
Richey Newman, Med Coll of PA
Bill Obremskey, Duke

Caroline Reich, Emory
Mike Rush, Kentucky
Debbie Weiner, U So California

XII. Elections

The OSR elected Clayton Ballantine to the office of Chair-elect.

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

Michael Gonzalez-Campoy, Mayo
Sarah Johansen, Dartmouth

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

Maribel Garcia-Soto
Sarah Johansen
Bill Obremskey
Mike Rush
Andy Spooner

XIII. NBME Pass/Fail

Vicki Darrow, M.D. reviewed what had happened to the initiative to have NBME scores reported Pass/Fail only during the past year. She concluded the review by reading a statement which she and Kim Dunn had read to the AAMC Executive Council reiterating OSR's stand on this issue. Students asked what might be done at this point to keep the issue from being buried. Suggestions from the floor included: a) talk with your medical school faculty -- as they are currently using the scores for curriculum development and evaluation, b) write to the AMA and the AAMC to express your concerns, c) refuse to provide your scores to program directors in interviews.

XIV. Stanford Health Policy Forum

David Zucker, OSR rep from Stanford, announced this year's forum, "How Changing Health Care Policy Will Affect People," focusing on topics such as AIDS, Health Manpower, and Indigent Care. The Forum will be held January 29-30, 1988, at Stanford.

XV. Task Force on AIDS

Kevin Flanigan, Rush, reviewed the first meeting of the AAMC Task Force on AIDS where he serves as the student representative. He requested that students send him any information/policy statements on what is happening at their schools. He is currently developing a survey for Rush students and, when it is completed, will send a copy to all OSR representatives.

XVI. Transition Forum

Joanne Fruth, M.D., OSR Representative-At-Large, reported on the Forum for Transition Issues which was held earlier that afternoon. She reported that, despite problems this initial year, participants had agreed to continue with a November 1 release date for deans' letters in 1988. She asked that OSR reps review the Universal Application Form in the Agenda and forward any suggestions for improvements to Wendy Pechacek at the AAMC.

Dr. Fruth also distributed a summary of the OSR-ATPM survey of good courses in health promotion and disease prevention which she did over the past year.

XVII. Remarks from Leaders of Other Medical Student Groups

A. Jeffrey Henderson, Association of Native American Medical Students, introduced his group and its purpose. He answered several questions from the floor regarding the Indian Health Service.

B. Howard Pomeranz, AMA-MSS, described that group and their current initiatives.

C. Tien-Bao Chao, American Medical Women's Association also introduced herself and AMWA's charge.

XVIII. Closing Remarks

Kimberly Dunn, OSR Chair, thanked Vicki Darrow, M.D., and Wendy Pechacek, OSR Staff Director, for their work during the past year and presented them with tokens of appreciation. She then urged the OSR to keep up their enthusiasm over the coming year for positive change in medical education. Kim Dunn adjourned the meeting at 4:45 p.m.