[No date, 1976]

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

OSR NEWSLETTER #1

TO: OSR Representatives

FROM: Rich Seigle

My first newsletter is an important one which requires your immediate attention. It consists of two "dissertations" on events and history surrounding the housestaff and health manpower resolutions enacted by the OSR at the Annual Meeting, the actions which were taken on these resolutions before the AAMC Retreat, and a questionnaire for you to complete and return.

These summaries will bring you up-to-date on the last few days of the Annual Meeting and on the events that have transpired since. Tom Rado and I attended the AAMC Retreat on December 11 and 12. The discussions which took place there were positive, and we reached a better understanding with the other AAMC officers of the role of OSR within AAMC. Dr. Cronkite, Chairman of AAMC, agreed that the process by which the Association had developed its position on housestaff neglected OSR input and assured us that the mistakes made will not be repeated. Tom and I felt that, in light of the positive discussions we had there, OSR's input in the AAMC will become more effective and we consequently agreed that it will be unnecessary for OSR to go outside the Association with dissenting views.

Please return the questionnaire by January 4, 1975.

HISTORY OF AMICUS CURIAE AND MANPOWER LEGISLATION

AMICUS CURIAE

April 1975 - At the Executive Council meeting, it was moved that the AAMC request their lawyers to submit a Friend of the Courts (Amicus Curiae) Brief to the National Labor Relations Board (NLRB) supporting the stand that house-staff should be considered students, not employees. There was one dissenting vote-Mark Cannon's.

May 1975 - Copies of the brief were sent to all members of the AAMC with an introduction by Dr. Cooper stating "It is my opinion that the brief should not only be viewed as a legal instrument - it is also a scholarly document that addresses the fundamental content, structure and function of Graduate Medical Education vis-a-vis the role and activities of Interns and Residents."

June 1975 - At the OSR Administrative Board meeting, Mark read a statement he had written outlining specific objections to the brief and requesting that AAMC disclaim the brief as an enunciation of AAMC policy. The Administrative Board voted to table the statement.

September 1975 - At the Administrative Board meeting, the statement was reintroduced with some modifications in wording and was passed to be read to the Executive Council. The statement concluded with "the OSR Administrative Board disagrees with this brief in spirit and finds particular fault in the points raised above." The statement was read in full to the Executive Council.

November 1975 - Resolution was passed at the National meeting mandating the OSR to present its dissenting views to its constituents, the NLRB, and the public. The resolution was read in the public assembly meeting November 4, 1975. The assembly voted that we not act on this resolution until it could be discussed further at the AAMC Retreat on December 10.

Final Action by the OSR - Our dissenting view is being expressed to our members in the minutes of the National meeting and to our constituents in the OSR Bulletin Board. Several medically-related magazines covered our dissenting views expressed at the Assembly meeting and will convey those to the public. The OSR will send its view to the Secretary of the NLRB.

HEALTH MANPOWER LEGISLATION (HML)

November, 1974 - January, 1975 - A discussion group on Health Manpower Legislation was chaired by Ernie Turner at the Annual Meeting. Resolutions passed by the OSR stated:

1. That the medical community should voluntarily act to set up programs to solve the maldistribution of primary care and the heavy expense of medical education.

2. That if mandatory service is required, it should be required of all health professionals.

3. That programs established must receive adequate financial support.

and more specifically that the OSR:

a. Opposes mandatory service by medical students.

b. Opposes service for a certain percentage of medical students as this is discriminatory against those who must accept financial aid.

c. Requests expansion and improvement of voluntary programs.

d. Requests AAMC to emphasize oversubscription to current voluntary programs.

e. Requests increase and improvement of primary care training opportunities.

The AAMC decided at the Annual Meeting to establish a task force on HML. Ernie Turner was on that task force with eight other members of AAMC. They completed their report by January and this report was reviewed and modified by the councils and the OSR. Comparing the task force final report to the OSR resolution, the AAMC position satisfied all the OSR recommendations except the provision that the medical community voluntarily solve the Nation's health care deficiencies. In the AAMC position, these improvements were conditions for capitation.

June 1975 - The Executive Committee was invited to meet with Senator Kennedy and Representative Rogers. Since the OSR does not have a representative on the Executive Committee, we requested that Steve Scholle be included in this group, and Steve was invited to attend the meetings with both congressmen. At one point in the meeting, Rogers asked Steve, "What do the students think about this?"

November 2, 1975 - The OSR passed the resolution that appears in the minutes.

Briefly the OSR stand as of November on specific issues is:

1. NHSC scholarships should be made available to all students desiring them.

2. NHSC placement should be flexible and perhaps patterned after the National Intern and Resident Matching Program.

3. Low interest student loans should be made available to individuals who need financial aid.

4. Capitation should be eliminated and special project money should be given for specific projects designed to:

   a. Establish remote site training for undergraduate medical students;

b. Provide primary care training for medical students;

c. Increase training of nurse practitioners and physician extenders.

5. Residency positions in primary care should be established in underserved areas with sufficient positions to accommodate the number of applicants.

November 10, 1975 - Bob Bernstein drafted a letter at my request to be sent to health subcommittee members. These were typed and names of Congressmen obtained.

November 13, 14, 1975 - I was called by Drs. Cooper and Swanson to vote on changing the AAMC position on specific topics. (See "Summary of Events concerning Resolutions" in this newsletter.) The outcome was agreement with three of the four positions. At that time, I reasserted our major differences concerning capitation money and stressed that the OSR dissenting views should be made known.

Final Action as of November 23, 1975 - Between the National meeting and this date, I heard views expressed by several board members on both sides of this issue. It became apparent that there was no "right" or "easy" action to take. Perhaps I can state both sides as I see it for acting on the resolution to disseminate our position on HML to members of the health subcommittees.

Pro- 1. Satisfies the mandate of the OSR members.

2. OSR has taken an independent stand and made known its dissenting view from the AAMC position.

3. The resolution may affect the legislation decided on in the Senate and in the compromise sessions between the House and Senate.

Con- 1. The OSR had effective input into the AAMC position and their bill reflects this. If it were passed, the OSR would be satisfied with it.

2. The resolution proposes in sections 1 and 5 positions that could not be carried out financially by the Congress or the Administration.

3. We might lose effectiveness in presenting our other issues of concern to the AAMC by acting on this resolution before the retreat.

Because I could see both sides to the position and could not defend one against the other, I felt the best decision at this time was not to act before the Retreat on December 10.

Final Notes -

a. I urge you to send in your current feelings on these positions so I can get an up-to-date sense of how the OSR members feel about the new developments I have presented.

b. The OSR position on health manpower primarily differed from the AAMC's position in regard to providions for capitation since we recommended the elimination of capitation. The elimination of capitation by Congress would have to be accompanied by a concomitant increase in NHSC scholarship for everyone needing them--a politically infeasible proposal. Faced with a situation that could jeopardize our relationship within AAMC and since the events surrounding the manpower resolution differed significantly from those surrounding the housestaff resolution, I obtained input from the Administrative Board and finally chose not to act.

c. As I mentioned in the covering memo, we reached an agreement with AAMC officers at the Retreat that we will act on "good faith" in the future. AAMC has agreed to be more responsive to our input and to make no major policy decisions without consultation with OSR. In return, we agreed that it will be unnecessary for OSR to express dissenting views publically and that we will work to maximize our input into AAMC positions.

SUMMARY OF EVENTS SURROUNDING THE HOUSESTAFF AND MANPOWER RESOLUTIONS AFTER PASSAGE ON SUNDAY AFTERNOON, 3-6 P.M.

Copies of the resolutions were given to the COD Administrative Board on Monday morning. Mark presented the resolutions and asked for questions. Dr. Bennett, Chairman of COD replied, "No Mark, I think it is clear what you plan to do." There was no discussion or action by the COD at that time.

On Tuesday morning, the board members who were still available were invited to an informal lunch with some members of the COD Administrative Board. We discussed our plans for acting on the resolutions which mandated that our views be publicly expressed. During the discussion, OSR officers expressed the feeling that publicizing dissenting views was somewhat of an obligation since it had been mandated by the OSR; on the other hand, we realized that effective work within the AAMC might be jeopardized by "going public." We emphasized the strength of the OSR mandate by pointing out that one resolution had been introduced (but subsequently defeated)urging OSR Administrative Board members to resign if the resolutions to express dissenting views could not be "implemented in such a manner as to lend identity and integrity to the OSR position." We also discussed the fact that since the Assembly meeting would be a public forum, and that there would be press present, anything read in that meeting would be public. COD board members pointed out that although they did not always agree with positions reached by AAMC, they felt that they had the option of writing letters expressing their individual dissenting views but that it was inappropriate for the council itself to take a dissenting opinion to the public.

At the Assembly meeting on Tuesday afternoon, Mark presented the content of the housestaff resolution explaining that the OSR had been aware when it voted 80 to 5 in favor of the resolution, that its action was contrary to the policy that AAMC speaks with a single voice. Mark also reported that our health manpower resolution was approved with a stipulation that it be sent to members of the health subcommittee members. A motion was approved in the Assembly that the OSR not act on its resolutions until they could be discussed further with other AAMC officers at the Retreat. Following this action by the Assembly, Mark stated that the OSR officers would ultimately decide on a course of action since they had a strong and informed mandate from their constituency for action. Following the meeting Mark and I were approached by reporters from several medical magazines to explain what the OSR was and to answer some questions about the resolutions.

In a later meeting with Dr. Gronvall, the newly-elected chairman of COD, Mark, and myself, Dr. Gronvall pointed out that action by the OSR at this time would be contradictory to the sense of the Assembly resolution. He further pointed out that such action would not be approved by the COD and that the OSR would be exercising a policy not in accordance with the tenets of AAMC. We ended the meeting by asserting the importance of our working more closely with our natural ally, the COD. I invited Dr. Gronvall to the January Administrative Board meeting, and he said he would plan to attned.

On the following morning, a meeting of the Executive Council was held to meet with Leroy Goldman, Senator Kennedy's staff assistant. He presented an up-date on Senate Subcommittee views. After he left, the Council discussed changing its stand

on some issues in light of more recent developments. The Executive Council voted that the Executive Committee would make a decision regarding these issues and that I be included in the committee decision. Also at this meeting, Dr. Gronvall handed me a letter stated that as chairman of the COD, he would not approve of our expressing our dissenting views to the public.

On November 13, Dr. Cooper, Dr. Swanson, and myself discussed the modification of AAMC's stance on some of the health manpower issues by conference call. AAMC was scheduled to testify before Senator Kennedy's committee on November 18. The issues discussed and my reaction to them are as follows:

1) If a school is required to have a fixed percentage of its entering class signed up for NHSC scholarships in order to receive capitation, the AAMC requests that this percentage be applied over new scholarships consigned from other classes that year. If the government wants 25% of an entering class of 100 to be signed up, this would mean that if 25 students in the third, second or first year class signed up for commitments, the school would satisfy its requirement. There are several advantages to this method and I voted to approve this change.

2) The second issue concerns an administration proposal that a school must set up an administrative unit in primary care or ambulatory care in order to receive capitation. The AAMC proposed stand was to point out that 90% of schools already satisfy this condition but to object to such direct involvement in curriculum by the government. I did not agree with this stand stating that "the student group feels this is a necessary step in satisfying the nation's health needs that should be voluntarily carried out by each medical school." I reiterated that our main area of dissent was that capitation should not exist at all and that more special project money be made available for projects such as this.

3) If the government plans to have a specified percentage of residencies in primary care, the AAMC recommends that this not be a definite percentage but regulated by CCME. AAMC would point out that CCME has already stated that 50% of residencies should be in primary care. I agreed with this position, adding that HEW should be involved in this process and that CCME should be given a time limit to carry out this aim. If they have not, another group should be designated.

4) AAMC would recommend that low interest leans be made available to needy students not wishing to sign up for scholarship commitments. AAMC would ask for an appropriation of $50 million instead of a proposed $15-10-5 million. This stand is in accordance with our resolution.

I submitted a written statement expressing the OSR views that I have mentioned above to AAMC. I concluded this statement with, "The OSR requests that its assenting as well as dissenting voice be included in the AAMC positions. The strength of AAMC's presentation should lie in the honest representation of the view of its voting members, in this case the Executive Committee. A yes/no vote on four points is practically no vote at all, as far as the OSR viewpoint is concerned. When AAMC mentions or is asked for the OSR position on these issues, it has an obligation to present our assenting and dissenting opinions, for the sake of its own credibility and the credibility of the OSR."

DRAFT

1975-76 OSR QUESIONNAIRE #1

In the interest of guiding the officers of the OSR who must make decisions in "real time," and in the interest of having the broadest possible participatory base for the OSR, we request your responses to the following questions. Please return this form in the enclosed envelope to AAMC by January 4, 1976. The response rate will affect the frequency of future questionnaires.

1) On a scale of 1 (throw the bums out) to 10 (couldn't have been handled better), how fully do you agree with the actions taken thus far. _____

2) With what actions would you have been fully satisfied? Please be specific. An understanding of your goals will be most important in guiding future decisions.

3,a) Are you comfortable with the role of OSR as a student group which works within a larger organization?

b) If the situation in the AAMC is such that the OSR may be overruled on any given issue, how should we work to maximize our voice?

4) Do you have in mind any specific goals to be sought at the January Administrative Board meeting?

5) Has your school elected an OSR alternate?

6) If your answer to 5) was "yes," will the alternate automatically become the next official OSR representative of your school?

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NEWSLETTER

TO: OSR Members

FROM: Tom Rado, Vice Chairperson

The purpose of this newsletter is to bring you up-to-date on some of the happenings at the recent Administrative Board meeting. Rich's newsletter and the minutes of the meeting are forthcoming, and these will apprise you of the discussions which took place in other areas.

One major issue which was discussed was financing education in the ambulatory care setting. The staff of COTH described the out-patient clinics of teaching hospitals as a major financial drain indicating that the cost of running an out-patient facility increases with the amount of teaching that goes on. While it's true that some clinics especially in areas like Opthamology and ENT are self-supporting, existing data indicates that in most instances quite the opposite is the case. Part of the problem arises from the imposition of stringent uniform accounting practices that tend to compartmentalize a hospital's funds, and make it very difficult for a losing proposition to be shored up by more healthy aspects of the operation.

Attached to this newsletter is a statement which presents the issue and outlines the probable causes for operating deficits of teaching hospital ambulatory care programs. This issue is quite complex, but this statement presents a fairly clear assessment of it.

While the accounting methods employed at major hospital centers are entirely beyond me, I am quite confident that the concerns raised by COTH staff and the Executive Council are quite real. In the course of our discussion of this matter I felt that it would be useful if we obtained some data from our

constituency on just how important is the undergraduate teaching function of the out-patient facility at our various institutions. In an effort to determine this I would appreciate hearing from you regarding the relative importance of ambulatory care facilities in the required clinical clerkships. You might want to report this in terms of the percentage of time that junior students spend in out-patient clinics in each of the following basic rotations: medicine, surgery, psychiatry, ob-gyn, pediatrics. Do you feel that this is an adequate amount of time, that it is too little, or that it is too much? Do you feel that the student's function in the OPD is primarily a learning experience, or primarily a provider of "scut" service? Please indicate your views on the attached questionnaire and return it to Diane Mathews for compilation. I want to underline very strongly that if OSR is to function in a truly vital (as opposed to a rubber stamp or reactive) capacity we must be willing to expend the necessary effort to obtain the sort of data that allows us to speak authoritatively for our constituency.

One of the areas in which AAMC and OSR will become very active within the next year or so is in developing an assessment of how students finance their medical education. Some data presented at the Executive Council meeting suggests to me that while we were engaged elsewhere, a crises has crept up on us. The AAMC has undertaken a study to obtain preliminary data on the problem, and some of the results of that study were quite alarming and I would like to present them to you in this newsletter. In a report to the Council of Deans it was observed that as federal support for medical students and guaranteed loans became increasingly scarce, entering medical students were drawn from an applicant pool whose net family income has been increasing. Thus, decreasing support for medical students has led to the appearance of an increasingly well-to-do applicant pool. As an example, during the period from 1964 to 1971 the number of students receiving loans and non-refundable grants increased from 31% in 1964 to 54% in 1971. During the same period the percentage receiving direct support from their families decreased from 71% to 54%. In contrast to these trends the proportion of students receiving loans and the proportion of students receiving non-refundable grants decreased between 1971 and the present period. At the same time the proportion of students reporting gifts or loans from their families increased from 54% to 64% when the last figures were obtained in 1975. More direct evidence for the existence of this problem may be drawn from the following data: In a 1973-1974 survey 24.2% of responding applicants reported that their family income was in the range of $10,000 to $11,999. The same survey conducted with 1974-1975 applicants has shown that only 12.4% reported their family income to be in that bracket. On the contrary in 1973-74, 32.9% of the applicants reported that their family income was in the range of $15,000 to $50,000 per year; in 1974-75 that figure had risen to 53.4% of the applicants. There is no reason to suppose that the trend will be reversed by itself. The Health Professions Scholarship Program which supplied $6.3 million to medical schools in fiscal 1974 was reduced to $2.8 million in fiscal 1975. This year it has been eliminated entirely. In 1975 $15.1 million were available to medical schools through the Health Professions Loan Program. This has presently been reduced to less than $10 million and first-year students are no longer eligible for these funds. In addition financial aid officers across the country are reporting that it is exceedingly difficult this year for medical students to receive funds from banks through the Federally Insured Guaranteed Student Loan Program which in 1974-75 supplied 28.3 million dollars to medical students.

The rest of the picture is similarly bleak. As students we are all aware of the problems involved with the Public Health Service/National Health Service Corps Scholarship Program and the Military Health Professions Scholarship Programs. Private funds such as ~~the~~ Robert Wood Johnson and National Medical Fellowships are also decreasing significantly.

I think that you will share my view that this is at most a distrubing picture. I know that the Council of Deans and the Executive Council will want OSR to join with them in developing some sort of strategy to reverse these dangerous trends. I urge all of you to think seriously about these problems and to mull over any possible ameliorative approaches which suggest themselves to you. We'll be talking more about this in future newsletters.

The Administrative Board explored the possibility of increasing the level of student input into AAMC decision-making by bringing about two changes. First, we suggested that the Chairperson of OSR be appointed to the Executive Committee. This group presently composed of six individuals, is extremely powerful. According to the AAMC Bylaws, it has the full power and authority to act in lieu of Executive Council when this body is not in session and to act on behalf of and to manage the affairs of the Association and to make any and all necessary and appropriate policy interpretations on behalf of the Executive Council. Although the Executive Council did not approve our motion, there was considerable feeling that the suggestion was not inappropriate. Several members of the Council voted with us, and when the motion was defeated it was decided that Rich will be consulted by Executive Committee on all matters of interest to students, in spite of the fact that he will not be a voting member. There is not doubt in my mind that this represents considerable progress over the stalemate which has in previous years surrounded suggestions such as these. The other area in which we thought to increase OSR input was to increase the number of votes on Executive Council from one to two, by including the Vice Chairperson as a voting member. This request will be referred to an AAMC committee which will be formed in the near future to review all such requests for a change in AAMC governance and structure. We did have an opportunity to discuss increasing the number of OSR votes on the Executive Council with the COD Administrative Board, and after lengthy discussion it became evident to me that the Council opposed it not because they were afraid of an additional vote, but because it included no proviso for insuring some level of continuity in the student representation. I think that one alternative might be for the OSR to request that the Chairperson and Immediate Past-Chairperson be voting members of Executive Council. This would allow for one new member and one two-year member to be continually present.

Lastly, I'd like to remind you that at the Annual Meeting we passed a resolution urging that some guidelines be drawn up regarding the amount of service performed by third and fourth year medical students. These guidelines included the total number of hours in hospital per week, the number of night-calls to be permitted, a minimum level of student-level seminars or teaching programs, and a position statement on the amount of "scut work" medical students ought to be doing. The resolution included no action statement however, and I will attempt to fulfill it by bringing it up at the upcoming meeting of the Group on Student Affairs in the hopes that deans of students will take a more active interest in this problem.

I'm sorry this was so long, but I felt that these were items you needed to be apprised of. Stay in touch.

OSR QUESTIONNAIRE #2

Educational Programs in the Ambulatory Care Setting

PLEASE RETURN COMPLETED QUESTIONNAIRE TO AAMC IN THE ENCLOSED POSTAGE PAID SELF-ADDRESSED ENVELOPE BY MARCH 5, 1976.

_____
Name of Respondent (Optional)

_____
Name of School (Optional)

During required clinical rotations through each of the following areas, please estimate the percentage of total time spent in out-patient clinics. Also indicate if you feel this is too much, too little, or "just right" amount of time. You might want to take an informal poll of your colleagues if you have not yet done one of these rotations, or if you feel that your personal experience was unique.

MEDICINE:-- Percent time in OPD:_____
_____ Too Much _____ Too Little _____ Just Right

Comments:_____

SURGERY -- Percent time in OPD:
_____ Too Much _____ Too Little _____ Just Right

Comments: _____

PSYCHIATRY -- Percent time in OPD:
_____ Too Much _____ Too Little _____ Just Right

Comments: _____

OB-GYN -- Percent time in OPD:
_____ Too Much _____ Too Little _____ Just Right

Comments: _____

PEDIATRICS -- Percent time in OPD:
_____ Too Much _____ Too Little _____ Just Right

Comments: _____

OTHER -- -- Percent time in OPD:
_____ Too Much _____ Too Little _____ Just Right

Comments: _____

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MEMORANDUM

TO: OSR Representatives

FROM: Tom Rado, OSR Vice-Chairperson

The last meeting of the OSR Administrative Board was a brief but busy one, and a number of rather important topics were discussed. In this newsletter and in the one you recently received from Rich, we hope to bring you up-to-date on the major issues of interest to OSR.

I will first mention that the AAMC Executive Council approved the formation of an ad hoc Committee on Continuing Medical Education for a period of two years. This committee will concern itself with the various issues and implications of the rapidly expanding field of continuing medical education. It is important that OSR have a representative on this committee, and if you are interested in this area and are able to serve a two-year term, please forward a curriculum vitae to your regional chairperson as soon as posssible.

On the national level, I think that the two most important events at the board meeting were the decision reached by the National Labor Relations Board (NLRB) regarding housestaff, and a study which was recently presented to Congress by the Institute of Medicine (IOM) on Medicare-Medicaid Reimbursement Policies. As you are probably aware by now, NLRB heard the case of Cedars-Sinai Medical Center in Los Angeles vs. the Cedars-Sinai Housestaff Association. In this case, the housestaff sought recognition as a labor organization in order to gain the protection of the National Labor Relations Act. This act guarantees among other things that after a vote by the conerned employees, a labor organization must be recognized in collective bargaining, and that legal strikes will not be met with mass lay-offs and possible criminal penalties. AAMC filed an amicus brief supporting the position that housestaff, being students, were not employees and therefore not qualified for the protection of the Act. The Physician's National Housestaff Association (PNHA) filed an amicus brief supporting the position of the housestaff. At our Annual Meeting, we voted to support the interns and residents in their efforts, and we sent to NLRB a letter stating our support for PNHA's position. The NLRB decision, which is in some respects precedent-setting, found that "the interns, residents, and clinical fellows are not employees within the meaning of the Act...and that the petitioner is not a labor organization within the meaning of the Act." The NLRB accepted the argument of AAMC that since most physicians take internships, residencies, and fellowships in order to qualify for certification, the years spent in these programs are truly a part of medical education. The Board further reasoned that since the pay received by housestaff is not determined by the nature of services rendered or by the number of hours spent in patient care, this pay is truly a stipend. A stipend is considered a scholarship for graduate study, and therefore not subject to negotiation through collective bargaining.

The NLRB decision was not unanimous, and one member, John H. Fanning, dissented from the four-to-one decision. In his minority opinion he argued that the Labor

Relations Act includes any employee unless the Act explicitly states otherwise and that students are not among the specific exclusions. Using the example of apprentices in various trades, he states "the fundamental question then is always whether the individual before (the Board) be that individual 'primarily a carpenter' or 'primarily a student' is nevertheless an employee under the Act." The rest of Fanning's dissent is based primarily on a careful analysis of housestaff working conditions in which he eloquently describes the long hours and limited supervision which almost universally characterize housestaff work.

By coincidence the NLRB decision came on the eve of the Administrative Board meeting. AAMC issued a statement essentially congratulating NLRB on their wisdom and Bob Harmon, President of PNHA, issued one denouncing the decision. Both statements were hurriedly arrived at and neither contained an analysis of where do we go from here. In the course of our discussions, the board noted that AAMC does not have a formal position statement regarding the educational quality of housestaff programs. After some discussion, we unanimously adopted the following resolution:

> In light of the recent decision by NLRB in the case of Cedars-Sinai Housestaff Association vs. Cedars-Sinai Hospital, it becomes increasingly important that the educational quality of the postgraduate medical experience be protected from erosion by excessive demands for the provision of services.
>
> THEREFORE, BE IT RESOLVED THAT:
>
> 1. The AAMC develop a formal position statement commiting the Association to the primacy of learning over service in graduate programs;
> 2. Accrediting commissions be urged to obtain input from housestaff regarding the educational quality of their programs;
> 3. Residents should be informed, perhaps through an accreditation pamphlet, of the importance of their input to the accreditation process;
> 4. The AAMC should make every effort to ensure adequate representation of housestaff views before the Association.

I think you will agree that this resolution is somewhat of a compromise. On the one hand, we felt it essential that OSR take a positive position in the face of the NLRB decision. On the other hand, we have not heard from housestaff representatives yet and believe it important that we hear their views prior to adopting a final stand. When this resolution was brought up before the Executive Council, the following statement was approved: "The Executive Council notes the OSR resolution, indicates its concern with the matter of housestaff education, and agrees to explore with positive intent the issues raised by the OSR." Rich and I felt that this was the most that we could possibly hope to get from the Executive Council at this rather confused time. I strongly urge all of you to be thinking about the problems generated by the NLRB decision, and to let me know if you have any thoughts regarding possible OSR positions and avenues of action which might be productive.

The next national item that we discussed was the Institute of Medicine's Study of Medicare-Medicaid Reimbursement Policies. Some of the issues addressed in the study include possible mechanisms for reimbursing teaching physicians, an area in which present Medicare-Medicaid regulations are inadequate. The entire study, however, is much more wide-ranging than that. Recommendations are made regarding means of achieving geographical redistribution of physicians with respect to specialty, and the relative level of input by foreign medical graduates. With regard to geographical

distribution, the study recommends that Medicare-Medicaid funds should be used as an incentive to support the expansion of training opportunities in the contact physician specialties. One recommendation in the study that the Executive Council specifically disagreed with was that with the exception of family practice, general internal medicine, and general pediatrics, the number of all other post-graduate training slots available as of July 1, 1977 be frozen at the level of positions filled as of July 1, 1975.

The study also suggested that Medicaid practices which pay physicians at lower levels in some geographic areas than in others be discontinued. It notes that the present number of residency slots may be greater now than the number which will be available in the mid-1980's, due to a possible reduction in the number of approved programs. This decrease in available slots will affect all medical graduates and some of the pressure could be taken off the U.S.-trained physicians if the opportunity for foreign-trained graduates to enter graduate medical programs were lessened. Specifically, the study urges that all incentives for physician immigration be eliminated, and that medicine should be removed from the Department of Labor's "Schedule A" as a shortage profession.

Interestingly enough as a sidelight, on page 21 of the study there is a discussion of the relationship between housestaff and the teaching physician. In this discussion appears the following statement: "The 'student' in this joint teaching and patient care activity is the house officer. In the sample hospitals, house officers spend 84% of their time in activities directly involving patient care. Only 10% of house officer time was reported as purely educational time away from patients and included, for example, time spent at seminars, lectures and library work. Their remaining 6% of their professional time was spent exclusively in teaching, research, and administration." I brought this paragraph to the attention of the Administrative Board, and it seems to me as though the IOM has the right idea in this area at least.

The Executive Council agreed with the major thrust of the IOM study, and will continue to discuss some of the specific recommendations at its June meeting. Since Bob Bernstein of the OSR board represented the OSR on the special committee set up to study the report, OSR made no independent recommendations or resolutions regarding this study. Staff at AAMC prepared a chapter-by-chapter summary of the findings of the study, and those who have a genuine interest should write to Diane Newman at AAMC headquarters requesting a copy of the summary.

Another problem we confronted is also a very important one. The prospects for adequate financial aid to medical students look increasingly dim as time goes on. With the held of some financial aid advisors, I drew up the following table:

AN ESTIMATE OF THE FINANCIAL AID
PICTURE AT THE END OF ACADEMIC YEAR 1975-76

Type of Aid	Present Level (# of recipients)	Anticipated Level
Military Scholarships	3600	3600
National Health Service Corps	1600	2500
Health Professions Loans	30000	11000
AMA-ERF Loans	2600	3000
Miscellaneous Sources (NMF, etc.)	5000	4000
TOTAL	42,800	24,100

ESTIMATED DEFICIT TO MAINTAIN PRESENT LEVELS: $20-30 million.

As you will note, the actual number of loans, assuming a constant amount of money per loan, is expected to decrease considerably. The figures could be made to look better if the actual amount received by each student were cut in half, thus allowing the total number of loans to remain constant. As we are all aware, however, this probably is not a feasible alternative. I think at this point there are two courses we ought to follow. First, I would ask all OSR representatives to inform their classmates of the potential effectiveness of writing to Congressmen. Students who find the possibility of continuing their education imperiled by a lack of loan funds, ought to make this situation clear to their Congressmen. I don't think that petitions or multiply-signed form letters would be nearly as effective as a fair number of individually-worked out, individually-signed notes. Secondly, I think that we as OSR representatives out to be thinking very seriously about developing an OSR position vis-a-vis the financial aid crisis. I hope that at our Annual Meeting we will have an opportunity to discuss the financial problems of medical students in a workshop situation. The more alternatives we have before us, the more fruitful our discussions will be.

An additional sidelight on the financial aid issue will be of interest primarily to those who are recipients of Armed Forces or Public Health Service/National Health Service Corps scholarships. As you know by now, these scholarships are presently being considered as taxable income due to the expiration on December 31, 1975 of PL 93-483. The AAMC has written to the Senate Finance Committee and the House Ways and Means Committee to seek some legislative relief for the students in these programs. It is advisable for students participating in these programs to write either to members of these committees or to their own Congressmen. Members of the two committees are listed below:

House Ways and Means (House of Representatives, Washington, D.C. 20515):

Al Ullman (D-Ore.), Chairman
Wilbur D. Mills (D-Ark.)
James A. Burke (D-Mass.)
Dan Rostenkowski (D-Ill.)
Phil M. Landrum (D-Ga.)
Charles A. Vanik (D-Ohio)
Richard H. Fulton (D-Tenn.)
Omar Burleson (D-Tex.)
James C. Corman (D-Cal.)
William J. Green (D-Pa.)
Sam Gibbons (D-Fla.)
Joe D. Waggonner, Jr. (D-La.)
Joseph E. Karth (D-Minn.)
Otis G. Pike (D-N.Y.)
Richard F. Vander Veen (D-Mich.)
J. J. Pickle (D-Tex.)
Henry Helstoski (D-N.J.)
Charles B. Rangel (D-N.Y.)
William R. Cotter (D-Conn.)
Fortney H. (Pete) Stark (D-Cal.)
James R. Jones (D-Okla.)
Andrew Jacobs, Jr. (D-Ind.)
Abner J. Mikva (D-Ill.)
Martha Keys (D-Kans.)
Joseph L. Fisher (D-Va.)
Herman T. Schneebeli (R-Pa.)
Barber B. Conable, Jr. (R-N.Y.)
John J. Duncan (R-Tenn.)
Donald D. Clancy (R-Ohio)
Bill Archer (R-Tex.)
Guy Vander Jagt (R-Mich.)
William A. Steiger (R-Wisc.)
Phillip M. Crane (R-Ill.)
Bill Frenzel (R-Minn.)
James G. Martin (R-N.C.)
L. A. (Skip) Bafalis (R-Fla.)

Senate Finance (U.S. Senate, Washington, D.C. 20510)

Russel B. Long (D-La.), Chairman
Herman E. Talmadge (D-Ga.)
Vance Hartke (D-Ind.)
Abraham Ribicoff (D-Conn.)
Harry F. Byrd, Jr. (D-Va.)
Gaylord Nelson (D-Wisc.)
Walter F. Mondale (D-Minn.)
Mike Gravel (D-Alaska)
Lloyd Bentsen (D-Tex.)
William D. Hathaway (D-Me.)

Senate Finance (cont.)

Floyd K. Haskell (D-Colo.)
Carl T. Curtis (R-Neb.)
Paul J. Fannin (R-Ariz.)
Clifford P. Hansen (R-Wyo.)

Robert Dole (R-Kans.)
Bob Packwood (R-Ore.)
William V. Roth, Jr. (R-Del.)
Bill Brock (R-Tenn.)

Another area which is of interest to all of us relates to the National Intern and Resident Matching Program (NIRMP). The new Executive Vice-President of NIRMP is Dr. John Graettinger, and he has made available data regarding the outcome of the match over the past six years. Dr. Graettinger's data showed that the number of post-graduate positions offered increased between 1955 and 1973 but decreased in 1974 and 1975. The number of U.S. graduates participating in the match has however continued to increase. For example in 1970 there were 15,567 total openings and 8,327 U.S. applicants. In 1976, there were 16,112 openings and 13,223 U.S. applicants. The total number of applicants (which includes foreign medical graduates) has also increased markedly. In 1970 if foreign graduates are also considered in the match there were 9,006 total applicants, but in 1976 if FMG's are also included there was a total of 19,796 applicants. It is clear from these facts that we are now in an era where the total number of applicants actually exceeds the total number of openings, a situation which existed in the 1975 and 1976 match. This tremendous increase in the number of FMG applicants participating in the match is curiously reflected in their relative success rate. In 1970, 96.7% of all students matched, while 97.3% of U.S. medical graduates matched. In 1976 only 73% of all students matched but the fraction of U.S. graduates matching was 91.9%. Thus, although the total applicant pool of foreign medical graduates has increased radically, their contribution to the total number of interns and residents has remained relatively constant. It must be recalled here that the situation is not likely to become looser in the future. All of the manpower legislation currently being considered, and the IOM study discussed above, include strict rules for the maximum number of first-year postgraduate positions which may be available. The relative ease of obtaining residencies in different areas, as gauged by the number of applications per opening, varies from specialty to specialty. As an example, in the 1976 match, there were 13.4 applications per opening in internal medicine, 8.2 applications per opening in obstetrics-gynecology, 8.1 applications per opening in family practice, and 7.7 applications per opening in surgery. I present these figures to you in order to give you some idea of the direction in which competition for postgraduate slots is going. I think it is evident that the only way we can even hope for a fair shake in this system is to ensure that the rules of a fair match are rigorously adhered to. As OSR representatives, it is especially important for us to keep ourselves aware of possible infractions of matching rules, and whenever possible at least bring them to the attention of our deans.

I will close this lengthy newsletter with a note regarding activity in some state legislatures. A bill in Mississippi would require that all medical students enrolling in the University of Mississippi School of Medicine enter into a contract with the school agreeing either to practice within the State as an active physician for a period of five years or "elect to repay one-half the estimated cost to the State of his or her medical training, the total cost being $100,000. This cost to the physician of $50,000 shall be due and payable on demand with interest accruing at 6% per annum." Apparently Mississippi is not unique in this. A bill

in the Massachusetts legislature would require a two-year period of medical service in areas of need by all graduates of the University of Massachusetts School of Medicine. A bill currently pending in the Arizona legislature provides that a graduate of a medical school located in that state would not be granted a license to practice medicine "unless such applicant has satisfactorily completed a twelve-month program of public service." A similar bill is pending in West Virginia. I hope that OSR representatives in these states are aware of these bills, and I would be very interested in hearing reactions from these representatives or anyone else who has thoughts on this issue. I personally feel that there are some inconsistencies in these bills and I also regard them as rather punitive to those people who attend state supported schools. Needless to say, these tremendous estimates of the "tuition" are simplistic at least in that they totally disregard the service function rendered by the University Hospital and its medical students.

That's all for now. I am always happy to receive comments and inquiries, so again let's stay in touch. Peace.

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

April 29, 1976

OSR NEWSLETTER #3

TO: OSR Representatives

FROM: Rich Seigle, Chairperson

To ensure adequate communication, I am covering some of the major topics discussed at the March OSR Administrative Board meeting and the AAMC Executive Council meeting in this newsletter. Also enclosed are the minutes of the OSR meeting. Tom Rado will be sending you the Vice-Chairperson's newsletter within a few days, and it will cover additional items of special interest.

LCME Guidelines for the Structure and Function of a Medical School. The Liaison Committee on Medical Education (LCME) proposed these guidelines (copy attached to the minutes) as an amplification of the policies set forth in "Structure and Function of a Medical School"--the official LCME statement of policies on which medical school accreditation decisions are based. The purpose of the guidelines is to clarify and expand upon existing LCME policy rather than to establish new policy. The Administrative Board closely examined the guidelines and recommended additions concerning teaching and performing service in the clinical years; specific listing of behavioral science courses; and athletic facilities and child care centers. The board was impressed by the guidelines' recommendations regarding faculty improvement and evaluation and the availability of confidential psychological counseling for medical students. The Executive Council tabled discussion of the guidelines until the June meeting. These guidelines are difficult to amend because of the reluctance of Executive Council members to be specific to any extent. I suggest that you review the guidelines and submit comments or recommendations to your regional chairperson.

Women in Medicine. The AAMC staff submitted a new policy statement on the admission of women to medical school. The OSR recommended an amendment to the proposed statement, and this was approved by the Executive Council. The approved policy statement is attached to the minutes.

The staff member assigned to the president's office to spend 30% time on women in medicine is Judy Braslow from the University of Maryland. The board met with Judy and discussed her plans and activities. She is enthusiastic and has many good ideas. Judy also expressed an interest in our study about medical student stress.

MCAAP Non-Cognitive Assessment Project. The board asked that they be kept informed of each step in the project because of its sensitive nature. Xenia Tonesk, staff

member in charge of the project, presented the latest developments to the board. The characteristics to be assessed are compassion, interprofessional relations, decision-making, physical and motivational staying power, coping capabilities, sensitivity in interpersonal relations, and realistic self-appraisal. Four groups have been contracted to submit instruments to assess these characteristics. The goals of the project are to enhance intuitive judgements now being made by admissions committees of non-cognitive criteria, to provide a means of assessing applicants based on a wider range of criteria, and to assist in counseling of applicants and students about alternative health careers and specialty choice.

The board expressed to Ms. Tonesk its concern over the potential for misuse of the non-cognitive instruments by admissions committees. We stated our concern that medical schools may be stifling or actually discouraging some of the attributes deemed desirable for a physicians (e.g., compassion, interpersonal and interprofessional relationships, and independent decision-making).

Increased Representation in AAMC Governance. At the January Executive Council meeting, the OSR made its second annual bid for a seat on the six member Executive Committee, and our support improved 500%, from 20-1 to 16-5. (If this keeps up, we'll take it next year!) In addition, the Chairman of AAMC gave verbal assurance that the OSR Chairperson will be consulted on matters of importance to OSR.

We have had discussions with the COD Administrative Board pertaining to adding a second OSR seat on the Executive Council. Dr. Gronvall, COD Chairman, and other members of the COD board stressed that if the Council is to support an OSR request for two voting seats, there will have to be a provision for ensuring continuity of the OSR representatives who serve on the Executive Council. They voiced particular concern about the potential for two new representatives each year. Without the full support of COD, our request will undoubtedly not be approved by the Executive Council.

The following are two of the options which we discussed which would ensure continuity of the two student representatives:
Chairperson and Immediate-Past-Chairperson--The problem with this option is that in many cases the Immediate-Past-Chairperson would be a house officer rather than a representative of a medical school. In order for AAMC to maintain its tax-exempt status, all voting members must represent one of the member institutions (i.e., a medical school).
Chairperson and Chairperson-Elect--With this option, the OSR would return to a system it once had by electing a Chairperson-Elect who would assume the Chairpersonship in the second year of office. The difference would be including a provision for removing the Chairperson-Elect from office if he or she was not fulfilling the responsibilities of that office. Although the mechanism has not been completely worked out, one possibility might be that the Administrative Board would have the power to remove the Chairperson-Elect from office by a two-thirds vote. Your comments about this matter would be appreciated.

Possible Discrimination Against Students with Service Commitments. Since the recipients of service-tied scholarships are graduating in large numbers for the first time this year, it may be too early to gather information on this matter. If you have information pertaining to this, contact your Regional Chairperson.

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Regional Meetings. The regional meetings are now in progress. We expect that the major topics which will be addressed at the regions include financial aid, women in medicine, stress, student liability insurance, ambulatory care, and possible new articles for inclusion in Medical School Admission Requirements (MSAR). Regional Chairpersons will report back to the Administrative Board about discussions held in their regions on these topics, and will submit any resolutions approved at the regional meetings to the board.

OSR NOTEBOOK
AO. 00 SECTION

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aamc association of american medical colleges

October 18, 1976

M E M O R A N D U M

TO: OSR Representatives

FROM: Rich Seigle, OSR Chairperson

SUBJECT: Chairperson's Newsletter

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Actions of the Liaison Committee on Medical Education (LCME)

The OSR board reviewed the recent accreditation decisions of the LCME:

University of Alabama, 3 years full accreditation
University of Minnesota at Minneapolis, 7 years full accreditation
University of North Dakota, 2 years full accreditation
University of Minnesota at Duluth, 3 years full accreditation
Eastern Virginia, 2 years full accreditation
Northeastern Ohio, letter of reasonable assurance granted
University of California-Irvine, 3 years full accreditation
Yale University, 7 years full accreditation
University of Mississippi, 4 years full accreditation
University of Nevada, 4 years full accreditation
*SUNY-Stony Brook, 1 year full accreditation
University of Texas at Houston, 2 years full accreditation
University of Cincinnati, 7 years full accreditation
University of Washington, 7 years full accreditation
University of South Alabama, 3 years full accreditation
Mayo Medical School, 3 years full accreditation
**Uniformed Services University of Health Sciences, 1 year provisional accreditation
University of South Carolina, 1 year provisional accreditation

After each school is listed the number of years before their next accreditation site visit. Most schools receive continued full accreditation if they have been accredited in the past. A provisional acceditation is for an intial class size and is granted to new schools that have not been accredited in the past; just before the charter class graduates, these schools are inspected for full accreditation. The other action possible by the LCME is probation.

*The OSR noted that there were numerous concerns about student problems listed in the accreditation report for Stony Brook at the Executive Council meeting. I asked that LCME pay close attention to the improvement of these conditions; this was agreed to by Dr. Schofield, the AAMC Representative and the AAMC Secretary to the LCME.

**Bob Cassell voiced concerns relating to the provisional accreditation of the Uniformed Services University of Health Sciences. Some Executive Council members were also concerned about the ability of the school to begin teaching in November, 1976. There were assurances from members of the Executive Council that the basic science faculty was complete and able to begin instruction on schedule. Some of the concerns it will be important to monitor are: student input at the school, course content with a broad base of viewpoints in teaching, and pressure on students who must volunteer for military service prior to admission.

MCAT and AMCAS Fee Increase

The Executive Council approved the raising of MCAT fees from $25 to $35 and AMCAS fees for the first application from $10 to $20 (fees for additional applications will remain the same). Tom Rado and I were invited to the meeting of the Finance Committee where this matter was discussed. The reasons for increasing the fees were: MCAT--(1) the new MCAT[SM] will be a full day test and consequently the sub-contract fee for giving the test is increasing by over $6, (2) $3 of the increase will be channeled into continued MCAT development, (3) the test fee has been raised only once in about nine years and inflation is saturating the system. AMCAS--(1) inflation is such that expenses will overtake income for the system next year, (2) it will cost the Association $100,000 to transfer computer systems for this service, (3) AMCAS fees have not been raised since the service was initiated seven years ago, (4) with more applicants using EDP and filing only one application, the initial cost of entering the system has far exceeded the fee charged for those students.

Tom and I requested a quarantee that these fees will not be raised for three years unless an unforeseen economic problem arises. This amendment was approved by the Executive Council, and I felt that there was sincere concern on the part of some Council members that the fees for these services had to be raised.

Committee of Interns and Residents (CIR) vs. Misiricordia Hospital Center

It was brought to the attention of the Executive Council that a suit has been filed by CIR in the New York State courts regarding jurisdiction over labor relations. The issue in the suit is whether the National Labor Relations Board which ruled that housestaff are students and not employees has appropriate jurisdiction in New York. The suit involves a jurisdictional question, and if successful would mean that in each state where the labor relations board has jurisdiction over hospitals, the state labor board would have to decide this question. This might mean that residents in one state could collectively bargain and those in another state could not. The case at present is in the New York State courts, but it is likely that, whatever the decision, the case will be appealed. The Executive Council authorized AAMC staff, in consultation with AAMC attorneys, to enter

the case as an amicus curiae if and when the case reaches the Federal court level.

Tom Rado and I expressed the opinion that the Association should not continue to expend effort on the matter of housestaff status. We pointed out that this will continue to widen the gap between the Association and graduate medical physicians. Although we urged against it, the Executive Council voted to grant staff the authority to enter the case if it reaches the Federal court. We then asked that the Executive Council be consulted concerning the content of the brief. Opposing views were that this was a question of jurisdiction and not of the definition of the role of housestaff. Therefore, it was felt that the Executive Council could contribute little to the writing of the brief if this view prevailed. Tom has written a resolution on this matter which will be presented at the Annual Meeting.

Health Manpower Legislation

On October 12, President Ford signed the Health Professions Education Assistance Act of 1976. This legislation will be reviewed in detail at the Annual Meeting; in the meantime, my interpretations of the most important points are: (1) The National Health Service Corps has been significantly expanded. (2) There will be a new program of federally insured loans for medical students. Students will be able to borrow up to $10,000 per year to an agregate total of $50,000 with maximum interest rates not exceeding 10%. In addition, scholarships will be available for students of exceptional financial need which will provide support for tuition and all other reasonable educational expenses as well as a stipend of $400 per month for a 12-month period. (3) Medical students will now be eligible to borrow under the National Direct Student Loan program. (4) Capitation will be $2,000 in fiscal 1978, $2,050 in fiscal 1979, and $2,100 in fiscal 1980. (5) The bill requires that schools, in order to receive capitation, set aside a number of positions for U.S. students enrolled in foreign medical schools who have successfully completed two years of medical school and have passed Part I of NBME. This is a one-time provision applicable only to U.S. citizens who were students in a foreign medical school before the date of enactment of the bill. (2) Also in order to receive capitation, the bill requires that 35, 40, and 50 percent of all first-year residencies be in primary care specialties (family practice, general internal medicine, and general pediatrics). The national trigger mechanism is perserved whereby schools will be required to meet these percentages on an individual basis only if the goals are not met on a national basis during the first year.

COD Administrative Board Meeting

At the COD meeting, the board reviewed a postion statement regarding the inappropriateness of considering financial or political influence in the admissions process. The OSR board had reviewed this statement, and we suggested that the COD adopt a reworded version of the statement (see minutes, page 5). The COD board proposed that an appropriate statement along these lines be included in the Guidelines for the Function and Structure of a Medical School. The statement will affirm that admission to medical school should be based on and defined in criteria, which are available openly, and that the selection process itself is the prerogative of the school's academic faculty.

The COD board also reviewed a proposal submitted by July Braslow, Special Assistant

to the AAMC President for Women in Medicine, that women liaison officers be appointed at each medical school. The COD board supported this proposal and agreed to recommend that all deans appoint a women liaison officer. If you have a women's group at your school you might suggest to your Dean that this designation is available and that the leader of the group be appointed. Also make sure that your Dean does decide to appoint an individual from your school to this position so that the women at your school will receive information about women's affairs.

Graduate Medical Education

The report of the OSR Task Force on Graduate Medical Education was approved by the OSR board and was presented to the Executive Council. The Council received the report, and agreed that it would be an agenda item for the January meeting. It was also noted that the issues raised by OSR would be discussed at the AAMC officers' retreat in December.

Rules and Regulations

The final revision to our Rules and Regulations regarding the creation of the position of Chairperson-Elect will read: "The Chairperson-Elect shall automatically assume the office of Chairperson at the conclusion of the Annual Meeting unless he receives a vote of no confidence from the Administrative Board at the last regularly-scheduled meeting prior to the annual business meeting of the OSR." Also, with respect to a recall provision, the proposed addition to the Rules and Regulations will read: "Any officer of the OSR may be recalled by a two-thirds vote of those present and voting at any official OSR meeting." The Rules and Regulations changes were sent to you last week. Tom Rado will be writing a paper with full coverage on this topic for the Annual Meeting.

OSR Annual Meeting

I've talked with Peter Kotcher and we have decided that rather than sending you a questionnaire regarding your specific concerns or areas of interest, that we would ask you to write to either Diane Newman at AAMC or to me about any issues that you feel have not been covered. The minutes of the September meeting, this newsletter, and information about the Annual Meeting, should give you a good idea of the issues we are currently dealing with. If you have an interest which has not been mentioned, please let us know so that we can include it in one of our sessions at the Annual Meeting. I hope that you will all be able to attend the San Francisco meeting.

aamc association of american medical colleges

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Yale University, 7 years full accreditation
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University of Nevada, 4 years full accreditation
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**Bob Cassell voiced concerns relating to the provisional accreditation of the Uniformed Services University of Health Sciences. Some Executive Council members were also concerned about the ability of the school to begin teaching in November, 1976. There were assurances from members of the Executive Council that the basic science faculty was complete and able to begin instruction on schedule. Some of the concerns it will be important to monitor are: student input at the school, course content with a broad base of viewpoints in teaching, and pressure on students who must volunteer for military service prior to admission.

MCAT and AMCAS Fee Increase

The Executive Council approved the raising of MCAT fees from $25 to $35 and AMCAS fees for the first application from $10 to $20 (fees for additional applications will remain the same). Tom Rado and I were invited to the meeting of the Finance Committee where this matter was discussed. The reasons for increasing the fees were: MCAT--(1) the new MCAT[SM] will be a full day test and consequently the sub-contract fee for giving the test is increasing by over $6, (2) $3 of the increase will be channeled into continued MCAT development, (3) the test fee has been raised only once in about nine years and inflation is saturating the system. AMCAS--(1) inflation is such that expenses will overtake income for the system next year, (2) it will cost the Association $100,000 to transfer computer systems for this service, (3) AMCAS fees have not been raised since the service was initiated seven years ago, (4) with more applicants using EDP and filing only one application, the initial cost of entering the system has far exceeded the fee charged for those students.

Tom and I requested a guarantee that these fees will not be raised for three years unless an unforeseen economic problem arises. This amendment was approved by the Executive Council, and I felt that there was sincere concern on the part of some Council members that the fees for these services had to be raised.

Committee of Interns and Residents (CIR) vs. Misiricordia Hospital Center

It was brought to the attention of the Executive Council that a suit has been filed by CIR in the New York State courts regarding jurisdiction over labor relations. The issue in the suit is whether the National Labor Relations Board which ruled that housestaff are students and not employees has appropriate jurisdiction in New York. The suit involves a jurisdictional question, and if successful would mean that in each state where the labor relations board has jurisdiction over hospitals, the state labor board would have to decide this question. This might mean that residents in one state could collectively bargain and those in another state could not. The case at present is in the New York State courts, but it is likely that, whatever the decision, the case will be appealed. The Executive Council authorized AAMC staff, in consultation with AAMC attorneys, to enter

the case as an amicus curiae if and when the case reaches the Federal court level.

Tom Rado and I expressed the opinion that the Association should not continue to expend effort on the matter of housestaff status. We pointed out that this will continue to widen the gap between the Association and graduate medical physicians. Although we urged against it, the Executive Council voted to grant staff the authority to enter the case if it reaches the Federal court. We then asked that the Executive Council be consulted concerning the content of the brief. Opposing views were that this was a question of jurisdiction and not of the definition of the role of housestaff. Therefore, it was felt that the Executive Council could contribute little to the writing of the brief if this view prevailed. Tom has written a resolution on this matter which will be presented at the Annual Meeting.

Health Manpower Legislation

On October 12, President Ford signed the Health Professions Education Assistance Act of 1976. This legislation will be reviewed in detail at the Annual Meeting; in the meantime, my interpretations of the most important points are: (1) The National Health Service Corps has been significantly expanded. (2) There will be a new program of federally insured loans for medical students. Students will be able to borrow up to $10,000 per year to an agregate total of $50,000 with maximum interest rates not exceeding 10%. In addition, scholarships will be available for students of exceptional financial need which will provide support for tuition and all other reasonable educational expenses as well as a stipend of $400 per month for a 12-month period. (3) Medical students will now be eligible to borrow under the National Direct Student Loan program. (4) Capitation will be $2,000 in fiscal 1978, $2,050 in fiscal 1979, and $2,100 in fiscal 1980. (5) The bill requires that schools, in order to receive capitation, set aside a number of positions for U.S. students enrolled in foreign medical schools who have successfully completed two years of medical school and have passed Part I of NBME. This is a one-time provision applicable only to U.S. citizens who were students in a foreign medical school before the date of enactment of the bill. (2) Also in order to receive capitation, the bill requires that 35, 40, and 50 percent of all first-year residencies be in primary care specialties (family practice, general internal medicine, and general pediatrics). The national trigger mechanism is perserved whereby schools will be required to meet these percentages on an individual basis only if the goals are not met on a national basis during the first year.

COD Administrative Board Meeting

At the COD meeting, the board reviewed a postion statement regarding the inappropriateness of considering financial or political influence in the admissions process. The OSR board had reviewed this statement, and we suggested that the COD adopt a reworded version of the statement (see minutes, page 5). The COD board proposed that an appropriate statement along these lines be included in the Guidelines for the Function and Structure of a Medical School. The statement will affirm that admission to medical school should be based on and defined in criteria, which are available openly, and that the selection process itself is the prerogative of the school's academic faculty.

The COD board also reviewed a proposal submitted by July Braslow, Special Assistant

to the AAMC President for Women in Medicine, that women liaison officers be appointed at each medical school. The COD board supported this proposal and agreed to recommend that all deans appoint a women liaison officer. If you have a women's group at your school you might suggest to your Dean that this designation is available and that the leader of the group be appointed. Also make sure that your Dean does decide to appoint an individual from your school to this position so that the women at your school will receive information about women's affairs.

Graduate Medical Education

The report of the OSR Task Force on Graduate Medical Education was approved by the OSR board and was presented to the Executive Council. The Council received the report, and agreed that it would be an agenda item for the January meeting. It was also noted that the issues raised by OSR would be discussed at the AAMC officers' retreat in December.

Rules and Regulations

The final revision to our Rules and Regulations regarding the creation of the position of Chairperson-Elect will read: "The Chairperson-Elect shall automatically assume the office of Chairperson at the conclusion of the Annual Meeting unless he receives a vote of no confidence from the Administrative Board at the last regularly-scheduled meeting prior to the annual business meeting of the OSR." Also, with respect to a recall provision, the proposed addition to the Rules and Regulations will read: "Any officer of the OSR may be recalled by a two-thirds vote of those present and voting at any official OSR meeting." The Rules and Regulations changes were sent to you last week. Tom Rado will be writing a paper with full coverage on this topic for the Annual Meeting.

OSR Annual Meeting

I've talked with Peter Kotcher and we have decided that rather than sending you a questionnaire regarding your specific concerns or areas of interest, that we would ask you to write to either Diane Newman at AAMC or to me about any issues that you feel have not been covered. The minutes of the September meeting, this newsletter, and information about the Annual Meeting, should give you a good idea of the issues we are currently dealing with. If you have an interest which has not been mentioned, please let us know so that we can include it in one of our sessions at the Annual Meeting. I hope that you will all be able to attend the San Francisco meeting.