



association of american medical colleges

OSR ADMINISTRATIVE BOARD MEETING

January 27, 1981 12:00 pm - 6:00 pm
Room 827 - One Dupont Circle

January 28, 1981 9:00 am - 3:00 pm
2nd Floor Conference Room-One Dupont Circle

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

September 24, 1980
 AAMC Headquarters
 Washington, D.C.

Chairperson-Elect
Regional Chairpersons

-- Lisa Capaldini
 -- Susan Haack (Southern)
 -- Louis van de Beek (Northeast)
 -- Mary Barton, M.D. (Central)
 -- Doug Hieronimus (Western)

Representatives-at-Large

-- Arlene Brown, M.D.

Immediate-past-Chairperson
AAMC Staff

-- Greg Melcher
 -- Peter Shields, M.D.
 -- Jim Bentley, Ph.D.
 -- Janet Bickel
 -- Robert Boerner
 -- Beth Jaeger
 -- Joseph Keyes
 -- Mary McGrane
 -- August G. Swanson, M.D.

- I. Ms. Capaldini called the meeting to order at 9:15 a.m.
- II. The minutes of the June 25 meeting were approved without change.
- III. Consortium of Medical Student Groups

Ms. Capaldini reported that Jerry Cade, former chairman of AMA-SBS, had initiated a move to change the voting status of those member organizations of the Consortium which have parent bodies; rather than being a full voting member OSR would become an ex-officio member. The Administrative Board felt that this change is inappropriate because it is important for each group to have the right to articulate its views through voting and that within the context of the Consortium the OSR can vote its view without seeking prior approval from its parent body.

IV. Graduate Medical Education Advisory Committee

GMENAC (pronounced gem-a-knock) was chartered by the Secretary of HEW in 1977 to study the health manpower requirements of the country through the year 2000 and to recommend solutions for the problems identified. GMENAC members were organized into five technical panels which dealt with the following subjects: the modeling of physician distribution and supply, the financing of graduate medical education, geographic distribution of physicians, the undergraduate educational environment, and the use of non-physician health personnel. A series of 106 recommendations were developed

and 34 are contained in the final report.

Dr. Swanson presented to the Board the major thrusts of these recommendations and of AAMC's comments..

GMENAC predicts that by 1990 there will be an excess of 70,000 physicians in the country. This prediction is based on a complex modeling system which was used to estimate requirements. The basic data for modeling were (a) prevalence of disease, (b) time required to diagnose and treat disease, and (c) physician productivity. In achieving final predictions, many assumptions had to be made by the consultants involved in the modeling techniques. Whether their assumptions will hold true is a point of considerable controversy. Nevertheless, GMENAC has estimated that all but seven specialties or subspecialties will be in oversupply by 1990. The seven are psychiatry, child psychiatry, emergency medicine, physical medicine and rehabilitation, preventive medicine, hematology/oncology, and anesthesiology. Nuclear medicine is predicted to be at par with requirements. Oversupplies are predicted in the primary care specialties (family practice - 4,000, internal medicine - 3,500, pediatrics - 5,000, and Ob/Gyn - 10,000). General surgery tops the list at nearly 12,000. GMENAC recommends that the entering medical school class be reduced to 10% below the 1978 level by 1984. This would be a class of 14,850 and would require an 18% reduction below the anticipated entering class of 1982. Twenty percent reductions by 1986 are suggested in entering residency positions in most specialties which are predicted to be in oversupply.

The AAMC has serious reservations about the methodology employed in computing the requirements; the softness of the data base and changes in technology which could occur preclude using the figures generated by the GMENAC model as the basis for massive changes in the present system. Another concern is that across-the-board reductions of entering class sizes might severely distort some educational programs, and there is also potential for disruption of available residency positions among specialties. GMENAC also recommends that more research and evaluation should be conducted on factors relating to the geographic distribution of physicians. Dr. Swanson reported that evidence is becoming available that physicians are moving into smaller communities because of the practice opportunities they offer and noted that there will always be some communities and neighborhoods where physicians will be unwilling to locate; therefore, expending scarce resources on further distribution studies is probably unnecessary. The third major AAMC objection to the recommendations is that a successor to GMENAC be established by statute. Forecasting the future numbers of various specialties can be based on data available from organizations in the private sector, and the National Center for Health Services Research and the National Center for Health Statistics can provide the federal role in monitoring manpower requirements. Dr. Swanson concluded that future planning for physicians manpower is complex and multidimensional and that these issues will continue to be the subject of much discussion.

V. Report on U.S. Citizens Studying Medicine Abroad

Dr. Swanson summarized a recently published General Accounting Office (GAO) reported titled "Policies Regarding U.S. Citizens Studying Medicine Abroad Are In Need Of Careful Review and Reappraisal". GAO studied six foreign medical schools (Univ. Central Del Este, Univ. of Nordestana, St. George's

Univ., Autonoma Univ. of Gualalajara, Univ. of Bologna and Univ. of Bordeaux); it estimated that these six schools enrolled about half (5400) of all Americans studying medicine abroad. Data from AAMC & ECFMG indicate that 10 foreign schools enroll over 70% of U.S. citizens studying abroad. The GAO study found that none of these schools offered a medical education comparable to that available in the U.S. because of deficiencies in admission requirements, equipment, facilities, faculty and curriculum. This finding is buttressed by an analysis of the performance of such students on the Medical Science Knowledge Profile (MSKP) exam. Dr. Swanson explained that AAMC's sponsoring of this exam replaces the Coordinated Transfer System under which U.S. citizens could take the National Boards, Part I (last year the National Boards made the decision to stop offering Part I to individuals not enrolled in a U.S. medical school). On the first administration of the MSKP this June, of the 1974 examinees, 1601 were from foreign medical schools; 40% of these failed to achieve an average score. Only eight per cent of a comparable reference group of students from U.S. schools fell below the average. Both the results of the MSKP administration and of the GAO study reveal that the efforts of the schools which enroll the largest numbers of Americans studying abroad are not matched by efforts to provide an adequate education. With reference to the National Board's restricting eligibility to take Part I, Mr. van de Beek noted that some Americans in foreign medical schools believe that this decision stemmed from their high performance on this test. Dr. Swanson replied that overall their pass rate had been only in the 50% range and that the decision was based on a desire to maintain the integrity of the National Boards sequence as a certification for licensure exam.

Another of the concerns addressed in the GAO report is that the federal government is indirectly subsidizing foreign medical schools through Guaranteed Student Loans and G.I. benefits provided to Americans studying there. Another is the need for a uniform standard by which to evaluate students trained abroad. Dr. Swanson concluded that, while the Association differed with some of the specifics of the recommendations on these problems, the report paints a clear picture of the problem created by the schools which have policies directed toward attracting large numbers of U.S. citizens.

VI. Universal Application Form for Graduate Medical Education

After study of more than 100 applications forms obtained from residency programs, the Association developed a model form and distributed it to student affairs deans and program directors for suggestions for modifications. A revised form (copy attached to minutes) was distributed this summer to 671 teaching hospitals; of the 341 hospitals which responded 84% have indicated acceptance of the form. Present plans are to distribute the form to students (class of '82 will be the first class) through their dean's offices at the same time NRMP materials are distributed and to defray the printing costs by a \$1 increase in the NRMP student fee. Ms. Capaldini noted that the recommendation was to approve the form and this plan. In response to a remark about questions #20 and #21 on the form, Mr. Boerner noted that the Group on Student Affairs had preferred that no question about the National Boards or FLEX be included but that some accommodation was necessary in order to gain program director's approval of the form and to obviate the mailing of supplemental forms to students. Mr. van de Beek objected to the inclusion of question #24 on service obligation, but other Board members felt that if a student has such an obliga-

gation, that fact might as well be out in the open.

ACTION: The OSR Administrative Board approved the Universal Application Form and the plan to cover its printing costs.

VII. General Requirements Section of the Essentials of Accredited Residencies

(Mr. Keyes explained that the General Requirements Section has not been revised since the Liaison Committee on Graduate Medical Education (LCGME) was established in 1972. Last September, the Executive Council ratified a draft which was subsequently modified through discussion with the other sponsoring organizations of the LCGME. As revised, the General Requirements Section places increased responsibility on institutions providing graduate medical education to ensure the quality of their programs and establishes stronger guidelines for review of programs for the purpose of accreditation. This document comprehensively outlines the responsibilities of the program director and teaching staff, including requirements regarding evaluation and advancement of residents, due process procedures, and written agreements with residents. Newer members of the Administrative Board expressed difficulty in being able to evaluate the document because of lack of background on the changes it represents. Staff explained that the new "Essentials" could be compared to the previous version as printed in the AMA's Directory of Residency Training Programs (the "Green Book") for evidence of the extent to which these requirements encourage greater institutional accountability and cooperation among programs offered at a single institution.

ACTION: The OSR Administrative Board approved the ratification of the General Requirements.

VIII. Medicare's "Moonlighting" Policy

Dr. Bentley outlined questions and problems related to the Health Care Financing Administrations (HCFA) modifying Medicare payments practices for services provided by "moonlighting" residents. Because of the complexity of the issue, it was necessary to give substantial background information. When a resident participates in an accredited graduate medical education program, the resident's stipends and benefits may be included as an allowable expense when the hospital determines its reimbursement from the Medicare program. Because Medicare recognizes these costs as institutional educational expenses, the resident may not be paid by Medicare on a fee-for-service basis for any patient services provided as part of his training program in the hospital. By definition, "moonlighting" residents are not engaged in a training program and Medicare has historically permitted payment for these services on a fee-for-service basis. To avoid abuse of this policy, however, Medicare has restricted fee-for-service "moonlighting" payments to residents performing services in hospitals other than the hospital where the resident is participating in his graduate medical education program. Approximately two years ago, Medicare officials found that the residents at the Wesley Medical Center in Wichita, Kansas were "moonlighting" in the same hospital in which they were participating in graduate medical education programs. Upon learning of this arrangement, Medicare disallowed the charges for services provided by "moonlighting" residents citing Medicare policy that precluded payments for moonlighting in the hospital where the resident is training. The hospital sued the Secretary of HEW alleging that a policy which paid "moonlighting" residents in some settings but not others was arbitrary, capricious, and discriminatory. The federal court in Kansas agreed with the hospital and ordered Medicare to change its policy.

Dr. Bentley enumerated some of the negative aspects of this change in policy: 1) hospitals with poor training programs could use "moonlighting" opportunities as a recruiting device; 2) it will stimulate residents' interests in "moonlighting" potentially to their detriment; 3) it will be difficult for the government to police the "during training/not training" dichotomy leading to suspicions of fraud and the possibility that Medicare will cease reimbursement for educational costs altogether; and 4) it will be confusing for a patient who is seen during the day by a resident in training to be charged a fee when seen by the same resident at night. The Board acknowledged these problems but expressed the view that the AAMC should not oppose the change in Medicare policy. Dr. Shields noted that, especially for residents in subspecialty programs, "moonlighting": in the emergency rooms offers valuable opportunities to upgrade general medical skills, and that it does not make sense to have to go across town to seek these when opportunities are available at the training institution. Dr. Brown said that because the number of hours in training per week are clearly specified in a resident's contract, accountability should not be so difficult a problem, and that "moonlighting" in the same institution carries the advantage of working with the same staff and patients. The Board felt that the residency program accreditation process should ensure that the number of hours in training are sufficient and of sufficient quality such that the potential for "moonlighting" interfering with the educational process is minimized and therefore recommended that the AAMC work with HCFA to develop administrative rules separating "moonlighting" from residency training.

IX. Due Process Project

Dr. Brown presented to the Board the results of her study of the due process guidelines received from schools. The paper includes a background summary of due process in medical school, a table showing percentages of schools which specify various provisions in their due process procedures, and a model set of guidelines. The Board approved the draft, noting that this model would serve to protect both the rights of students and institutions and thanked Dr. Brown for her work on this project. It was decided to include the results of this project in the OSR Annual Meeting agenda for OSR approval of the model guidelines and also to offer these to the GSA Steering Committee for their comments. It is hoped that the final document will be mailed to OSR representatives and deans of student affairs in November.

X. Status of Health Manpower Legislation

Ms. McGrane, AAMC legislative analyst, reported to the Board that both the House (H.R. 7203) and the Senate (S.2375) had passed with little debate their respective versions of the health manpower legislation which will replace the Health Professions Educational Assistance Act of 1976. The two bills are very different, with the House version the more costly and the less innovative. H.R. 7203 continues the current capitation program at phased-down levels and retains with some modifications the current student aid programs. The Senate bill proposes a new form of institutional support under which schools would receive an amount per student in return for the fulfillment of certain national objectives such as increasing the percentage of minority students enrolled and expanding education in preventive and community medicine. It also would replace the Health Professions Student Loan program with a new low-interest, needs-based, service commitment loan program. Ms. McGrane stated that a date had not yet been set to attempt to conference these two bills and that AAMC was still in the process of analyzing and formulating positions on a number of their provisions. A side-by-side analysis of the two bills will be included in the

OSR Annual Meeting agenda book and an overview of the current situation will be offered at the first OSR business meeting. With regard to the reauthorization of the Higher Education Act, she noted the likelihood that a compromise would be reached between House and Senate conferees on their respective bills; this measure will raise the interest rate and borrowing limits on the Guaranteed Student Loan program. Mr. Boerner reported that the major lender under the Health Education Assistance Loan (HEAL) program, Chase Manhattan, had processed 1300 of the 1800 applications received this summer and fall and was planning to return the remainder; the bank is threatening to stop lending under this program unless the interest rates are raised from those proposed in either the House or Senate Bills or through a change in the current authorizing legislation.

XI. Resolutions from Regional Meeting

Dr. Barton presented a resolution submitted by Hugh Johnston (Medical College of Wisconsin) regarding the disproportionate number of minority and low income students enrolled in service-commitment scholarship programs. The Board recognized some factual errors in the resolution as written, and Dr. Barton agreed to work with Mr. Johnston in rewriting it. The Board approved for action at the Annual Meeting two resolutions passed by the Western region in April. The first recommends that more and better information be provided to high school and premedical advisors so that they can more effectively assist their students to assess medicine vis-a-vis other careers. The second resolution calls for provision to medical students of adequate instruction in certain clinical procedures prior to their beginning clinical rotations.

XII. Annual Meeting

The Board finalized their plans for the Annual Meeting. One member raised the possibility that during last year's elections some regional 'bloc' voting had occurred, and the Board agreed that this should be discouraged. In order to assure orderly handling of resolutions, the Board appointed Dr. Brown to serve as parliamentarian at the business meeting. Ms. Bickel reported on a conversation she had had with Dr. Jack Graettinger regarding the proposed contents of his presentation at the Sunday morning discussion sessions and presented his proposal for revisions in the NRMP Match; these revisions will be included as an information item in the Annual Meeting agenda book. As a last item of discussion, the Board decided that a copy of the model questionnaire for graduate training evaluation should be included in the folders which are distributed at the meeting so that students are reminded of availability.

XIII. The meeting was adjourned at 4:15 p.m.

Nominations of Students to AAMC Committees*

The OSR Administrative Board is asked to nominate a student to each of the following three committees:

1. Journal of Medical Education Editorial Board: Preference should be given to second and third year students; the appointment will continue through December of the year the student graduates. Nominee should have a broad interest in medical education and good writing skills.
2. Flexner Award Committee. Committee members are mailed information on nominees for this award and 'meet' via a conference call.
3. Women in Medicine Coordinating Committee. Meets once in March each year to discuss ideas for and plan Women in Medicine Annual Meeting activities.

*Applications received from the membership follow

Resolutions

Action: The OSR approved the following resolutions:

A. Teaching of Foreign Languages and Cultural Issues

In view of the significant and increasing proportion of the national population that is primarily Spanish speaking, and
whereas language and cultural barriers result in the delivery of inadequate or inappropriate care, and
whereas the ability to overcome such barriers will enrich students' educational experience and/or future options, and
whereas the ability to care effectively for this portion of the population broadens the choice of settings for graduate education and practice,
Be it resolved that the OSR assemble information on current Spanish (and other) language/cultural programs made available to medical students, provide member schools with this information through their curriculum or student affairs committees, and encourage the establishment of such programs in response to the students' needs.

B. Improving Medical Care for the Aged

whereas our patient population is increasingly an aging one, and
whereas there are deficiencies in medical education dealing with the unique physical, social and psychiatric needs of the elderly,
Be it resolved that the OSR recommends the Ad Board undertake a study to examine basic science curricula, physical diagnosis courses and clinical clerkships toward the end of improving health care for the elderly.

C. Cost Containment Education

With rising health care costs, cost effectiveness of medical procedures becomes more important. While the OSR recognizes that some schools have made progress in educating students to consider the balance between data and dollars, others have yet to address this issue. We seek to reaffirm the value of teaching cost effectiveness to medical students, to housestaff, and to practicing physicians and urge the AAMC to encourage the teaching of cost effectiveness as a necessary part of the training of all physicians.

D. Medical School Curriculum Reform

whereas the art and science of medicine is an active process involving problem-solving, creative reasoning, and careful application of basic science information to patient related problems, and
whereas the medical student is often placed in a situation where learning is a passive process and requires the rote memorization of facts in a manner inconsistent with the development of thought processes involved in the future application of such data, and

whereas the medical school is shouldered with the responsibility not only for the dissemination of knowledge but also for the development of thought processes in students consistent with excellence in patient care,
Be it resolved that the OSR support the exploration and implementation of creative alternatives that encourage active student participation in learning (e.g. small group sessions, student presentations, preceptorships, problem-solving exercises) and that they gather information on existing programs consistent with this resolution and disseminate it to the medical schools.

E. Senior Electives

whereas students have widely varied senior-year elective needs, and
whereas participation in electives at programs outside a student's medical school can be invaluable for the student in evaluating residency programs as well as for allowing these programs a close look at potential applicants,
Be it resolved that the OSR urges that medical schools encourage and support students to take senior year electives at other institutions as well as at their own.

F. Improving Teaching in Medical School

whereas excellence in teaching is a long standing goal of the AAMC and
whereas teaching is a skill which can be improved with instruction and feedback,
and
whereas many instructors in medical school have had limited prior teaching experience, and
whereas research is also an important and indispensable activity of all medical schools,
Be it resolved that the OSR urges medical school departments to monitor the teaching experiences of their faculty and provide constructive feedback for them, and that medical schools provide opportunities in the form of workshops, seminars, etc., for their instructors to learn and develop their teaching skills, and that they encourage their faculty to avail themselves of these opportunities, and
Be it further resolved that the OSR urges the medical schools to give equal weight to both teaching and research in evaluation and advancement of faculty members, and
Be it further resolved that the OSR urges the AAMC to study methods for measuring and improving teaching performance.

G. Medical Ethics

whereas ethical behavior is an integral aspect of the practice of medicine and such behavior should be manifested by all medical professionals from the beginning of their training,
Be it resolved that: 1) OSR formulate a model code of academic and professional ethical behavior for medical students which addresses both the preclinical and clinical experiences, to be distributed to the medical schools, and that the schools be urged to formulate their own codes and publicize them to their students, faculties and administrative bodies; 2) that OSR draft a model academic and professional honor code which could serve as a contract between each student and the medical school regarding the individual's

commitment to uphold the ethical standards of the community; 3) that the OSR request the AAMC to urge medical schools to renew their commitment to ethical behavior, especially on the part of undergraduate medical students, and to include in their curricula formal teaching of ethics as it pertains to the practice of medicine.

H. National Board Examinations

whereas the current format of the National Board examination sequence parallels the traditional division of medical education into basic and clinical sciences, and

whereas many medical schools now attempt to integrate the four years by including clinical materials in the first two years and basic science material into the later, and other schools have implemented innovative schedules eliminating this traditional segregation, and

whereas curricular innovation should not be hampered by national examination structures,

Be it resolved that the OSR supports the concept of a Comprehensive Qualifying Exam covering the undergraduate years of medical training, replacing Parts I and II, to be used for the purposes of medical licensure.

I. Capital Punishment

whereas several states use physicians in the administration of capital punishment, and

whereas this utilization of physician manpower runs so contrary to the spirit and letter of modern medicine,

Be it resolved that OSR condemns the use of physicians in the administration of capital punishment.

J. Uniform Enrollment Reductions

Recent studies, including GMENAC, have projected surpluses of physicians and have predicted that these surpluses will contribute to escalating medical care costs. While this correlation between physician supply and accelerating expenditures may be accurate, the problem of spiraling costs cannot be effectively or ethically addressed by indiscriminate, across-the-board cuts in medical school enrollment. Because the enrollment reductions recommended by GMENAC would disproportionately affect newer medical schools, some of which have significant minority group enrollment and innovative curricula, the OSR opposes any such uniform enrollment reduction measures.

K. Recommendations of the Graduate Medical Education National Advisory Committee

GMENAC has projected a surplus of 70,000 physicians by 1990 and 120,000 by the year 2000 and on the basis of these figures recommends that: medical schools reduce the size of their classes by 10% below the 1978 level; the entry of foreign medical graduates to the U.S. be severely limited; and elimination of federally guaranteed loans to students studying medicine abroad. As future providers of health care, we express the reservations about the concept of "physician surplus" as well as about the accuracy of the predictions and urge that the implications of the GMENAC report be carefully studied by AAMC.

L. Service Contingent Loans

whereas cost should not be a barrier to medical education, and
whereas tuitions have increased at an alarming rate, making it increasingly
difficult for students to finance their education, and
whereas sources of financial aid have become increasingly scarce,
Be it resolved that the OSR support a service contingent subsidized loan program
designed to address health manpower needs within the United States as part
of a comprehensive health education assistance program, and
Be it further resolved that such a program allow completion of graduate medical
education before service begins and that the choice of service requirements
be broad enough to permit the graduating physician to pursue the program of
graduate medical education of his/her choice.

M. Financing Medical Education

whereas the rising cost of medical education makes the need for financial support
a reality for most medical students and may adversely affect:
diversity among those entering medical school,
specialty choices of graduating students,
geographic distribution of physicians,
motivations of medical students
and, finally, the delivery of medical care,
Be it resolved that the Ad Board and the GSA study various options for a unified
system for financing medical education, and that at least the following
options be investigated:
A. complete government financing of medical education for all students
regardless of need with concomitant mandatory service obligations.
B. universally available private or federal loans with repayment plans
consistent with the spirit of equality and freedom of choice for any
student entering medicine.

N. Improved Counseling of High School and Premedical Students

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

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

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

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

O. Instruction in Clinical Procedures

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

P. In Support of Public General Hospitals

The constitution of the World Health Organization recognizes health as a fundamental human right. It is at this time not a right enjoyed by all individuals. Recognizing this inequality, the World Health Assembly resolved in 1977 that the principle social goal of governments in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".¹ In order to attain this goal, the United States must address the problems of the 49 million Americans designated as medically underserved, the 20 to 25 million Americans without health insurance, and the 19 million Americans with inadequate health insurance coverage. The current structure of the health care system in the United States distributes this right to the medically indigent through public general hospitals which provide a vital healthcare resource in areas of health service shortages.²

Be it therefore resolved that the OSR recognizes and supports the following roles of public general hospitals:

- providers of health care to the medically underserved;
- providers of a significant amount of ambulatory service, emergency service, intensive care service and, medicosocial services in our nation's cities.

-providers of education for a significant number of health care professionals.

Be it further resolved that these sentiments be represented in any pertinent business of the OSR.

References: 1) "People", an article on health care in the world in Scientific American, September, 1980/
 2) The Future of the Public General Hospital, Report of the Commission of the Hospital Research and Educational Trust, 1977/

Q. Medical Education -- A Question of Reference

whereas we believe that a physician's competence should be defined in terms of fulfillment or non-fulfillment of absolute criteria and not in terms of fulfillment or non-fulfillment of relative criteria, and
whereas today's practice of medicine is by its nature based on absolute criteria and not on norms and community peer review systems are, by their nature, based on absolute criteria, and
whereas a goal of medical education should be to engender and reinforce self-accountability and not to foster non-productive competition through comparing students among themselves,
therefore the current system of relative evaluations, as exemplified by the NBME and employed by a majority of medical schools (where students are judged not on their mastery of course materials but in relation to relative mastery of objectives) is found wanting,
Be it resolved that the OSR supports the basic philosophic approach to medical school education of absolute criteria based evaluation and encourages its adoption.

DOCUMENT OF UNDERSTANDING
THE CONSORTIUM OF MEDICAL STUDENT ORGANIZATIONS

1. DEFINITION OF THE CONSORTIUM:

The Consortium of medical students consists of the following ^{member} organizations:

American Medical Student Association (AMSA)
American Medical Association-Student Business Section (AMA-SBS)
National Conference of Student Affiliate Members of the
American Academy of Family Practice (NC-SAM)
Association of American Medical Colleges-Organization of
Student Representatives (AAMC-OSR)
Student National Medical Association (SNMA)
La Raza Medical Association (La RaMA)
Student Osteopathic Medical Association (SOMA)

2. PURPOSES OF THE CONSORTIUM:

- 1) To facilitate communication between the member organizations of the Consortium;
- 2) To serve as a vehicle for expressing the common concerns of all medical and osteopathic students, in the political arena, in academic communities, and in any other appropriate forums.

3. DETERMINATION OF CONSORTIUM POLICY:

Any member of the Consortium may propose that the Consortium establish and publicize a position regarding any relevant issue. Each member of the Consortium shall have one vote to cast in determining Consortium policy. If any member of the Consortium casts a dissenting vote on any proposed position or action of the Consortium, then the proposal can not become Consortium policy. All seven members of the Consortium must vote before new policy can be established.

Internal affairs of the Consortium will be decided upon by simple majority vote of members present at an official Consortium meeting. Four members of the Consortium must be present in order to hold an official meeting.

4. COMMUNICATIONS:

A Consortium Communications Coordinator will be appointed and supported by one of the seven member groups each year. This responsibility will rotate between all members of the Consortium. Each Coordinator will hold that position for a period of not longer than one year.

4. COMMUNICATIONS: (continued)

The Coordinator's responsibilities will be to distribute any relevant information to all members of the Consortium and to facilitate communications between all member organizations. The Coordinator will assist in the scheduling of Consortium meetings and establishing agendas for those meetings.

5. AMENDMENTS:

This Document of Understanding may be amended by votes of five of the seven Consortium members.