STATUS OF REDUCED-SCHEDULE RESIDENCY REMAINS IN DOUBT

The reduced-schedule residency is a relatively new concept in medicine. These programs have emerged during the last decade as an alternative to traditional residency programs for probably two reasons. First, the increased enrollment of women in medical school has almost certainly resulted in an increase in physician-physician and student-student marriages. Secondly, recent social changes have created an atmosphere where people consciously reassess the relative importance of personal and professional goals. Presently, physicians entering residencies are trying to achieve a new balance between the personal, family, and professional aspects of their lives. It is no longer universally accepted that being a physician demands total denial of outside pleasures and interests.

There are two major types of reduced-schedule residencies. In one type (known as shared-scheduled positions) conventional part-time positions are offered, salaries are half the usual stipend, and the time required to reach board eligibility is proportionately increased. This type of program may be offered to an individual or to a pair of students. In the latter case, the couple shares time and patient responsibility and assures continuity of care.

The other type is based on alternating blocks of time away from the program. A two-year residency would become twice as long with the house officer performing his or her duties in perhaps three-month rotations with equivalent time off between blocks. Two people sharing such a residency would simply alternate responsibility.

Housestaff today seek these programs for a variety of reasons. Physician couples who have decided to share equally in the responsibilities of housekeeping and child rearing make up a small but important population. Another group is comprised of women physicians, committed to the profession but unwilling to defer child bearing and family responsibilities to the post-residency years. Still others seek these programs in order to pursue research interests, usually at the same institution.

Since their inception, reduced-schedule residencies have existed in a grey zone of semi-official acceptance. Institutions do not advertise such positions, and the NIRMP listing of approved residencies makes no special note of their existence at certain hospitals. The Liaison Committee on Graduate Medical Education (LCGME) does not have special guidelines to assure their quality.

At a recent AAMC Executive Council meeting this issue was discussed and some members of the council argued that AAMC should not actively encourage institutions to offer reduced-schedule programs. They maintained that medicine was a full-time job requiring a full-time commitment. They argued that official endorsement of the concept would inevitably result in a population of under-motivated, part-time physicians. It was their feeling that the present status of these programs was adequate to deal, on a personal level, with the very few cases who demonstrate a genuine need for a reduced-schedule training program.

There will be more discussion of this issue before a decision is reached. OSR has consistently endorsed the concept, and we would like you to let us know your thoughts on this question by responding to the survey on page 3.

OSR OPINION SURVEY—*Continued*

6) Reduced-schedule residencies are compatible with high quality training.

7) Reduced-schedule residencies will promote the proliferation of poorly motivated and under-trained doctors.

8) Reduced-schedule programs should be developed openly, accredited by standard means, and listed as such by NIRMP.

9) This newsletter has served a useful function by providing new information.

10) Additional issues published three or four times per year would be useful.

0 5 10

Comments on areas discussed in this issue or on other matters of concern relating to medical education (use separate sheet if necessary):

Optional:

Name Date

OSR REPORT

Published by the Association of American Medical Colleges for the Organization of Student Representatives. Distributed free of charge to all U.S. medical students.

Editor: Diane Newman, AAMC Division of Student Programs, One Dupont Circle, N.W., Washington, D.C. 20036, (202) 466-5057

OSR Report

Volume 1, Number 1
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OSR National Chairperson: Thomas A. Rado, Ph.D.

OSR National Chairperson-Elect: Paul Scoles

HEARINGS HELD TO AMEND LABOR ACT

The right of housestaff to form collective bargaining units under the protection and rules of the National Labor Relations Act (NLRA) has been hotly contested for the past few years. Last year, the issue came to the public eye after a series of strikes. At that time, housestaff at five hospitals asked the National Labor Relations Board (NLRB) to assert jurisdiction over them. This action would have given housestaff the right to vote on whether or not they wanted to be represented by a union in contract negotiations with their hospitals.

The AAMC entered the case as *amicus curiae* (friend of the court) in opposition to the housestaff petition. AAMC, which represents the

(Continued on page 3)

U.S. STUDENTS IN FOREIGN SCHOOLS: MANPOWER PROVISIONS STIR WIDESPREAD DEBATE

The new health manpower law (PL 94-484) contains a provision that in order to receive 1978-80 capitation grants, medical schools must accept into their M.D. programs a number of American students who have completed basic science studies at foreign medical schools.

This provision was hastily added to the law in Conference, and it was initially popular with proponents of the theory that U.S. health care problems are due primarily to a physician shortage. It soon became apparent, however, that the issue is much more complicated. The law specifies that schools cannot reject these students for academic reasons if the students have passed Part I of the National Boards. Schools can only use non-academic criteria in justifying their failure to accept the required number of transfer students from foreign medical schools. In this way, passage of NBME Part I is substituted for the schools' usual applicant evaluation procedures. The deans of many medical schools feel that being forced to admit a specified number of students "around" the standard admission process is an unjustified threat to the autonomy of their institutions. Others feel that the law is discriminatory—that it allows rejected applicants who were wealthy enough to attend high-priced foreign schools access that their poorer counterparts did not have. It is also thought to be possible that students from foreign medical schools might take available third-year slots from students in U.S. two-year medical schools.

Since there is currently no reliable estimate of the actual numbers of students involved, it is not possible to predict the full effect of the new law. Because of this and because of great difficulties which will undoubtedly accompany the verification and translation of documents, it is unlikely that the law can be implemented until academic year 1978-79. AAMC has testified in a Pennsylvania lawsuit brought to force earlier implementation of the law and has explained the problems which schools would face if forced to implement the transfer provisions on such short notice.

OSR has reviewed the provisions of PL 94-484 relating to U.S. students studying abroad; in general, we share the views of AAMC regarding these aspects of the law. We feel that this provision will be hard to implement, that it is somewhat discriminatory, and that it does represent an unwarranted intrusion into the admissions process.

Some medical school deans have indicated that they may recommend that their schools refuse capitation rather than comply with this provision. OSR has consistently argued against this course of action. According to the law, students cease to qualify for the new Federal Program of Insured Loans for Health Professions Students when their schools become ineligible for capitation. Under these conditions, we feel that refusal of capitation would result in undue hardship for large numbers of medical students.

PERSPECTIVES: CREATIVITY IN THE SILENT CONSTITUENCY

This issue of *OSR Report* marks the beginning of a major new direction for the Organization of Student Representatives (OSR) of the Association of American Medical Colleges (AAMC). AAMC has played a decisive role in shaping medical education for over a century. The Association is a parent organization of every major committee charged with the evaluation, accreditation, and planning of medical education. In many cases it has line-item veto power over the decisions of these committees. In spite of this, I would guess that the majority of the 60,000 medical students in this country are unaware of its existence.

The OSR, established in 1970, is the mechanism whereby student opinion is made known to AAMC. Today we have two votes on the AAMC Executive Council, we are invited to participate as members of various AAMC task forces, and we recommend student members to standing AAMC committees. Every accredited U.S. medical school is invited to elect a representative to OSR. OSR members receive a great deal of information about areas in which AAMC has interest. In general, they have been awed by the complexity of the problems facing a system which educates physicians, treats huge numbers of patients, and tries to respond to public needs and government demands.

In the past, the role of OSR has been to react rather than to initiate. This has occurred because of the complexity of the issues and the lack of communication between OSR members and their medical student constituency. This newsletter is part of our effort to improve the situation.

In this issue we deal with three important topics. First, we want to keep you abreast of the issues behind proposed legislation which may alter the nature of the housestaff experience and to ask your help in determining our response. Second, we believe that you have a genuine "need to know" about impending changes in the status of U.S. citizens studying medicine abroad. Finally, we ask you, Is the reduced-schedule residency an idea whose time has come? Or is it a poor approach whose net effect will be an erosion of the quality of the housestaff experience for those involved?

Each year at the AAMC Annual Meeting, the OSR elects an Administrative Board which functions throughout the year to carry out the resolutions passed by the Organization and to respond to new questions as they arise. We will be asked to take a position on the issues mentioned above. If our stance is not to be the product solely of our somewhat isolated deliberations, we must have your views and arguments. It is our hope that through this *Report* and the opinion survey on page 3 we might stimulate from the creativity of medical students proposals for new answers to such nationally important questions.

The OSR Administrative Board is subdivided into working groups whose members develop expertise in areas of specific concern to medical students. The main job of these members is to gather data in the form of facts, questions, and proposed solutions. You are an important and largely untapped source of such data. In the list which follows this letter, the members of the Administrative Board are identified along with the areas in which they are working. If you are interested in one or more of these areas, if you have questions or ideas, contact these people. *We will respond to you.*

To keep the student voice in AAMC viable and creative, we are trying to develop input at two levels. The opinion questionnaire in this issue is the first level. Interaction with specific Administrative Board members is the second. We are an organization of students, and we represent student interests. It is in all of our interests to stay in touch.

Tom Rado
OSR Chairperson

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Chris Webb (Western Chairperson)
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NIRMP
Cheryl Gutmann (Central Chairperson)
1660 North LaSalle Street #1405
Chicago, Illinois 60614

LABOR ACT *(Continued from page 1)*

major teaching hospitals in the U.S., presented an argument based on the premise that interns, residents, and fellows are students on stipend, rather than employees on salary. (Students in general are not eligible for NLRB recognition.) A point raised by AAMC was that the housestaff experience is a requirement for post-M.D. certification. This, they argued, places it in a class with other types of post-graduate study.

A second AAMC argument was based on cost analysis. They pointed out that because of the training housestaff receive, it is more expensive for a hospital to have a residency program than to hire an equivalent number of employee physicians. Finally, AAMC argued that the special relationship which presently exists between housestaff and their service chiefs is delicate and critical to the educational experience. They maintained that it would be irreparably damaged if a negotiation atmosphere, complete with shop stewards and formal bargaining, were to prevail.

Housestaff and medical student groups, including OSR, took an opposing view. Basically, we argued that housestaff perform vital services in the areas of patient care and under-graduate teaching. While it is true that housestaff learn new skills while performing service, OSR argued that this does not in itself classify them as students. In addition, the housestaff groups questioned the validity of hospital accounting practices which fail to distinguish between savings in patient (or community) dollars and savings in university hospital dollars. Housestaff groups maintain that immense patient costs would accrue if private physicians were called upon to perform all of the services presently provided by housestaff.

The NLRB ruled against the petitioning housestaff groups, but reserved the option of hearing other petitions and deciding in each instance whether the training or the service aspect was more prominent. In the meantime, housestaff organizations have sought legislative relief. In the last weeks of the 94th congress, Representative Frank Thompson (D-N.J.) introduced a bill which would specifically amend the NLRA by defining interns, residents, and fellows as employees. Mr. Thompson has reintroduced his bill (H.R. 2222) in this session.

The most recent hearings on the Thompson Amendment were held in Washington on April 4. Testimony urging defeat of the amendment was offered by the president of AAMC and officers of the American Hospital Association. The Physicians National Housestaff Association, AMSA, and the AMA testified in favor of the amendment. AAMC testimony held that the NLRA, originally designed for the industrial sector, was not applicable to "graduate medical students." AMSA and PNHA urged speedy passage of the bill.

During the development of the AAMC position on H.R. 2222, OSR supported a compromise stance. It is our view that there are aspects of the housestaff experience which are amenable to collective bargaining—wages, hours, and working conditions. There are also aspects in which education is the issue and where classical academic mechanisms are probably more appropriate. It is entirely possible that AAMC is correct in prophesying grave difficulties for post-graduate medical education if the Thompson Amendment passes. It is also true, however, that housestaff have just grievances which might be best settled in the egalitarian atmosphere of collective bargaining.

OSR continues to study the diverse responses generated by the Thompson Amendment. Our long-range effort is to work toward a solution which will provide assurances for the educational quality of housestaff programs and will also guarantee housestaff, as workers, the same rights which other segments of the labor force have already won.

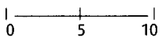
OSR OPINION SURVEY

We would like you to take thirteen cents and a little of your time to let us know your thoughts on issues we have raised in this newsletter. Please tear this form out and sent it to:

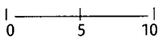
Diane Newman
Division of Student Programs
AAMC
One Dupont Circle, N.W.
Washington, D.C. 20036

For each of the statements below, please make a mark on the line between *"0" (strongly agree)* and *"10" (strongly disagree)*. Note that the midpoint *"5"* may be used to indicate *"no opinion."*

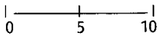
1) The living standards of housestaff will improve significantly if permitted to unionize.



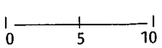
2) The educational quality of housestaff programs will decline if residents are given employee status.



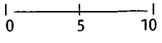
3) I would like a union to represent my interests when I become a house officer.



4) The allocation of slots for U.S. students presently at foreign medical schools is a step towards solving the nation's health care needs.



5) The preferential treatment shown to American students in foreign medical schools discriminates against the remainder of rejected applicants and students in two-year schools.



(over)

ACCREDITATION *(Continued from page 2)*

may be granted for some portion of the maximum ten years with progress reports due at specified intervals. In recent years, two schools have been placed on probation until certain deficiencies were remedied while no school has been denied accreditation.

The accreditation of schools is conducted in several phases. First, about a year before the actual accreditation site visit, the school conducts an institutional self-study, examining in detail all the phases of the school's operation—everything from curriculum to animal quarters. The results of the survey, often amounting to several thousand pages of documentation, are sent to the LCME. A site visit team is appointed which reviews the self-study document and visits the school for about four days, meeting with faculty, administrators, and students, and examining the facilities.

A report of the visit and an accreditation recommendation are prepared by the team and circulated to all members of the AAMC's Executive Council and the AMA's Council on Medical Education (CME). The final accreditation decision is made by the LCME and ratified to satisfy certain licensure requirements by the parent bodies.

Student input into the accreditation process is at three levels. First, and most importantly, students should participate in all phases of the institutional self-study. This participation often provides students with a different perspective on the strengths and weaknesses of their schools and allows them in turn to provide their perspectives on the problems and possible solutions. Occasionally, due mostly to lack of communication, students are not included in the institutional self-study process. When this occurs, a formal request to the dean is usually all that is necessary to include students on the self-study committee. A new policy of the OSR will provide OSR representatives at schools scheduled for accreditation site visits with a copy of the *OSR Accreditation Handbook* well in advance of the site visit.

The second level of student participation occurs during the visit of the site team. A meeting is scheduled including the entire team and representatives of the student body. Only students and site visitors are present at this meeting, and students should use this time to be completely candid about their concerns. Site study teams are extremely sensitive to the concerns of students and regard themselves in a sense as student advocates. Although students may be reluctant to speak up about their concerns for fear of having an adverse effect on the accreditation decision, they should keep in mind that an effective examination requires both honesty and candor. The accreditation process provides an opportunity for medical schools to look closely at all phases of their function and to identify problems and solutions. Students have a unique view of the process of medical education, and their participation in the identification and resolution of these problems—during the institutional self-study phase and during the site visit—is vital.

The third type of student participation in the accreditation process occurs at the national level. Site visit reports are routinely circulated to the parent councils, and the two students who sit on the AAMC Executive Council and the student on the AMA-CME have the opportunity to review and comment upon all site visit reports and recommendations. Their comments are submitted directly to the LCME along with comments from other members of the parent councils. In addition, the LCME recently asked both AAMC and AMA to appoint one student each to sit as non-voting members on the LCME. It is too early to tell what role the student LCME members will play on the committee, but the OSR and other medical student groups feel that achieving the long-term goal of attaining student representation on the very influential LCME is, in itself, a victory for medical students.

CONGRESS PASSES BILL TO AMEND HEALTH MANPOWER ACT

In late December President Carter is expected to sign a bill which would amend the U.S. foreign medical student (USFMS) capitation provision of the 1976 health manpower law. As noted in the last issue of *OSR Report*, the original USFMS provision was highly controversial, and at least 14 schools had announced that they would refuse capitation rather than comply with the requirement that they admit, without regard to usual academic admissions criteria, a specified number of U.S. students who were studying medicine abroad prior to October 12, 1976.

If, as anticipated, the new law is signed by the President, it would require medical schools to increase their third-year classes by 5% in 1978 in order to receive capitation grants. Under the new law, schools would not receive credit for USFMSs voluntarily enrolled in 1977, but a significant change is that schools would be able to use any normal academic criteria in selecting the students they wish to admit. Schools would receive credit towards the 5% enrollment increase not only for USFMSs enrolled abroad prior to October 12, 1976 but also for transfers from two-year U.S. schools and for students in special Ph.D.-M.D. programs in the U.S. The pool of students who would be eligible for transfer under the new law has been estimated to be more than twice the number of places (about 800) which would be made available by this third-year enrollment increase.

OSR REPORT

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Editor: Diane Newman, AAMC Division of Student Programs, One Dupont Circle, N.W., Washington, D.C. 20036, (202) 466-5057

OSR Report

Volume 1, Number 2
Winter 1977/78

Published by Association of American Medical Colleges for The Organization of Student Representatives

In This Issue:

OSR National Chairperson: Paul Scoles

OSR National Chairperson-Elect: Peter Shields

CHAIRPERSON'S PERSPECTIVES

This is the second edition of *OSR Report*—the first of this academic year and the first under a new slate of OSR national officers. We've decided to use this issue to tell you a little about what the AAMC is and does and about what the OSR does within the AAMC.

The AAMC is best known to medical students as the organization which administers the New MCAT and AMCAS. These two services are only a small part of the operation of the Association, which includes as members 122 medical schools, 63 academic societies, and 400 teaching hospitals. The AAMC is the voice of the medical education community, and it represents that community in a variety of public and private forums.

The OSR, one of the governing constituent bodies within AAMC, provides student input to the working of the Association. The channel is direct; the OSR Chairperson and Chairperson-Elect sit as voting members of the AAMC Executive Council and OSR representatives sit on virtually all task forces, working groups, and student-related committees of the Association.

The OSR is a representative rather than a membership body. Each school designates one OSR representative, and these students are charged with conveying the concerns and viewpoints of their fellow students to the AAMC and, conversely, with transmitting information from AAMC about national issues back to the students at their schools. If you have questions or concerns to communicate to OSR or AAMC, I would encourage you to contact me or any of the Administrative Board members listed on page 2. We do our best to represent your interests on the national level, and we try hard not to become isolated or complacent. We operate most effectively, of course, if we can maintain close communication with all medical students. Please let us hear from you; we need as much feedback as possible.

Paul Scoles
OSR Chairperson

FINANCIAL AID FOR MEDICAL STUDENTS: A SHIFT IN PUBLIC POLICY

The enactment of the health manpower law (PL 94-484) over a year ago signaled a major shift in public policy with respect to the financing of medical students' education. However, the failure of the federal government to issue regulations to implement the new legislation during the past year has produced uncertainty for students and financial aid officers for this academic year.

Two underlying assumptions form the basis of student financing mechanisms in PL 94-484:

(1) *Student financial aid can be used as a lever to ensure the even distribution of physicians by specialty and by geographic practice location.* Federal financial aid for medical students has been available in ever-increasing amounts—as both scholarships and loans with generous repayment provisions—since a U.S. doctor shortage was identified in the early 1960's. Since then, these student aid programs, in conjunction with various types of institutional incentives for increased sizes of medical school classes, have produced significant increases in absolute numbers of U.S. physicians. Nevertheless, legislators continue to hear from their constituents about severe shortages of medical personnel in rural and inner-city areas. Both the executive and legislative branches of government have therefore come to believe that merely increasing the number of doctors is not enough; mechanisms must also be designed to assure that physicians will serve the tax-paying public in the locations and specialties in which they are most needed. Hence, PL 94-484 created a new and ex-

(Continued on page 3)

ISSUES, PLANS, AND DIRECTIONS FOR COMING YEAR

This year, as in the past, the OSR has identified several areas of particular concern to medical students, and members of the OSR Administrative Board have been designated to coordinate OSR efforts in each of these areas. If you are interested in any of these topics, contact either the individuals listed or OSR Chairperson Paul Scoles.

Financial Aid—The crisis in financial aid for medical students is a subject of continuing concern to OSR and AAMC. Immediate-Past-Chairperson, Tom Rado, serves on the AAMC financial aid task force which is currently developing strategies for viable and satisfactory sources of funding for medical students. Fred Emmel and Clay Griffin are also very knowledgable on the subject and will be coordinating our work in this area.

Directory of Graduate Medical Education Programs—There is a consensus within OSR that students need a significant amount of additional objective information on available graduate training programs than is currently offered in the *NIRMP Directory*. Administrative Board members Molly Osborne and Dan Miller are exploring with NIRMP the feasibility of expanding the Directory to include additional data.

Stress—Finding ways to identify and reduce non-productive stress in medical education has been an on-going interest of OSR. At the recent Annual Meeting, the OSR approved a resolution on a related topic—the effects of sleep deprivation on the learning process—which will serve as a focus for our efforts this year. Dennis Schultz and Paul Scoles will be working with other board members to develop a report on this subject with specific proposals for AAMC policy.

Graduate Medical Education—The OSR continues to be interested in housestaff affairs. With the legislation to grant housestaff the right to unionize under the National Labor Relation Act stalled in Congress, our attention has shifted to more general concerns about graduate medical education and alternative forms of residency training. Cheryl Gutmann, the student member of the AAMC Task Force on Graduate Medical Education, keeps the Administrative Board informed about all issues and developments relating to graduate medical education including NIRMP.

Legislation—It is a monumental task to keep track of the mountain of state and federal legislation relating to medical education. This year, Jim Maxwell will keep abreast of legislative developments at the state level, and Peter Shields will concentrate on national health legislation. Jim and Peter will be assisted in this area by Fred Emmel, who is located in Washington.

Other Issues—Other areas of continuing interest to OSR are:

Women in Medicine: Molly Osborne
Minority Affairs: Clay Griffin and Paul Scoles with the assistance of Winston Griner of the Student National Medical Association
Curriculum & Evaluation: Dennis Schultz
National Board Exams: Mike Mahl

STUDENT PARTICIPATION IN MEDICAL SCHOOL ACCREDITATION

During the past several years, OSR has been actively engaged in an effort to increase medical student participation in the accreditation process. The work of OSR in this area has been particularly successful, and it now can be said that formal mechanisms exist for students to be involved in every aspect of the accreditation process.

In order to understand how students fit into the total picture of medical school accreditation, a little background information is essential. The group which is charged with the responsibility of accrediting medical schools is the Liaison Committee on Medical Education (LCME). Formed in 1942, its membership consists of six representatives from AAMC, six representatives from AMA, and two public members. In addition, the Association of Canadian Medical Colleges is represented by an observer/participant who votes only on Canadian medical schools, and the Secretary of HEW designates one non-voting representative.

The LCME conducts periodic reviews of American and Canadian medical schools. The spectrum of actions the LCME can take ranges from denial of accreditation to full accreditation for ten years. Usually, the actions taken by the LCME fall somewhere in between, and accreditation

(Continued on page 4)

FINANCIAL AID *(Continued from page 1)*

panded National Health Service Corps Scholarship program under which tuition, fees, and a monthly stipend are paid to recipient students, in exchange for their commitment to practice medicine in specified shortage areas. Those who control the federal purse strings have strongly endorsed this approach of straight-forwardly buying the physician services that the government perceives to be needed. The anticipated appropriation for the NHSC Scholarship program for this fiscal year is $60 million, which would support roughly 4,680 medical student recipients. The availability of NHSC Scholarships will permit some students who are utterly without financial resources of their own to obtain a medical education, but only if they are willing—for at least a portion of their careers—to accept certain restrictions on where and when they will practice medicine. However, the NHSC program is not, strictly speaking, a financial aid program since, as with Armed Forces Scholarships, need is not a criterion for selection of scholarship recipients.

(2) *Since physicians have been among the most highly remunerated workers in our society, those who do not agree to repay the cost of their medical education by service in an underserved area should be willing and able to repay in dollars, plus full interest, whatever funds they borrow for medical school expenses.* PL 94-484's new Federal Program of Insured Loans to Graduate Students in Health Professions Schools permits students to borrow up to $10,000 per year and originally permitted the annual interest rate on loans under the program to be as high at 10%. Current legislative amendments passed by the Congress and awaiting the President's signature would raise the maximum interest to 12% plus up to 2% for insurance against unpaid loans. Although repayment of principal does not begin until several months after completion of medical school and may continue for as long as 15 years, interest is payable throughout the life of the loan, including while the borrower is in school. A student who borrows $10,000 a year at 10% interest for four years of medical school will owe $4,000 in interest alone during the fourth year. What effects this debt level will have on students' specialty choice and geographic location and whether this level of debt burden (in addition to whatever debt the student may have incurred in undergraduate school) is manageable, particularly when salaries of young physicians in post-graduate training are taken into consideration, remains to be seen.

The absence of regulations to define the details of these two approaches to medical student financing renders both programs inoperative for the current school year. Further, funds available under the previously enacted Health Professions Loan and Health Professions Scholarship programs are diminishing. It appears that students are relying instead on other federal aid sources not targeted to the health professions (such as Guaranteed Student Loans and National Direct Loans), on privately sponsored loan and scholarship programs (such as AMA-ERF loans, the new Robert Wood Johnson Foundation guaranteed loans, and National Medical Fellowships), and on family contributions.

AAMC UNDERTAKES GRADUATION QUESTIONNAIRE

How and why physicians choose particular careers and modes and places of practice is of great interest to the nation's medical schools, the federal government, and the AAMC. AAMC collects much data about medical students during the application phase and as they progress through medical school, but until now, no systematic and complete data has been available to show what the "outcome" of medical education has been, i.e., how the medical education process affects the attitudes and aspirations of physicians in training.

In order to build a longitudinal database, AAMC is undertaking an annual survey of all graduating medical students to learn about their experiences in medical school, their plans for graduate medical education, and their ultimate plans for practice/career. The Medical Student Graduation Questionnaire will be administered at 110 medical schools in early 1978 prior to the announcement of NIRMP residency matching results.

Information from the survey will not only help to answer national questions about medical education and physician distribution but will also provide every medical school with feedback on how its graduating students view the strengths and weaknesses of the education program. One feature of the survey is a page provided for candid comments from students about their medical schools. With the student's consent, this portion of the questionnaire will be mailed back to the schools by AAMC (without any identifying information) so that schools may use these comments to evaluate their curricula, administrative policies, and other aspects of their programs.

OSR representatives who have been involved in the planning and development of the questionnaire have been very enthusiastic about the project as a means of collecting important longitudinal data and as a mechanism for students to directly influence the way in which their medical schools will educate future students.

It may be that predictions that medical education might someday be seen as a viable option by only wealthy students may already be turning into reality. The applicant pool for 1978 entering classes to schools of medicine is 10% smaller than was the 1977 applicant pool at this time a year ago. One possible interpretation of this phenomenon is that perceived financial barriers are convincing significant numbers of undergraduate students not to apply to expensive health professions educational programs. The issue of whether low- and middle-income students of all descriptions are abandoning thoughts of medicine as a career because they cannot afford medical school has profound implications for the nature of health care delivery in the future. The AAMC Task Force on Student Financing is examining this situation as a part of its charge to analyze how medical students are actually financing their education and how appropriate sources of financial assistance may be stimulated.

NIRMP *(Continued from page 3)*

greater freedom of choice than would be possible without a matching program. Prior to the creation of NIRMP, students were being forced to reach decisions about programs before they had a chance to complete all of their interviews and to rationally consider all of their alternatives. Because of the uniform-timing structure of NIRMP, all participating students and hospitals have a designated period of time to sort out what they know about each other and to reach thoughtful conclusions. NIRMP does not make decisions; it is simply a "black box" which facilitates the decision-making process.

Another misconception about NIRMP involves how the algorithm works to match students to programs. All students participating in NIRMP should carefully review the detailed description of the algorithm and the step-by-step analysis of the actual matching process which is included in the *NIRMP Directory*. As the analysis in the *Directory* clearly indicates, it is to a student's advantage to rank order programs according to desirability and not according to perceived chances of getting into those programs. Students who maximally utilize the match rank "long shot" programs first with more realistic choices ranked lower on the list.

NIRMP RULES AND VIOLATIONS

In order for NIRMP to best serve its consumers—students and hospitals—certain rules must be strictly adhered to by both parties. The fundamental principle for students to remember is that by participating in the match, they are entering into a binding, contractual agreement that they will apply only to programs registered with NIRMP and will accept the program to which they are matched. Naturally, hospitals must play by similar rules, and only cooperation from both sides will keep NIRMP a viable system.

Much has been reported in recent years about violations of NIRMP guidelines, and the most frequently publicized infraction has been the making of "deals" outside the match. Neither hospitals nor students may demand any sort of statement of intention from the other about how they will be ranked. No written or verbal agreements made prior to submission of the rank order lists are binding, and students would be ill-advised to regard them as such. Every year, a significant number of students who have listed only one choice on their rank order list (and who presumably have had a prior commitment from that hospital) have not matched.

Another common violation which occurs just prior to the release of the match results involves unmatched students and unfilled programs. Medical school student affairs deans often notify unmatched students of their status prior to the time of the general release of results in order to allow them extra time to adjust to the fact that they did not match and to consult with their families. It is not necessarily a violation for unmatched students to make alternative plans and to discuss their plans with a dean or faculty advisor, but it is a clear violation for students to take actions to secure positions prior to the time of general release of results. Likewise, it is a violation of NIRMP rules for program directors to make attempts to fill any unfilled positions before match results are released. The importance of uniform adherence to this rule is obvious. Premature action by some students puts other unmatched students at a very unfair disadvantage when attempting to locate a desirable position.

COUPLE MATCHING

NIRMP does have special provisions for students who wish to match together as a couple. Students who choose this option must complete a special form available in all deans' offices indicating whether they are seeking positions in the same hospital, the same community, the same metropolitan area, etc. The matching mechanism is more intricate for couple matching, and interested students should consult with their dean and/or contact the NIRMP office directly for a detailed description of the special considerations involved when two students match together.

The matching program has functioned well for the past 25 years by providing students the maximum amount of time possible to reach decisions about program choice while providing directors adequate time to plan their programs for the next year. Physicians who sought graduate training positions and the medical school administrators who counseled them in the pre-NIRMP era, will attest to the importance of maintaining the program through the mutual cooperation of both students and program directors.

To contact NIRMP: Write to 1603 Orrington Avenue, #1155, Evanston, Illinois 60201 or call 312-328-3440.

FUTURE OSR MEETINGS:
OSR Northeast Regional Meeting
May 10-12, Toronto, Canada
OSR Annual Meeting
October 21-24, New Orleans, Louisiana

OSR REPORT

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Editor: Diane Newman, AAMC Division of Student Programs, One Dupont Circle, N.W., Washington, D.C. 20036, (202) 466-5057.

OSR Report

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Spring 1978

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Association of American
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for
The Organization
of
Student Representatives

Special Issue:

The
Residency
Selection
Process

OSR National Chairman:
Paul Scoles

OSR National Chairman-
Elect: Peter Shields

CHAIRMAN'S PERSPECTIVES

Past issues of *OSR Report* have presented three or four current medical education topics in order to inform medical students about what is going on at the national level. This issue, however, will deal solely with one topic—the residency selection process—in an effort to bring some order to what has become an increasingly chaotic and confusing process. The transition from medical school to graduate training programs has become more complex in recent years due in part to a declining ratio of program places per graduate. Major initiatives have been undertaken by AAMC and OSR to examine the current structure of graduate medical education with particular emphasis on the transition phase. In light of these initiatives, the OSR decided to devote an entire issue of *OSR Report* to such topics as specialty selection, interviewing, and NIRMP with the hope of making the transition process as satisfactory as possible for medical students.

Since the OSR has been exploring issues related to residency selection for the past year, I have had numerous conversations with student affairs deans around the country who counsel students in this area. The one point that has been consistently raised is that students should approach their decisions about graduate programs in a rational, orderly, and calm manner. It seems that for too many students the business of looking for a suitable residency musters up bad memories of the medical school application process, and before they know it, the premed panic of not "getting in" and of fiercely competing with peers for those treasured places in medical school returns to haunt them. With careful planning and by taking advantage of the information sources which are available, the panic can be avoided and the residency selection process should go smoothly for all medical students.

I hope this issue will be helpful to you. As usual, if you have further questions or need specific advice, feel free to contact me or any member of the OSR Administrative Board.

Paul Scoles
OSR Chairman

RESIDENCY SELECTION TIMETABLE

The following outline provides suggestions about when various steps in the residency selection process should take place. This timetable is meant to give you a reasonable idea of the chronology of the process but by no means covers all special circumstances such as accelerated curricula and early graduation. All students are urged to consult individually with student affairs personnel or faculty advisors early in the process to map out their specific plans.

(Continued on page 3)

REPLIES NEEDED TO "SURVEY OF HOW STUDENTS FINANCE THEIR MEDICAL EDUCATION"

As of April 12, questionnaires had reached the AAMC for only 37% of the 10,937 students selected to participate in this important survey, which is sponsored in part by OSR. If you are in the sample and have not yet replied, *please do so immediately*. Full cooperation is essential to provide the data necessary to justify needed improvements in medical student financing.

RESIDENCY SELECTION BIBLIOGRAPHY

DIRECTORIES:

NIRMP Directory. Published annually in October by NIRMP and distributed to students via the deans' offices. Includes a complete description of the matching plan and an up-to-date listing of participating programs by specialty and by location.

Liaison Committee on Graduate Medical Education Directory of Accredited Residencies. Published periodically by the AMA and distributed to students via the deans' offices. The latest edition (1977-78) was published in February 1978. Includes descriptive data such as affiliation, control, and number of beds for all hospitals which offer accredited residency programs as well as data such as average daily census, annual admissions, and annual outpatient visits for all programs. Also contains the LCGME document, "Essentials of Accredited Residencies."

American Hospital Association Guide to the Health Care Field. Published annually by AHA and available in most medical school libraries. Includes data on control, average length of stay, number of beds, admissions, census, % occupancy, newborn statistics, expenses, and number of personnel for all AHA-registered hospitals.

Council of Teaching Hospitals (COTH) Directory. Published annually by the AAMC and available in all deans' offices. Provides information similar to that included in the AHA Guide as well as data on residency programs (number of positions offered/number filled/number filled by foreign medical graduates) for the 400 COTH member hospitals.

Directory of Institutions Offering Reduced-Schedule Training. Published by the Harvard Reduced-Schedule Residency Project, 25 Shattuck Street, Boston, MA 02115. The 1977 edition with addenda for new programs can be ordered at this address for $3.00/copy. Based on a survey of over 1700 hospitals with accredited residency programs, this directory lists the various reduced-schedule options available by location and by specialty.

BACKGROUND READING:

"An Applicant's Evaluation of a Medical House Officership," M. J. Raff and I.S. Schwartz, *New England Journal of Medicine,* September 1974.

"The Development of Views of Specialties During Four Years of Medical School," C.N. Zimet and H.L. Held, *Journal of Medical Education,* February 1975.

"A Formal Procedure for the Determination of Internship Preferences," L.B. Grochow and J.M. Grochow, *Journal of Medical Education,* March 1976.

Handbook of Medical Specialties, H. Wechsler, Human Sciences Press, New York, N.Y., 1976.

"Intellectual, Personality, and Environmental Factors in Career Specialty Preferences," R. Paiva and H. Haley, *Journal of Medical Education,* April 1971.

"Programs and Positions Available to U.S. Medical Students Through NIRMP, 1976," J.S. Graettinger, *Journal of Medical Education,* May 1977.

"Results of the NIRMP for 1978," J.S. Graettinger, *Journal of Medical Education,* June 1978 (in press).

"Selecting Your Internship and Residency," M.J. Raff and I.S. Schwartz, *The New Physician,* October 1974.

A Student's Guide to the Appraisal and Selection of Housestaff Training Positions, Available from the American Medical Student Association (AMSA) at no charge for AMSA members and for $1.00 for non-members.

TIMETABLE *(Continued from page 1)*

I. SELECTION OF SPECIALTY AND PROGRAM TYPE

During the SPRING OF THE THIRD YEAR, students should try to reach a decision about their preferred specialty in order to narrow down the range of programs of interest and to plan for their fourth year. At this time, many students arrange fourth-year electives at other schools as a means of gaining first-hand knowledge about programs at other institutions. Students having difficulty choosing a specialty might wish to discuss with an advisor or with fellow classmates the possibility of taking the Meyers Briggs Type Indicator or the Medical Specialty Preference Inventory (MSPI). MSPI is a relatively new test currently being used by several schools to help students assess their interest in the various specialties. It is structured in such a way that it can be used by students individually or as a tool for counseling by deans' offices.

Also during this time period, students should begin to think about program type (i.e., categorical, categorical*, and flexible). A categorical program is sponsored by one residency program with the content limited to the specialty area of the sponsoring program. A categorical* program is also sponsored and supervised by one residency program but may include experience in one or more additional specialty field(s). Flexible programs are designed to provide a broad clinical first year and are sponsored and supervised jointly by two or more residency programs.

II. INFORMATION GATHERING

During the EARLY SUMMER FOLLOWING THE THIRD YEAR, students should begin to collect information about programs of interest by reviewing references listed in the Bibliography and by writing for program brochures and application forms. In addition to the data available from these sources, the annual reports of individual teaching hospitals are potential resources for gaining insight into the institutional environment of training programs.

III. APPLICATION

By the END OF THE SUMMER students should have developed at least a tentative list of programs in which they are interested. When this has been accomplished, students can begin filling out applications and arranging with the dean's office for other necessary application materials such as letters of recommendation and transcripts.

IV. INTERVIEWS

The next step in the process, which should occur in the EARLY FALL OF THE FOURTH YEAR, is to schedule interviews with program directors. It is important to coordinate the interview schedule with the dean's office to avoid problems with the timing of letters of recommendation and potential conflicts with course work. Also during this time period, students may need to follow-up on applications if some programs have not yet responded to their initial contact.

The AMSA *Guide to the Appraisal and Selection of Housestaff Training Positions* is particularly helpful in terms of maximizing the interview as a learning experience for students. Most students will find it helpful to prepare for interviews by outlining on paper career goals and objectives and by listing specific questions they want to ask during interviews since certain types of information (e.g., the candid views of current housestaff about the program) can best be gained in the interview.

V. MATCHING

In MID-FALL, students will receive the *NIRMP Directory,* which lists all programs participating in the match. The *Directory* will also include a schedule of key dates for the match. Deadline dates vary slightly from year to year, but in general, the deadline for applications to programs is in early January with the student rank order list due at the NIRMP office by mid-January. The announcement of match results usually occurs in mid-March. For additional information about the matching process, see the article on NIRMP.

NIRMP—WHAT YOU NEED TO KNOW ABOUT THE MATCH

NIRMP—the National Intern and Resident Matching Program—may be an ominous term for students in their final year of medical school. Making decisions about which hospitals to apply to and how to rank programs on the student rank order list is a time-consuming endeavor which requires careful and deliberate thought. Because these decisions are major and because NIRMP is inextricably linked to their outcome, it behooves medical students to learn what NIRMP is and how it works.

An important and reassuring fact is that NIRMP has been successfully matching over 90% of participating U.S. students to hospital programs of their choice for over 25 years. In the 1978 match, 94% of U.S. students were matched to a program which appeared on their rank order list. During NIRMP's history, the nature of graduate medical education has changed dramatically, but the mechanics of the match have remained virtually unchanged. Students apply to hospital programs and then prepare a list, ranking in descending order of preference, the programs to which they have applied. Hospitals rank applicants in a similar manner, the two lists are fed into a computer, and each student is matched with the program highest on his/her list which offers him/her a place.

MYTHS ABOUT NIRMP

One of the most common misconceptions about the match is that by participating in NIRMP, students relinquish their decision-making authority to a third party. In reality, the existence of NIRMP guarantees students a

NARI

The National Association of Residents and Interns and Practicing Physicians (NARI) is a nonprofit membership association founded in 1959; since then, it has enrolled over 80,000 members. Dues are $12.50/year and are payable upon application for membership. In general, NARI's purpose is to offer members economic advice and assistance, group discount privileges, and insurance programs. Of greatest interest to medical students will be the $2600 Senior Student Loan Program. Associates Financial Services Corporation administers this program and requires that you furnish some form of life insurance. If you assign an existing policy, the annual interest rate for this loan is 16.9%. If you request Associates to provide credit life insurance, a nominal premium cost will be added to your monthly payments. With regard to the high interest rate, it is important to remember that this is not an educational loan. On their own, medical students with no collateral could probably not obtain a non-educational loan from a bank at even the highest of rates. In that sense this program provides a unique service, especially to students who do not qualify for financial aid but who require extra funds for interview travel, moving, etc.

Another service NARI offers is the arrangement of seminars on money management, including discussions of setting up a medical practice and of financial traps to look out for. For more information on arranging a seminar at your campus and on NARI and its spectrum of offerings, call Dennis Freeman at their toll-free number (800/221-2168; inside N.Y.: 212/949-5960).

SUMMING UP

It is important to keep informed about the current status of legislation affecting student financing. One excellent source of information to consult is the *Chronicle of Higher Education,* published weekly and subscribed to by most libraries. *The New Physician,* a magazine published monthly by the American Medical Student Association, is also a good source of current information. Another readily available reference on financial aid programs is *Medical School Admission Requirements,* published annually by the Association of American Medical Colleges. The 1980-81 edition will be coming out in April and will contain an extensively revised section on financial information for medical students, including an up-dated bibliography.

Many benefits accrue from becoming educated about the financial aid scene—not the least of which is that you can write cogent letters to your Congressman expressing your concerns. Of course, the main benefit is that such knowledge, especially during these times of limited resources, is prerequisite to making sensible financial decisions. Though you may sometimes feel that most of your financial decisions are made for you—either directly, by your financial aid officer or parents or indirectly, by Congress—you have a larger field of action than you might think and numerous difficult decisions ahead. The more you know about managing your personal finances and about how changes in the financial aid picture may affect you, the broader your field of action and the wiser your choices will be.

FOOTNOTES

[1]*Undergraduate Medical Education: Elements, Objectives, Costs*—A Report by the Committee on the Financing of Medical Education. Washington, D.C.: Association of American Medical Colleges, October 1973.

[2]*Cost of Education in the Health Professions,* Parts I and II. Washington, D.C.: National Academy of Sciences, January 1974.

[3]Joseph A. Califano, Jr., Secretary, Department of Health, Education and Welfare. Remarks presented at the annual meeting of the Association of American Medical Colleges, New Orleans Hilton Hotel, New Orleans, Louisiana, October 24, 1978.

[4]Travis L. Gordon, *Studies of Medical Student Financing, 1977-78: Preliminary Report.* Washington, D.C.: Association of American Medical Colleges, October 1978.

[5]Forebearance: A special arrangement whereby the lender may delay principal and/or student billed interest payments to relieve the borrower's financial hardship when repayment is due.

[6]Default: Failure to meet financial obligations on maturity of notes or contractual agreements. Defaults are recorded on an individual's permanent credit record and that individual is subject to lawsuit.

[7]*COTH Survey of House Staff Policy & Related Information, 1978.* Washington, D.C.: Association of American Medical Colleges.

FUTURE OSR MEETINGS:

OSR Southern Regional Meeting
March 22-24, Little Rock, Arkansas

OSR Western Regional Meeting
April 21-24, Pacific Grove, California

OSR Central Regional Meeting
May 3-5, Rochester, Minnesota

OSR Northeast Regional Meeting
May 10-12, Boston, Massachusetts

OSR REPORT

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OSR Report

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for
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of
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Special Issue:

Your Funds and
Your Future: a Guide
to Financial Planning

CHAIRMAN'S PERSPECTIVES

The OSR Administrative Board believes that the single most troublesome worry for all but the most fortunate of medical students is finances. Most of us, as students, have been dependent for most of our lives and have had to sit, in most cases quietly, watching tuitions increase and financial aid become more difficult to find. There is every reason to believe that this situation will get worse before it gets better. One contribution the OSR can make in the face of this grim situation is to offer you this issue of the *OSR Report* on personal finances. In fact, this issue might well bear the label "Warning: May contain information you won't want to hear." Only if you believe that foresight is better than hindsight, will you want to read on.

Although this issue will probably be of greatest value to those students who have borrowed or soon will be borrowing money, it deserves a broader audience since it provides basic information on budgeting, banks, and the like and since no one can predict what situations may arise which will require the borrowing of funds. This pecuniary primer begins with a brief discussion of the cost of a medical education and how medical students are currently financing that portion of this cost which is charged to them. The next sections are about borrowing money and contain a guide to budgeting, a sample chart for keeping track of loans, and a methodology by which you can estimate what portion of your salary during graduate education will need to be set aside for debt repayment. A final section should help you make sure you have covered all your financial bases. While we understand that the discussion of various aspects of money management offered here cannot be exhaustive, we know that many students do not have ready access to these kinds of information and thus hope that this issue will provide a helpful introduction to the topic.

There are many other aspects of finances which we did not attempt to address here: sources of and recent developments in financial aid; the uncertain future of government support for medical education; predictions about the effect of a doctor oversupply on physicians' incomes. Medical students need to broaden their financial horizons beyond the next tuition increase and their source of information beyond their overworked financial aid officer. We hope that the information presented here will provide a prod in that direction, and we would greatly appreciate any comments you have on our efforts.

Peter Shields
OSR Chairperson

IN THE BEGINNING WAS FINANCIAL AID?

A word about the cost of a medical education is an appropriate introduction. Because medical schools not only train doctors but also produce research and provide patient care, separately estimating the average cost of one of these activities is a complex task, one which was undertaken by the AAMC in 1973[1] and by the Institute of Medicine in 1974.[2] The results of the AAMC study show the institutional cost of an undergraduate medical education in the twelve schools studied to range between $16,000 and $26,000 per student per year in 1972 dollars, depending on the individual school being considered. In 1978, this means an average of $125,000 for the four-year term, based on the AAMC estimate for full resource cost of $31,400 per student per year. Among other things, these figures reveal that even schools which charge over $10,000 per year in tuition must additionally rely upon many other sources of support in order to provide a quality program.

Since 1963, the federal government has been a major source of such support. A major objective of the government in providing financial assistance was to cure a perceived shortage of doctors by increasing the supply. Now that a national oversupply of physicians is projected by 1990[3]—with no guarantee that, allowed to choose freely, doctors will enter locations or specialities in short supply—it should be no surprise that the character of government support is changing and that medical students are being asked to bear more of the burden in terms of tuition, service commitment and high interest loans.

The size of this burden has caught many medical students unprepared. Prior to entering medical school, they did not give the question of financing much thought, believing that acceptable alternatives would be available. It has come as a shock to many that there is no more "easy money"—a fact well-documented in the September 1978 issue of *The New Physician*. The most recent figures on how medical students are financing their education[4] reveal that average annual expenses rose from $7,085 in 1975 to $9,260 in 1978 and that the proportion of students receiving scholarships dropped from 45% to 42%; of those receiving scholarships in 1978, 29% were National Health Service Corps or Armed Forces award recipients. In the last three years, the proportion of students depending to some extent on loans increased from 50% to 56%. These percentages are not mutually exclusive, for most students who receive grants also rely on loans. This study also reports that the proportion of students with debts has increased from 44% in 1968 to 73% in 1978; the average debt for senior students has climbed from $4,397 to $13,800 during this time period.

Times are changing, creating new demands on and expectations of the medical profession and physicians-in-training. Not only are medical students going to be learning more about hospital cost containment; in order to prevent distruption of their studies, medical students are also going to have to learn more about personal money management. Some students have opted to forego the lion's share of financial hassles by accepting a service-obligated "scholarship" contract. To be sure, freedom from financial worries is not the only reason students seek such contracts, but it is an understandably important consideration. However, here are some of the fears associated with these service programs: (1) there are not enough scholarships for people who need them; (2) the characteristics of the programs keep changing from the time students sign the contract, e.g., taxability of the monies; (3) there might not be enough spots or proper process to place physicians in shortage areas when they enter the service obligation via the NHSC; (4) accepting an obligation may interfere with career and family planning. Other complaints are really sour-grape arguments from individuals who did not read the contract carefully enough before signing.

But alternatives can be just as frightening. Students whose families cannot fully support them and who have not gained acceptance into a service commitment program face the rocky road of loan-garnering and debt management. Here is some advice that may help to smooth the way.

ABOUT BORROWING MONEY

The student financial aid picture is an everchanging one; thus, a good proportion of the information which you may have gathered and studied during college is out-of-date. And your own financial situation has probably changed since then as well. The lesson here is: if you require funds to complete medical school, you need to keep abreast of the financial aid scene in order to make informed decisions about your financial situation.

The first step is to obtain *detailed descriptions of existing loan programs,* so that you can decide which ones may be of use to you, and a *glossary of financial terms* (e.g., deferred interest, maturity date, etc.), the understanding of which is prerequisite to completing an application for a loan. An increasing number of financial aid officers are putting together financial aid handbooks which include these kinds of information. If you do not have access to such information, an excellent handbook has been developed at George Washington University. You may obtain a copy by writing to Ms. Jean Hammer, Director of Financial Aid, George Washington University School of Medicine and Health Sciences, Washington, D.C. 20037.

The rest of this section is a guide to the more complicated and less often addressed aspects of borrowing money—budgeting, banking, and keeping track of your loans.

completed a three-year residency. The principal must be repaid in ten years.

The second phase of this exercise is to consult the table below on house officer stipends. Because average salaries vary not only by region by also by type of hospital and because the salaries given represent gross income, i.e., before deduction of income and social security taxes, this chart can be used only as a very rough guideline. These caveats aside, pick a first-year salary, divide by twelve and compare this amount to your computed monthly debt payments. Continue this process for the remaining years of post-graduate training. You can probably estimate an annual 5 to 6% increase in the stipends shown in the table, recognizing that lower annual increases may be on the horizon as a result of voluntary or compulsory cost containment.

If, as a freshman or sophomore, you feel unable to project the extent of your borrowing, you are encouraged to take a stab at it anyway and to complete the above-described exercise. While there is still time, you can take steps to avoid the financial trap that some of your upperclassmen friends find themselves in.

If the comparison of salary and debt payment frightens you, discuss your concerns with your financial aid officer; be sure to bring your work sheets with you for this appointment. In coming to terms with your financial situation, here are a few additional points to keep in mind. First of all, repayment schedules are not writ in blood. In dealing with hardship cases, lenders may exercise forebearance[5] or be willing to renegotiate a loan and to design a repayment schedule which you should be able to manage. The success of such negotiations will depend on your willingness to bare your financial soul. Working *with* lenders—as opposed to avoiding your predicament, with default[6] the likely outcome—is always in your own best interest. Your credit rating may not seem so important now, but a good rating will seem essential in a few years when you will require funds for setting up practice or purchasing a house. Remember also that in addition to having a legal responsibility to pay your debts, you have a moral one. Your repayments make it possible for others to attend medical school. One final reminder: in figuring your federal income tax, if you itemize deductions, you can deduct interest payments from your adjusted gross income.

OTHER OPTIONS TO CONSIDER

Loan Repayment Programs

The good news: Several states sponsor loan repayment programs for medical students who are residents. These states provide substantial loans to students who will contract to practice in that state's underserved areas upon completion of training. To ascertain if your state offers such a program, write to: National Health Council, Inc., 1740 Broadway, New York, New York 10019 or phone: (212) 582-6040.

The bad news: Prior to the signing into law of the Health Professions Educational Assistance Act of 1976, most types of loans were "forgiveable" in exchange for service in a shortage area. This law states that "henceforth, when funds are available, the loan repayment provisions are limited only to the Federally funded Health Professions Student Loans." Thus, this enactment greatly narrowed the loan repayment provisions. The reason for this change was the perception that the forgiveness option was not being used, an incorrect and premature observation.

Tuition Payment Plans

Several commercial financing companies offer payment plans for graduate education. The interest rates are generally between 11 and 12%, and funding is usually limited to parents of students. Under these plans, parents may borrow up to $20,000. Payment of interest and principal begins immediately in monthly installments.

For more information, write to:

Girard Bank
Education Loan Section
1339 Chestnut St.
Philadelphia, PA 19107

Richard C. Knight
Insurance Agency, Inc.
6 St. James Ave.
Boston, MA 02116

The Tuition Plan
Concord, NH 03301

Riggs National Bank
Dupont Circle Branch
1913 Massachusetts Ave.
Washington, D.C. 20036

School Chex
Irving Trust Co.
P.O. Box 12231
Church St. Station
New York, NY 10249

1978 Median Stipend, by Region[7]

Year of Training	Northeastern	Southern	Midwestern	Western	Nationwide
1st Post-MD Yr	$14,230	$12,302	$13,999	$13,568	$13,860
2nd Post-MD Yr	15,227	13,090	14,675	15,104	14,801
3rd Post-MD Yr	16,112	13,810	15,474	16,447	15,681
4th Post-MD Yr	17,066	14,450	16,148	17,490	16,465

Budgeting

Many accepted this salutary habit long ago. Many find the thought so unpleasant that they have never really tried it. But, like it or not, budgeting is the first step in sensible financial management. On page 4 is a sample budget which might serve as a guide to the uninitiated in this art of predicting expenses and resources. Although your personal budget should be more detailed, your financial aid officer should share with you the institutionally prepared budgets so that you can compare amounts under such umbrella categories as housing, transportation and medical expenses. This comparison might reveal an extravagance you need to think twice about or a problem on the horizon best dealt with before the fact. Here are a few additional suggestions for designing a financial calendar:

1) Prepare a budget you can live within: underestimation can lead not only to a sense of failure followed by out-of-hand rejection of the whole process but also, and more importantly, to the jeopardy of your physical and mental health.

2) Trim your budget of luxury items: remember that when you are relying on loans every dollar you spend must be repaid with interest and that some pleasures are postponable until a paycheck can absorb the expense.

3) Use your budget as a decision-making tool: *before* signing a lease or buying a car, weigh all of the concomitant expenses, e.g., insurance, then consult your worksheets to determine the impact of your decision.

4) Create a well-organized file for your financial papers: get in the habit of writing down your expenses at the end of each week. Keeping track of errors and victories in planning will provide a useful guide for the future.

5) Open a savings account: even if you are able to add only occasional, small amounts, a savings account has three-advantages—interest accumulates; the total depletion of resources (a source of truly unproductive stress) is prevented; and the account may be useful as an indicator of reliability and foresight to a loan officer who needs proof of these two traits.

Getting to know your bank

It is a very good idea to establish an open, working relationship with a loan officer at your bank. Before you can hope to establish a relationship, you will need to consider the following facts: 1) Banks accept less of a return on educational loans than on virtually every other kind of investment; not only are the interest rates lower but collection and administrative costs are higher. Moreover, when students default on federally-insured loans, banks retain the notes on their books for months, without earning interest, because the government is often slow in paying these accounts. 2) Relationships of banks with their student borrowers are often strained because of the high default rate, minimal returns, and the fact that students tend to view bankers as bogeymen. Students do not realize that banks often participate in educational loan programs mainly because they believe in education and want to provide a community service. 3) Even though the educational loan business is a relatively new industry, lenders are already becoming very worried about the amount of debt they are saddling students with; thus, a reticence on their part to lend you funds should not automatically be construed as a kind of prejudice or distrust. The *business* of loan officers is money management. They are prepared to give you advice you may not know you need.

Keeping Track

Before signing a loan application or promissory note be sure to determine the following information: 1) the maximum amount that may be borrowed per academic year as well as the maximum aggregate amount; 2) the interest rate and whether the interest is deferred until after graduation, subsidized, or payable while you are in school; 3) whether the interest, if not deferred, is payable monthly, quarterly or annually; 4) whether the loan may be repaid at any time without penalty; 5) if repayment of the principal and/or interest can be deferred through residency training; 6) the grace period and the number of years allowed for repayment; 7) whether the loan can be forgiven for practice in a physician shortage area; and finally 8) what the required monthly payment will be during the repayment period. Additionally, try to help your financial aid officer help you by following directions on loan applications, allowing enough time for processing, and keeping records of all transactions. Below is a chart titled "Record of Outstanding Loans"; you are encouraged to copy this chart or develop your own system for keeping track of loans.

STUDENT RECORD OF OUTSTANDING LOANS

						Repayment Terms		
Name of Loan/Lender	Date Incurred	Amount Borrowed	Interest	Date Due	Grace Period	Repayment Period (years)	Minimum Monthly Payment	Student's Projected Monthly Income
1.								
2.								
3.								
4.								
5.								

There are many sound reasons for keeping such a chart up-to-date. One of these is to prevent your "exit interview" with your financial aid officer around graduation time from becoming a shock treatment. At this interview, you and the aid officer will review your total financial obligations. It is the latter's responsibility to ascertain if you understand repayment terms, the importance of keeping lenders informed of address changes, and the like. If you enter this interview prepared and informed, it will be an unparalleled opportunity for clearing up any doubts you have and for double-checking your records. If not, it will be an unpleasant collision between you and the financial world you are about to enter.

Sample Budget

Expenses from____to____	*Estimated*	*Actual*
A. Special		
Tuition & school fees		
National Boards exam fee		
Newspapers/journals		
Books & newspapers		
Interest payment		
Savings account		
B. Housing		
Mortgage/Rent		
Utilities		
Telephone		
Electricity		
Gas		
Maintenance		
Furniture		
Other		
C. Food		
Groceries		
Household supplies		
Lunches		
D. Transportation		
Bus/subway		
Auto		
Licenses/fees		
Gas & oil		
Maintenance		
Bicycle		
E. Medical/Dental		
Drugs		
Doctor/Dentist		
Glasses/contacts		
F. Clothing/Personal		
Clothing		
Cleaners/laundry		
Personal care items		
G. Amusement		
Vacation fund		
Books/crafts		
Special events		
H. Insurance		
Hospitalization		
Life		
Auto		
Home owners		

Total Expenses vs. Income

Monthly Income ____
Other Income ____
Total ____
Less Total Expenses ____
Surplus (+)/Deficit (-)____

DEBT MANAGEMENT

The first step in debt management is a prospective one: know how much you owe in principal and interest at any given time. The next step is to calculate how the payments which will be required during the residency years will stack up against an estimated salary. Senior students who have not already done so and juniors who can estimate their debt upon graduation should not delay in referring to their chart of outstanding loans and creating a repayment schedule. While calculus is not prerequisite to such an exercise, a thorough understanding of repayment conditions for each type of loan is: required and minimum monthly payments, length of grace and interest deferral periods, and length of repayment period are important variables. For each type of loan a separate sheet will be required. Your goal is the creation of a schedule which resembles in format the example offered below. Finally, add each schedule into a master repayment calendar, from which you will be able to see at a glance your monthly and annual obligation to lenders.

Example: for the sake of simplicity, let us assume that the student has borrowed $10,000 per year in medical school at 10% simple interest. The student has been paying the interest on the loans while in school and repayment of principal will not begin until the student has

REPAYMENT SCHEDULE

Amount borrowed		Repayment Period:
$40,000	Interest rate: 10%	10 years

Interest Payments

	PER MONTH	PER YEAR
1st Year of Residency	$333.33	$4000
2nd Year of Residency	$333.33	$4000
3rd Year of Residency	$333.33	$4000

Principal and Interest Payments

	PER MONTH	PER YEAR
1st Year in Practice	$666.67	$4000 Principal $4000 Interest
2nd Year in Practice	$633.33	$4000 Principal $3600 Interest
3rd Year in Practice	$600.00	$4000 Principal $3200 Interest
4th Year in Practice	$566.67	$4000 Principal $2800 Interest
5th Year in Practice	$533.33	$4000 Principal $2400 Interest
6th Year in Practice	$500.00	$4000 Principal $2000 Interest
7th Year in Practice	$466.67	$4000 Principal $1600 Interest
8th Year in Practice	$433.33	$4000 Principal $1200 Interest
9th Year in Practice	$400.00	$4000 Principal $ 800 Interest
10th Year in Practice	$366.67	$4000 Principal $ 400 Interest

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FUTURE OSR MEETINGS:

OSR Central Regional Meeting
May 3-5, Rochester, Minnesota

OSR Northeast Regional Meeting
May 10-12, Boston, Massachusetts

OSR/AAMC Annual Meeting
November 3-6, Washington, D.C.

OSR REPORT

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OSR Report

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Special Issue:

Taking Part in the Health Legislation Process: A Guide for Medical Students

OSR National Chairman: Peter Shields

OSR National Chairman-Elect: Dan Miller

CHAIRMAN'S PERSPECTIVES

The demands of medical school on our time and energies often seem to leave little of these two commodities for other endeavors. One of the more unfortunate results of our remaining submerged in day-to-day assignments is that we rarely get a glimpse of the big picture of what's going on in health. While we all realize that health is big business (about 9% of the Gross National Product in 1978), my experience tells me that few medical students realize the extent to which: 1) health funding is a *political* process and 2) the outcome of negotiations which are right now taking place on Capitol Hill will affect their immediate and future situations. It is easy to be confused by and disgruntled with the political process in this country, but such a dismissal will not change the fact that in the coming year or two legislation will be passed which will affect you—as a medical student, resident, and practitioner. Laws don't make themselves; they are the creation of elected officials who are responsive to their constituencies. To be sure, some Congressmen are already well-informed about the health issues on which they vote. However, a greater number are not; and many individuals, including your dean and faculty, find it important to educate legislators about the effects that various Congressional actions may have. On some of these issues—and the best example is student financial assistance—medical students simultaneously expressing their concerns represent testimony which cannot be ignored.

Learning about the health legislation arena should be viewed as integral to the medical education process; it represents yet another area with which you will need to be familiar in order to protect your own interests and the interests of your patients. Now is the time to accept this responsibility and we hope this issue of *OSR Report* will help to prepare you. First described are those items in President Carter's FY 1980 budget which are crucial for you to know about, followed by an outline of the federal budget process. The second section refreshes your memory on how a bill becomes a law. The last section lists the key congressional committees and contains suggestions on how to maximize your input into the legislative process. Obviously, this issue represents only an outline of the subject—the issues facing the health care industry and health professions education are enormously complex and the political process is a challenge to understand. But it is a place to start, and I and the other members of the OSR Administrative Board look forward to hearing your reactions to our efforts.

Peter Shields
OSR Chairperson

REPLIES NEEDED TO "SURVEY OF HOW STUDENTS FINANCE THEIR MEDICAL EDUCATION"

As of April 6, questionnaires had reached the AAMC for only 30% of the 11,062 students selected to participate in the final phase of this important survey, which is sponsored in part by OSR. If you are in the sample and have not yet replied, *please do so immediately*. Full cooperation is essential to provide the data necessary to justify needed improvements in medical student financing.

THE BUDGETARY AND LEGISLATIVE SCENARIO

The underlying theme of the play which is currently being enacted on Capitol Hill is the effort to restrain governmental spending in order to reduce the overall federal deficit and to curb inflation in response to increasingly vocal and dissatisfied taxpayers. Easily recognizable subplots include the Carter Administration's determination to contain rising health care costs and the projected national oversupply of physicians. Thus, while deeply disturbed, the alert members of the health audience were not surprised by President Carter's Fiscal Year (FY) 1980 budget requests and FY 1979 rescission messages.

A rescission is an effort by the Administration to cut or eliminate funds which have already been appropriated by Congress for the current fiscal year; President Carter asked Congress to rescind nearly $168 million which had already been allotted to the Health Resources Administration for health professions education. The 1980 budget request is for a total budget authority, i.e., ceiling, of $57.6 billion for health programs, only 16% of which is for "controllables," i.e., non-Medicare or Medicaid expenditures. Programs aimed at reforming the health system (e.g., health maintenance organization development, conversion of unused hospital beds) appear to be what the President is most interested in expanding. However, it is evident that funding proposed for health professions education programs is far below what is needed to maintain the quality and diversity of the programs. This is how the funding picture is shaping up in the two areas which will have the greatest immediate impact on medical students—financial aid and capitation grants.

Financial Aid Programs

An introduction to current developments in student financial assistance must begin with the Health Professions Education Assistance Act of 1976 (PL 94-484). A comprehensive discussion of the student assistance elements of PL 94-484 is contained in the Report of the AAMC Task Force on Student Financing[1] and in a brochure entitled *Fundamentals*[2] prepared by Francis French, Director of Academic Services, University of Michigan. A brief summary, laden with acronyms, must suffice here. This piece of legislation: 1) emphasized the National Health Service Corps (NHSC) as the device by which the maldistribution of physicians would be alleviated; 2) created the Exceptional Financial Need Scholarship (EFNS) Program for First-Year students, which was then funded at so low a level that only 242 medical students could be accomodated during 1978-79; 3) continued the Health Profession Student Loan (HPSL) Program which also was not funded at a meaningful level; and 4) created the Health Education Assistance Loan (HEAL) Program, designed to be less attractive than the NHSC but without recognition of the unmanageability of the debt levels which will result if students are forced to rely upon it.

Worse yet is the news contained in the FY 1980 budget request. While the President failed to gain Congressional approval for a rescission of HPSL funds for FY 1979, his FY 1980 budget contains *zero* dollars for both the EFNS and HPSL Programs, thereby eliminating new funding for the only need-based programs nationally available, and only enough money for the NHSC Program to maintain the current number of medical student enrollees at approximately 4390 (only seven percent of the total medical school enrollment).

Capitation Grants

The Comprehensive Health Manpower Act of 1971 formally established the capitation mechanism as the primary federal method of providing institutional support to U.S. medical schools. The funds are provided on the basis of enrollment, i.e., *per capita*, with eligibility determined by whether the school responds to federally-identified national health goals. Capitation awards have declined substantially since FY 1972 (from $2065 per medical student to $1370 in FY 1978) but the requirements for eligibility have not. For example, only last fall, schools admitted U.S. Foreign Medical Students with an implicit promise for continued capitation support.

Some Letter Writing Tips

All of the foregoing is preparation for the bottomline of the process: your communicating your views to your legislators. The cardinal rule in writing Congressmen is: speak for yourself. They are not interested in "canned" messages or form letters (and they can spot them); they want to know what *you* have to say.

Here are some basic ground-rules to remember:

- type your letters if at all possible
- include your name, school and address—and your signature
- be courteous and brief
- verify your facts
- write to U.S. Senators and Representatives at their Washington offices using the following format and addresses:

The Honorable Jane Doe U.S. House of Representatives Washington, D.C. 20515	The Honorable Jane Doe U.S. Senate Washington, D.C. 20510
Dear Ms. Doe:	Dear Senator Doe:

As you have probably gathered from the above descriptions of the budget and legislative process, the timing of your involvement is very important. If you enter the process when a bill has gone to conference, you are much less likely to influence the outcome than if you had expressed your opinion when the bill was in subcommittee. It is also important to have accurate information on the current status and potential impact of the bill about which you are writing. But the most important thing is that you do write to inform your Congressmen of your views. If this issue of *OSR Report* elicits only one letter from each of you to each of your Senators, that represents 124,000 letters! In the political arena there *is* power in numbers. And it is wrong to believe that students lack credibility with legislators. After all, you are not only consumers of medical education but also the health care providers, researchers and teachers of the next decades. By virtue of this role, you are *expected* to speak out on education and health issues. Indeed, your silence will be interpreted as approval of whatever health legislation is promulgated. The time to get involved is now.

FOOTNOTES

[1]Report of the Task Force on Student Financing. Washington, D.C.: Association of American Medical Colleges, September 1978.

[2]Frances D. French, *Fundamentals:* a synthesis of proceedings of five workshops in financial aid program administration. January 1979.

[3]*How Our Laws Are Made*, Stock No. 052-071-00547-1, Superintendent of Documents, Government Printing Office, Washington, D.C. 20402 ($1.50/copy).

[4]*Congress and Health*, second edition, National Health Council, Inc., 1740 Broadway, New York, New York 10019.

[5]You may subscribe to the AAMC's "Weekly Activities Report" by writing to Membership and Subscriptions, AAMC, One Dupont Circle, N.W., Washington, D.C. 20036. Subscription price: $15/year (43 issues).

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This January, President Carter asked for a rescission of $58.7 million of the $120 million appropriated for FY 1979 for medicine, osteopathy and dentistry (MOD) schools. That Congress approved $24 million of the requested rescission came as a bitter disappointment to medical educators. This defeat augers ill for the outcome of the current debates over President Carter's FY 1980 budget which requests *zero* dollars for MOD capitation grants. Evidently, the rationale for this withdrawal of support is that there is no longer a national shortage of physicians. However, the costs associated with expanded enrollment, which schools accomplished in response to federal initiatives, are recurrent; they continue by virtue of commitment for new faculty, expanded physical facilities, etc. Reduction in capitation support will not only significantly reduce schools' flexibility in program planning and ability to meet commitments but will also likely cause tuitions to rise. As is shown above, current financial aid programs are woefully inadequate to assist students in bearing such increases.

A Word About the Budget Process

The size and complexity of the federal budget requires that a large part of the initial task of budgeting be delegated to the Executive Branch. Within 15 days after Congress convenes each year, the President submits a proposed federal budget, representing the culmination of a year of preparation by agency officials. Three different types of Congressional committees then begin their reviews. *Budget* committees decide how much money can be made available, given limitations on revenue, for all the functions of the government, e.g., defense, health. *Authorizing* committees, which describe what a particular program is intended to accomplish, establish absolute ceilings on the public monies to be spent on a program. Finally, *appropriations* committees then decide how much can be actually be spent for a specific program in a specific fiscal year or years within the limits set in the authorizing legislation.

The most important aspect of the workings of these committees for you to know about is that funds can be *authorized* at any level for a program but unless they are also *appropriated* at a meaningful level, the program will not function as intended. A good example here is the Exceptional Financial Need Scholarship Program, funding for which was authorized at $17 million but for which only $7 million was appropriated in FY 1979. The House and Senate Appropriations Committees and their health subcommittees therefore merit great attention. Authorizing bills must be "reported out," i.e., committee deliberations must be completed, by May 15. Appropriations bills cannot be reported before this date. The actions which take place during the period between May 15 and October 1, when the new fiscal year begins, are extremely complex and will not be described here. The crucial thing to remember is that appropriations committees can become forums for change in health programs.

UNDERSTANDING THE LEGISLATIVE PROCESS

Knowing how Congress works is a prerequisite to effective input into the law-making process. Look upon it as a long, slow, complex game of give-and-take with numerous opportunities for you to influence the players (unless, of course, you prefer to remain a silent member of the audience). You don't need to be familiar with all the fine points, but understanding the basic rules of play will stand you in good stead so long as health issues are political issues, in other words, for the foreseeable future. While the following is only a bare bones summary of the rules, it should help to prepare you for active participation; if you desire a more detailed description *How Our Laws Are Made*[3] and *Congress and Health*[4] are two highly readable and easily obtainable booklets.

In a capsule this is what normally happens: A member of Congress introduces a bill. Bills initially introduced into the Senate are designated by the letter *S.* preceding their number and those introduced into the House, by the letters *H.R.* Once introduced, a bill is referred to one of the 11 standing committees of the House of Representatives or the 15 standing committees of the Senate. Each is referred to the committee or committees having jurisdiction over the subject with which the bill deals. The committee chairman then usually refers the bill to the appropriate subcommittee, whose chairman may schedule public hearings. Depending on the nature of a bill, hearings may be conducted for a few hours or last for several weeks. The subcommittee next holds "mark up" sessions at which amendments to the bill are considered and recommendations are prepared for submission to the full committee. What happens to a bill at this level frequently determines its eventual fate. At the end of the mark up sessions, the subcommittee votes either to recommend it favorably, with or without amendment, or to table it. If the bill is tabled, it is in effect killed for the current session of Congress. A bill favorably reported is next reviewed by the full committee, which, because of the breadth and magnitude of issues, generally relies heavily upon the conclusions of the subcommittee. The committee also holds mark up sessions during which the bill may be amended and then either reports the bill to the full House or Senate or tables it.

Several procedural items precede actual floor vote on a bill, including assignment of calendar numbers. Bills placed on a calendar are voted upon in order of numerical sequence, although both chambers have rules to bypass this sequence. A bill may be further amended during floor debate. When a bill has been passed, it is sent to the other chamber. A bill may separately pass both Houses of Congress but, having been amended at the subcommittee, committee and/or floor levels, emerge in different form from the legislation approved by the other body. When this happens—and it often does—the first body may vote to accept the bill as approved by the second. If it is not accepted in that form,

the bill must be sent to a conference committee whose task it is to reconcile areas of disagreement, then to make recommendations to both Houses, who in turn vote to approve or disapprove the recommendations. Should the conference committee fail to reconcile differences, the bill is said to "die in conference." Once approved by Congress, a bill goes to the President, who may sign it into law or veto it. A veto may be a specific action, or if Congress is not in session, the simple refusal to sign. Congress may override a veto by a two-thirds vote of both houses. Once the President signs, or fails to veto a bill, it becomes a law and is is assigned a public law number. The public law numbers run in sequence starting anew at the beginning of each Congress (which lasts two years) and are prefixed by the number of the Congress—e.g., the first public law of the present Congress is designated PL 96-1.

Even after passing through this lengthy process, a law may still never be fully implemented. Many laws require funding and getting funds appropriated requires enactment of another separate piece of legislation. Laws which establish a program also require the responsible federal agency, e.g., HEW, to propose regulations for the program's administration. This is often a long, necessarily slow process which provides interested parties with additional opportunities to express views that may significantly affect a program's final form. In some instances, the public will be invited, via a "Notice of Intent" published in the *Federal Register*, to comment on options developed by drafters of regulations. After the comments received have been evaluated, formal proposed regulations are written and interested parties have another opportunity to comment. Once the period established for public comment has ended, final regulations are adopted and published. The Exceptional Financial Need Scholarship Program once again provides a good example of how a promising program created by law (PL 94-484) can be subsequently eviscerated. Not only was the program not funded at a meaningful level but the final regulations defined "exceptional need" to mean "zero resources" so that a student with even $10 in a savings account would not be eligible.

Thus, you see the tortuous, winding staircase which is our legislative process and the multitude of doors which open on to it and which you can open.

WHO'S WHO IN HEALTH LEGISLATION

Listed on pages 5 and 6 are the members of the committees which have the most impact on health legislation; each of these committees has a health subcommittee. Under each committee and subcommittee the majority members, i.e., Democrats, are given first, followed in italics by the minority members, i.e., Republicans. The first Senate and House committees listed are the major authorizing committees for health programs. The Senate Finance Committee and the House Ways and Means Committee raise revenues through taxes, and programs such as Medicare are entirely their responsibility. The Senate Finance Committee also has jurisdiction over the Medicaid program. Medicare and Medicaid are especially important programs because they finance health care and comprise a significant proportion of all federal health dollars. The Senate Human Resources Committee and House Interstate and Foreign Commerce Committee authorize most other health legislation, such as that dealing with student loans and biomedical research. The amount of funds approved by Congress to be spent for any specific health program in a fiscal year is determined by the last pair listed—the House and Senate Appropriations Committee.

Keeping in Touch

Admittedly, keeping on top of the health legislative scene can be a full-time job, and you probably feel that you have little enough time for non-medical research and reading without trying to follow Capitol Hill activities. However, this effort should be viewed as part of the medical education process, and medical students can work together to keep informed. Perhaps your student government leaders could arrange to have a space set aside in the library or lounge as an information center. Current newspapers and periodicals with good national coverage could be kept there and a group of students could share the responsibility for marking items of special interest so that others can find them at a glance. OSR members are repositories of information on current health legislation which they could make available, e.g., the AAMC *Weekly Activities Report*[5] and periodic memorandas from AAMC President John Cooper to deans and members of the AAMC Assembly describing important events on the Hill. Also posted should be the roster of Congressmen from the state in which your school is located, showing whether they serve on any health committees or subcommittees. You could seek the cooperation of your financial aid officer to provide up-dates on legislation affecting student assistance programs. One individual could be responsible for obtaining copies of bills and laws of interest; free copies of these can be obtained by sending a self-addressed label to the House Document Room, U.S. Capitol Building, Washington, D.C. 20510. You can also learn the current status of any bill by calling (202) 225-1772 and giving the person who answers the number of the bill. A final idea offered here is that one of the coordinators of this effort, perhaps in conjunction with the dean's office, be designated as the repository for copies of communications to Congressmen; this would not only allow students to exchange approaches but also deans could gauge the level of their students' involvement. These are just a few suggestions on how you might begin to organize an information exchange system. Probably because of lack of time and interest many students will not get involved. But certainly there is a core of students at each school who are ready to accept the responsibility to become informed.

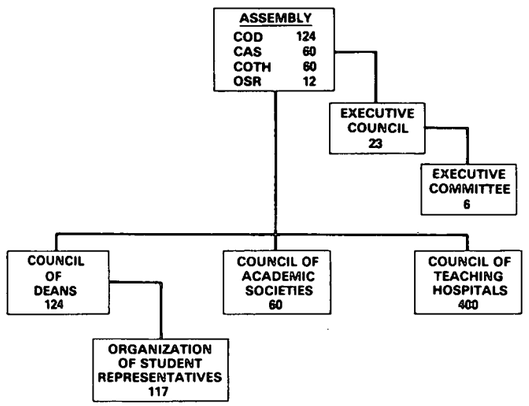
A SHORT QUIZ ABOUT OSR

1. WHAT IS THE OSR?

   A group of medical students, one from each school which chooses to participate '(112 in 1978-79), that works together with deans, faculty and teaching hospital administrators to formulate the programs and policies of the AAMC.

2. WHAT IS THE AAMC?

   The Washington-based organization representing all 125 U.S. medical schools, over 400 teaching hospitals and 60 academic and scientific societies, which works to insure the high quality of medical education in this country. The AAMC provides many services to its members, including annual publication of directories of medical school admission requirements and curricula descriptions. As health care and education issues become more and more complex, the combined wisdom of each party involved is needed, especially in such areas as the transition between undergraduate and graduate medical education, the supply of clinical researchers and federal support of medical education; the AAMC provides this forum for the exchange of ideas and opportunities to combine perspectives toward the end of common action. Because the President's and Congressional staffs, members of HEW, and the NIH look to the AAMC for leadership on issues dealing with medical education, it is particularly important for the Association to arrive at clear, unified positions. In order to incorporate such a diverse span of interests on such intricate matters, its governance is necessarily complex; some idea of its organization can be obtained from the following diagram:



3. WHAT DOES THE OSR DO?

   OSR representatives meet together once a year at the AAMC Annual Meeting. At this meeting much time is spent in the informal sharing of problems and concerns, many of which are the subjects of the discussion sessions and programs which are offered to provide arenas for more formal, multi-level consideration of important issues. At their annual business meeting, the OSR passes resolutions expressing their perspectives and goals and elects an 11-member Administrative Board which meets quarterly in conjunction with the Boards of the other AAMC councils and which carries out OSR projects during the year. OSR regional spring meetings are also held, in conjunction with the AAMC Group on Student Affairs (medical school admissions, financial aid and student affairs officers), at which OSR members can become better acquainted with each other and deal with issues of high local priority. Thus, the OSR has two very important roles: input into the AAMC's programs and policies and output to their constituents, i.e., all medical students. This output takes many forms, some more visible than others. *OSR Report** is perhaps their most recognizable product, followed by the OSR Accreditation Handbook which is sent to members at schools preparing for LCME site visits. OSR also pursues long-term projects; for instance, efforts to increase the amount and quality of information on residency programs resulted this year in distribution to OSR members and student affairs deans of a model survey for alumni's evaluation of their graduate programs. Present projects also include increasing the amount of information available to medical students on extramural electives and due process guidelines.

   Because each medical school can elect only one official and one alternate representative, OSR does not compete with other medical student groups for members. In order, however, for its dual role to be maximally effective, you need to take an active interest in the selection of your representative (especially if *you* want to be elected!) and communicate to him or her your priorities and concerns. This person can provide helpful links between happenings at your school and national events and can access many of the AAMC's numerous information resources. It really is a two-way street. Find out more about it by contacting any of the OSR Administrative Board members.

*Extra copies of last year's issues on the residency selection process, financial planning and debt management, and the health legislation process are still available and may be obtained by writing to the address below.

OSR/AAMC Annual Meeting
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Washington, D.C.

OSR REPORT

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OSR Report

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In this Issue:

CHAIRMAN'S PERSPECTIVES

This issue of *OSR Report* brings to your attention a problem, the full extent of which has just recently come to light—that is, the declining numbers of physicians participating in research and entering academic careers. This decline not only spells trouble in terms of the quality of medical education that those who follow us will receive but also threatens the progress of those many areas of research which depend upon the unique capabilities of the physician-investigator. In the midst of continual dialogues about the need for primary care physicians, of financial aid being linked to service in underdoctored areas, of curriculum innovations in the direction of first-contact medicine, and of the expansion of residencies in family practice, general internal medicine and general pediatrics, we were surprised to find that another, completely different shortage area in medicine had appeared. Most of us have probably also become rather skeptical about projections of what kinds of physicians are needed, given the Federal government's seemingly quick change in policy about whether this country is over- or under-doctored and the resulting difficulties medical schools are having to face. Nevertheless, as you will learn if you read this issue, a problem is here which holds in jeopardy the future quality of clinical teaching and research.

It is noteworthy that at our 1978 Annual Meeting, the OSR passed a resolution urging greater availability of research opportunities for medical students. The governing body of the AAMC adopted the OSR resolution, thus stimulating a number of related efforts not only to expand research opportunities for medical students but encompassing the entire range of factors having to do with research training. Even if you have already dismissed the idea of devoting a portion of your career to research, you will benefit from understanding the research training situation because, regardless of which area of medicine you choose, constraints similar to the ones at work here will be involved. If you have an open mind about research or know for sure you want to participate, the following pages should be most helpful. I hope you will contact me or any other member of the Administrative Board if you desire more information on the issues addressed here or if we can be of assistance in any other way.

Peter Shields
OSR Chairperson

THE NEED FOR M.D. INVESTIGATORS

Without the physician-investigator there to observe the links, discoveries in basic science laboratories and problems on the wards and in the clinics remain as unrelated as medical students often perceive the basic science and the clinical years to be. Possessing both research and clinical skills, these individuals play the all important cross-over role between lab and bedside. While any alert physician will convert details observed in practice into a learning experience, the physician-investigator has the training and resources necessary to design and carry out the experiments which form the basis of new clinical practices, new drugs and new devices. Combining the continual search for relationships between diseases and their treatment with testing and demonstration of these relationships, the work of the M. D. investigator may be the most challenging and exciting that the medical profession has to offer.

Research is usually combined in various degrees with patient care and teaching and can range from occasional participation in epidemiological studies or drug trials to a full-time commitment. Likewise, there are no hard and fast rules regarding training for research; training can begin as late as the post-residency level or can be a continuous engagement

beginning with enrollment in an M.D.-Ph.D. program. However, at all levels there is now evidence that participation of medical students and physicians in research and preparation for research careers have declined:

A. A recent attitudinal study of medical students at Harvard showed that the percentage of graduating students assigning a high priority to research dropped from a peak of 49% in 1963 to 2% in 1976 (1). AAMC studies have also indicated that while 39% of medical school graduates in 1960 stated that research would be a component of their careers, only 20% expressed the intent to devote any portion of their careers to research in 1979 (2).
B. The principal means of providing research training to physicians has been through the mechanism of fellowships supported by the National Institutes of Health (NIH). The number of M.D.s in these training programs has fallen from 4600 in 1971 to 1800 in 1977; these 1800 trainees filled only 70% of the clinical training positions available from NIH (3).
C. Data from the AMA show that the number of physicians reporting research as a primary activity has decreased from over 15,000 in 1968 to fewer than 8,000 in 1975 (4); during the same seven years the number of full-time faculty at U.S. medical schools increased by 160%. Moreover, in 1966 approximately 44% of competing research grant awards to new principal investgators were made to M.D.s; in 1978 M.D.s received only 23% of the total number of new and competing grant awards.

While solutions may not be obvious, the implications of these trends are clear. The continuing search for new scientific knowledge to improve the nation's health depends on the constant influx of bright and dedicated M.D.-investigators; the data show that their numbers are decreasing at a time when the public increasingly expects the medical profession to cure cancer, test new drugs, and deal with environmental diseases. Moreover, an important role of the physician-investigator is teaching medical students and residents, whose numbers have never been greater. Delegating primary teaching responsibilities to individuals who lack direct involvement with the expansion of biomedical knowledge will result not only in "old" medicine being taught but also in the absence of M.D.-investigator role models, which is in turn likely to intensify the shortfall in clinical teachers. With respect to the need to increase the number of physicians from minority groups, this problem is particularly noteworthy: medical schools have difficulty recruiting and graduating minority students in part because there are few minority physicians who have research training and who can serve as role models.

COMING TO GRIPS WITH THE PROBLEM

The reasons underlying the declining numbers of medical students expressing an interest in research and of physicians undertaking research training are very complex. Probably the national surge of interest in primary care has deflected a certain amount of faculty and student attention and has, at the least, masked the development of the research manpower shortage. At the undergraduate level, inadequate counseling about research opportunities and careers and limited funds to support student laboratory projects and summer fellowships appear to be problems at many schools. Other potential causes for students' declining interest in academic careers include lack of stimulating exposure through laboratory courses and limited informal interaction with faculty. Further more, results from the AAMC Graduation Questionnaire show that fully 82% of the class of 1979 thought that during medical school emphasis on research techniques was absent or minor.

Certainly, economics have played a role in creating the present situation. With the need to repay ever increasing educational debts, many young physicians feel they may not be able to afford the additional training required to become competent investigators. Students also realize that physicians who practice full time have greater income than researchers or teachers. Many other factors, some readily addressable, some subtle, are involved.

However, a large portion of the problem may simply be the result of misconceptions about the rewards of and opportunities in research. Undertaking research and teaching does not limit opportunities for patient care. Research training funds to support young physicians are going unused. Budgeted but unfilled faculty positions in U.S. medical schools are abundant. Realistic students know that practice opportunities in "garden spots" and attractive metropolitan areas are rapidly decreasing and that academic physicians enjoy clinical facilities and other career advantages not available to the unaffiliated practitioner. Medical students who find any appeal in the idea of research and teaching should not close their eyes to these facts. Explore your interests with faculty and deans. Seek out opportunities at your school to pursue a research project. And consider the elective and tutorials offered at NIH.

Finally, remember that research experience during medical school can be of value to every student regardless of career intention. It provides skills useful in evaluating journal articles and publications on which clinical care is based. It sharpens abilities to observe and record data on patients. It encourages an appreciation of how medical knowledge is generated. Moreover, it provides evidence to a residency program director of an inquiring mind.

Hopefully, a heightened awareness of the national clinical researcher manpower shortage and the combined energies of AAMC, NIH, and all other organizations involved will result in increased incentives and opportunities to participate in research. Hopefully, also, those of you who have research talents will take full advantage of these opportunities, to your own personal benefit and toward the end of improving medical care for the citizens of the world.

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*****NOTICE TO CLASS OF 1980*****

Your attention is directed to the feedback information from the AAMC Graduation Questionnaire in this October's *NRMP Directory*. Based on responses from 8,382 of last year's graduates, data include why they chose their specialty and hospital programs. Due in part to suggestions from the OSR Administrative Board, this year's questionnaire is to be distributed to most seniors in early December and returned to the AAMC prior to the January rank order list deadline. Your cooperation in completing this important survey will benefit future medical students as well as being of value to your school and to the AAMC.

OPPORTUNITIES AT NIH

The National Institutes of Health is the Federal Government's primary agency for the support of biomedical research. Most of the support is for "extramural" research conducted in the nation's medical and dental schools, universities and other research centers. About one-tenth of NIH funds is used to support "intramural" research, which is primarily conducted on the 306-acre campus in Bethesda, Maryland.

One of NIH's intramural activities is a program of elective courses open to students from any of the nation's medical schools. The staffs of several Institutes collaborate to supply an in-depth exposure to nine clinical subsecialities: Anesthesiology Computers in Medicine, Endocrinology-Metabolism, Genetics, Hematology-Oncology, Immunology, Nuclear Medicine, Psychopharmacology, and Surgical Oncology. The essence of this educational experience is a close association between the student, clinical associates, and physician-scientists in several of the Institutes. The courses are 8 or 9 weeks in duration and not all electives are offered each session. Although stipends are not offered and living quarters are not presently available on the NIH campus, students will be assisted in finding housing in the community and reimbursement for roundtrip transportation between NIH and the medical school will be arranged. Applications to participate will be accepted from January 1, 1980 through March 1, 1980. Interested students should not delay in writing to the following address to obtain the additional necessary information. Requests should be for the "1980-81 Catalog of Clinical Electives for Medical Students":

Associate Director
The Clinical Center
National Institutes of Health
Bethesda, Maryland 20014

NIH also offers laboratory tutorials in the biological sciences emphasizing the investigative approach to medical problems. These are arranged through communications between the NIH staff member and a faculty sponsor. Therefore, interested students should contact directly the investigator of their choice. Names of the investigators, as well as information concerning the various laboratories, are provided in the *NIH Scientific Directory and Annual Bibliography*. Write to:

Office of Clinical Reports and Inquiries
The Clinical Center
National Institutes of Health

Finally, for your information, your dean recently received an announcement from NIH inviting application for an award to support short-term research training experiences for medical students. Schools which receive awards will be able to offer to their students, on a competitive basis, previously unavailable funded opportunities to gain research training. It is hoped that awards can be made and the program initiated by the spring of 1980.