

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 17, 1975

5:00 p.m.	Business Meeting	<i>Chevy Chase Room Washington Hilton Hotel</i>
7:30 p.m.	Cocktails	<i>Dupont Room</i>
8:30 p.m.	Dinner	<i>Chevy Chase Room</i>

September 18, 1975

9:00 a.m.	Issues Session <i>(Coffee and Danish)</i>	<i>Monroe West Room Washington Hilton Hotel</i>
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon	<i>Lincoln West Room Washington Hilton Hotel</i>
	Executive Council Business Meeting	
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 17, 1975

I. REPORT OF THE CHAIRMAN

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1. Approval of Minutes of CAS Administrative Board Meeting of June 19, 1975 1
2. All action items in the accompanying Executive Council Agenda
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Student Evaluation Within the Institutions

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

June 19, 1975

AAMC Headquarters
Washington, D.C.

PRESENT: Board Members

Rolla B. Hill, Jr.
Chairman-Elect (Presiding)
F. Marion Bishop
A. Jay Bollet
Carmine D. Clemente
Ronald W. Estabrook
Robert G. Petersdorf*
Leslie T. Webster

Staff

Vicki Bardolf
James B. Erdmann
Mary H. Littlemeyer
Thomas E. Morgan
Mignon Sample
August G. Swanson

ABSENT: Jack W. Cole
Robert M. Berne
Thomas K. Oliver, Jr.

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of April 3, 1975, were adopted as circulated.

II. Action Items

A. Applications for Membership

ACTION: The applications for membership of the Society for Gynecologic Investigation and the American Society of Plastic and Reconstructive Surgeons were unanimously approved for recommendation to the full Council.

B. Reinstatement to Membership

ACTION: The request for reinstatement to membership status from the American College of Obstetrics-Gynecology was approved.

*Ex Officio

C. Academic Medical Center Problem Identification Survey

Joe Keyes, Director of the AAMC Division of Institutional Studies, joined the Board and summarized the plans to conduct a Delphoid Survey to identify problem areas in the governance of academic medical centers. The planning was to include the Council of Deans in Round I and the Council of Academic Societies and the Council of Teaching Hospitals in Round II if they elect to participate.

ACTION: The CAS Administrative Board voted unanimously that the Council of Academic Societies should participate with the Council of Deans in a study to identify problems in academic medical center governance.

NOTE: The nature, purpose and method of the study are described in the letter mailed on July 18, to designated faculty in each of the 114 medical schools, a copy of which is attached.

There was some discussion as to the selection of faculty among the Council of Academic Societies and assuring an institutional representation, i.e., on a school-by-school basis, some schools have as many as eight CAS representatives, whereas some schools have no CAS representatives. From a later analysis it was found that in 30 schools there was neither a representative nor officer of the 58 CAS member societies which numbers 274 names. Dr. Webster suggested that the Dean be designated to nominate a faculty participant in such schools. Another suggestion was that if the CAS designee does not wish to participate, he nominate an individual he might think more appropriate to participate. Dr. Petersdorf urged that the CAS join the survey in Round I, and this was accomplished.

D. 1976 CAS Spring Meeting

ACTION: The CAS Administrative Board voted unanimously that the Council of Academic Societies should convene its spring 1976 meeting in Philadelphia together with the proposed International Conference on Educational Patterns and Measurement being sponsored by the National Board of Medical Examiners.

E. Report of the CAS Nominating Committee

The proposed ballot for the Administrative Board positions to be filled in the fall was distributed at the meeting. Dr. Petersdorf objected to having three of the 12 slots filled by individuals who were on the Nominating Committee. Dr. Webster said that he expressed a similar concern at the time of the Nominating Committee meeting but was reminded that earlier a member who was on the Nominating Committee had been chosen by the Nominating Committee to stand for Chairman-Elect.

Another matter that was brought up was the new requirement that whoever is on the Board must for the duration of his or her tenure serve as the official representative of his or her society. It was said that this rule infringes on the rights of the individual societies. Or, if the societies chose to change their official CAS representatives, they could leave the Board leaderless.

ACTION: The CAS Administrative Board voted unanimously to recirculate the slate proposed by the full committee for reconsideration to its members whose names do not appear on the slate. Resignations from the Committee were received from two members whose names were chosen for the slate and that a third member will be requested.

With regard to membership of future CAS Nominating Committees, an additional action was taken as a safeguard against a similar situation.

ACTION: The CAS Administrative Board voted unanimously to accept as an operating procedure the policy that no current members of the CAS Administrative Board be eligible to serve on the Nominating Committee. This will not require a change in the CAS Rules and Regulations.

The CAS Administrative Board next turned its attention to the Executive Council Agenda.

F. Provisional Institutional Members

ACTION: The CAS Administrative Board voted unanimously to approve for election to provisional institutional membership in the AAMC the University of South Carolina, Columbia, School of Medicine.

G. Criteria for Election to Provisional Institutional Membership

ACTION: The CAS Administrative Board voted unanimously for modification of the AAMC criteria for election to Professional Institutional Membership as set forth in the Executive Council Agenda on pages 16-17.

H. COTH Ad Hoc Membership Committee Report

Dr. Swanson gave a brief summary of the background and evolution of the COTH Ad Hoc Membership Committee Report. Dr. Petersdorf spoke against the report because standards were not delineated. The result of this could be that corresponding member hospitals with subquality programs might interpret this as a tacit approval of subquality programs. With the recommendation that the word subscriber (not member) be used, he had no problem with the report. The following action was, therefore, adopted.

ACTION: The CAS Administrative Board voted unanimously to approve the recommendations of the COTH Ad Hoc Committee (pages 21-22 in the Executive Council Agenda) with the accompanying recommendation (pages 19-20 in the Executive Council Agenda) that institutions would be designated as "subscribers" rather than "members" and with the stipulation that each separate Council should determine whether it wishes to adopt the "subscriber" category rather than this being automatically extended to the COD and CAS (as in the recommendation on pages 19-20 of the Executive Council Agenda).

I. Ratification of LCME Accreditation Decisions

ACTION: The CAS Administrative Board voted unanimously to ratify the LCME Accreditation decisions as set forth in the Executive Council Agenda on pages 36-38.

J. The CAS Administrative Board noted the budget of the Coordinating Council on Medical Education. No action was required, and none was taken.

K. Coordinating Council on Medical Education Relations With Parent Organizations

ACTION: The CAS Administrative Board voted unanimously to approve the policies recommended to improve the responses of the parent organizations to CCME reports and recommendations as set forth in the Executive Council Agenda on page 40.

L. AMA Policy on Eligibility of Foreign Medical Students and Graduates for Admission to Graduate Medical Education

ACTION: The CAS Administrative Board voted unanimously to approve the recommendation that the pathways into graduate medical education in the United States should be defined by the LCGME and forwarded to the CCME for approval and forwarding to the parent organizations for ratification.

M. National Health Insurance

ACTION: The CAS Administrative Board voted unanimously to approve the Report of the National Health Insurance Review Committee as distributed at the meeting and attached to these minutes.

N. Amendment of AAMC Bylaws

ACTION: The CAS Administrative Board voted unanimously to approve the proposed amendment to the AAMC Bylaws as set forth in the Executive Council Agenda on pages 47-48 with regard to representation to the Organization of Student Representatives by institutional members whose representatives serve on the OSR Administrative Board.

O. Conference on Epidemiology

ACTION: The CAS Administrative Board voted unanimously to approve the following recommendation:

The Association encourages the Health Resources Administration to bring together representatives from the organizations and agencies listed in paragraph 6 of the conference report, for the purpose of developing the goals and objectives of an expanded effort in training in epidemiology. The outcome of this effort should be a document providing sufficient detail on goals so that the faculties of health professional schools may judge their programs against a national consensus.

P. Task Force Responses to GAP Recommendations

ACTION: The CAS Administrative Board voted unanimously on the following items -- reactions of COD, CAS, GME and OSR to summary of Task Force responses to the GAP Committee's major recommendations (Executive Council Agenda pages 65-74):

- Recommendation 1. The CAS accept the COD modification of the CAS recommended substitution.
- Recommendation 2. The CAS accepts the GME substitution.
- Recommendation 3. The CAS reaffirms its recommended substitution.
- Recommendation 4. The CAS accepts the last 3 paragraphs on page 68 as recommended by the COD. The CAS withdraws the 3 CAS recommendations (top page 69). The CAS supports neither the GME recommendations (page 69) nor that of the OSR (page 70).
- Recommendation 5. The CAS accepts the COD recommendation (page 71).
- Recommendation 6. The CAS accepts the GME recommendation (page 72).
- Recommendation 7. The CAS accepts the COD recommendation and rejects the OSR recommendation (page 73).
- Recommendation 8. The CAS reaffirms its position and rejects the OSR recommendation (page 74).

Q. Future Board Meetings

For the benefit of those who were unable to attend the all-day Board Retreat on June 18, a brief account of the activity was given. Those who had attended felt the session, which provided an opportunity

to consider substantive issues that the Council will be confronting in the near future and long-range. Since all business is now conducted in the morning preceding the joint session with the other two Councils, it was decided that the business meeting should be put ahead to the evening before the regularly scheduled meeting. Then on the following morning, the Board can consider prospective issues. The following action was taken in this regard:

ACTION: The CAS Administrative Board agreed to hold its quarterly business meeting from 5:00 - 8:00 p.m., the evening prior to the regularly scheduled meetings. The following morning will be devoted to considering prospective issues for which Board members will develop discussion papers.

For the September meeting the following Board members agreed to prepare study papers which will be distributed to the other Board members ahead of the meeting to stimulate their thinking and to serve as the basis of the discussion. These papers need not be extensive but will serve to identify the issues and the alternatives that exist. Staff will collate and forward to the committee background documents for reference.

Continuing Medical Education -- Drs. Bollet and Clemente

Research Training -- Drs. Petersdorf and Webster

R. Annual Meeting

ACTION: The topic selected for the joint CAS-COD-COTH meeting at the time of the Annual Meeting is "Maximum Disclosure: Individual Rights and Institutional Needs."

S. Adjournment

The formal meeting was adjourned at 12:30 p.m. in time for a joint luncheon with the Administrative Boards of the other two Councils. The business meeting of the Executive Council followed.

MHL:car

7/17/75

Attachments: (1) Letter Regarding Delphoid Survey
(2) Report of the National Health Insurance Review Committee

REPORT OF THE
NATIONAL HEALTH INSURANCE REVIEW COMMITTEE
1975

The United States as a matter of public policy should recognize the essentiality for the education and training of sufficient physician manpower to provide adequately for the medical services of its citizens. The education and training of the required physician manpower for this country will provide the public with physicians educated and trained in the social milieu of this country and with a high degree of medical knowledge obtained in its excellent medical schools and the health care institutions which provide accredited programs in graduate medical education.

- (1) For purpose of reimbursement under national health insurance the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources applicable to clinical post-doctoral medical education should be deducted from total cost prior to determining reimbursement cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.
- (2) Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.
- (3) The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.
- (4) A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the addition of needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.

- (5) The reimbursement policies must reflect that there are valid differences among the various types of providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and intensity of services provided by the teaching hospital; and (3) the teaching hospital's commitment to the incremental costs of providing the environment for medical and paramedical educational programs.
- (6) Philanthropy must be encouraged and its importance to the health care system recognized. Philanthropic contributions have provided non-profit and public hospitals with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and for innovative programs. This vital support has stimulated research and development in medical care organization. More specifically, the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Second, hospital reimbursement formulas should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the Governing Body of the respective hospital subject only to the approval of authorized planning agencies.

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

June 18, 1975

Mayflower Hotel.
Washington, D. C.

Present: Board Members

F. Marion Bishop
Carmine D. Clemente
Ronald W. Estabrook
Rolla B. Hill, Jr. *
Leslie T. Webster

Absent: Board Members

Robert M. Berne
A. Jay Bollet
Jack W. Cole
Thomas K. Oliver, Jr.
Robert G. Petersdorf **

Present: Staff

Vicki Bardolf
Mary H. Littlemeyer
Thomas E. Morgan
August G. Swanson

The CAS Administrative Board met for a day in advance of the regularly scheduled meeting to analyze thoughtfully some current and future issues and to provide guidance to staff on the positions the AAMC should take as representative of the Council of Academic Societies. The morning session focused on biomedical research problems. Topics addressed were:

- what effect does the Baumann amendment and increasing Congressional supervision have on basic biomedical research?
- what efforts should be made to obtain a realistic extension of research training legislation?
- what position should AAMC take on the growing tendency to legislate NIH programs on a categorical basis (so-called "disease-a-month" legislation)?
- what position should we adopt on the NIH's responsibilities for programs which erode its research mission (e.g. health care delivery)?
- is the confidentiality of research protocols essential to the peer review process and biomedical research funding?

* For part of the meeting

** Ex Officio

In the balance of the meeting the probable impact of recent and impending legislation and regulation on undergraduate and graduate medical education was considered with regard to:

A. Undergraduate Medical Education

-- Increasing federal and state interference in the selection of medical students:

- a) Restrictions on accepting out-of-state students
- b) Restrictions on admission policies which are considered discriminatory as against requirements for affirmative action
- c) Mandated acceptance of U.S. FMGs through COTRANS or the Fifth Pathway

-- Increasing federal and state interference in academic program development:

- a) The three year curriculum
- b) The requirement for 50% of graduates having a 6 weeks "remote site" experience
- c) Legislated Family Medicine departments and residencies to the exclusion of other primary care specialties
- d) Legislated medical schools without regard to facilities, faculty or resources (the VA schools)

B. Graduate Medical Education

-- Federal involvement in graduate medical education

- a) Lack of a national policy on the future financing of graduate education and teaching hospitals
- b) Potential involvement of the National Labor Relations Board in housestaff unionization
- c) Federal regulation of the numbers and types of residency positions to be filled

-- CCME/LCCME and the accreditation of graduate medical education

- a) Growing number of recertification and relicensure requirements by specialty boards and state boards of medical licensure

- b) Increasing "profitability" of continuing education attracting entrepreneurs
- c) AMA policies for accreditation of continuing medical education and institutional residency programs

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

The Board reconvened for cocktails and dinner with representatives of the COD Administrative Board and staff. After dinner, Dr. Donald S. Frederickson, newly appointed Director of the N.I.H. discussed with the group his views of the future of the N.I.H. and biomedical research.

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MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: AMERICAN SOCIETY OF HEMATOLOGY

MAILING ADDRESS: Ropes & Gray (Principle Ofc) Dr. Thomas B. Bradley (direct correspondence)
* 225 Franklin Street Secretary to this address
Boston, MA 02110 V.A. Hospital
4150 Clement St.
San Francisco, CA 94121

PURPOSE: The purposes of this corporation shall be to engage exclusively in charitable, scientific and educational activities and endeavors including specifically but not limited to promoting and fostering, among the many scientific and clinical disciplines, the exchange and diffusion of information and ideas relating to blood and blood-forming tissues and encouraging investigations of hematologic matters. No substantial part of the activities of the corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation; nor shall this corporation participate or intervene, by publishing or distributing statements or in any other way, in any political campaign on behalf of any candidate for public office.

MEMBERSHIP CRITERIA: Any person with a doctoral degree or its equivalent, who is a permanent resident of any American country and who has manifested a continuous interest in any discipline important to hematology as evidenced by work in the field, original contributions, and attendance at meetings concerning hematology, is eligible for active membership.

NUMBER OF MEMBERS: 2106

NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: October 12, 1957

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Revised December 3, 1973 1. Constitution & Bylaws

December 1974 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

* Business Office: Charles B. Slack, Inc.
6900 Grove Road
Thorofare, NJ 08086

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

X YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

Section 501(c) (3) and Section 509(a)

3. If request for exemption has been made, what is its current status?

- X a. Approved by IRS
- b. Denied by IRS
- c. Pending IRS determination

4. If your request has been approved or denied , please forward a copy of Internal Revenue letter informing you of their action.

Dean Katsis, M.D., President
(Completed by - please sign)

June 20, 1975
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Miss Vicki Bardloff

NAME OF SOCIETY: Association of Medical School Departments of Biochemistry

MAILING ADDRESS: Dr. Henry Z. Sable, Secretary
Association of Medical School Departments of Biochemistry
Department of Biochemistry
Case Western Reserve University School of Medicine
Cleveland, Ohio 44106

PURPOSE: To promote discussion of problems of interest and concern to
Departments of Biochemistry located in medical school environments.

MEMBERSHIP CRITERIA:

Regular membership: Departments of Biochemistry in Medical Schools
in the United States and Canada (and other locations
by petition).

Associate membership: Departments of Biochemistry in Universities which
do not have Medical Schools, but in which a special
interest in medical or health education exists.

NUMBER OF MEMBERS: 91 Institutions.

NUMBER OF FACULTY MEMBERS: Estimated 1,500.

DATE ORGANIZED: April, 1973

SUPPORTING DOCUMENTS REQUIRED (Indicate in blank date of each document):

November 20, 1973 1. Constitution & Bylaws

February 21-23, 1975 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested:

Section 501 (c) (3)

3. If request for exemption has been made, what is its current status?

a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Carl S. Vestling
(Completed by - please sign)

10 July 1975
(Date)

NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

Recently the Association of Program Directors in Psychiatry began discussing the possibility of having all of psychiatry move out of the matching plan. Whether or not such a decision will be voted is hard to predict. The program directors in psychiatry have been particularly dissatisfied with the matching plan because several of the prestigious psychiatric hospitals have no other residency programs and, therefore, there is no peer pressure within their institutions to stay within the matching plan.

The NIRMP Board is considering several options in developing new leadership and new management direction with the retirement of Jack Nunemaker in October. Although the Board has not yet acted, it appears that an individual unconnected with any national organization will be chosen as Director. The possibility of having the services for the matching plan provided by the AAMC as an adjunct to its AMCAS program is being considered. However, there is considerable sentiment among other Board members to keep the matching plan independent and in Chicago. One modification of the hospital contract for the matching plan was approved by the Board. This requires that all program directors, in addition to the hospital administrator, sign the agreement. It is hoped this will call to the attention of the program directors their individual obligations in seeing to it that their institution abides by the rules.

A survey of medical students was conducted last year at the time of the match to determine how many may have been approached to make agreements in violation of the rules and spirit of the matching plan. A report of that survey is attached. It appears that there is an increasing effort to recruit students outside the plan. The OSR-inspired monitoring committees, which have been established in over half the medical schools, have not proven particularly effective. Only one student last year was willing to be identified in reporting a violation of matching plan rules by a program director.

There appears to be a consensus that it is important that the matching plan continue and be improved. The Council of Academic Societies in March of 1974 expressed its positive support for the matching plan. It is recommended that a report on the status of the matching plan be provided at the Annual Meeting.

GSA-NIRMP SURVEY
BACKGROUND INFORMATION

The GSA-NIRMP Survey was developed by the GSA Ad Hoc Committee on Professional Development and Advising and AAMC staff in response to concerns expressed primarily by student affairs deans and medical students about the increasing numbers of violations to NIRMP procedures. The GSA-OSR Monitoring Program was initiated in 1974 and 54 of 71 schools who responded to a September 1974 questionnaire reported that they had either established or planned to establish a committee to receive reports of violations during the 1974-75 academic year. Despite the development of this program, there was growing concern voiced by several constituent bodies that students continued to be pressured by program directors to enter into advance agreements outside NIRMP. A second impetus for the survey stemmed from the desire expressed by both students and GSA members to assess the usefulness and adequacy of various counseling systems established by schools to aid students in making graduate medical education program choices.

The survey instrument consisted of two questionnaires--one which was to be completed by all graduating students and one which was to be completed by student affairs deans. The student questionnaire focused on such questions as whether they had been contacted by program directors to make agreements in violation of NIRMP guidelines, whether they had actually entered into such agreements, and whether they had received adequate counseling about program choices and the matching process. GSA members were then asked on a separate form to compile their school's student responses and also to provide data on their school's counseling system and NIRMP monitoring mechanism.

Sixty-three (63) schools responded to the survey which represents approximately 60% of medical schools with a 1975 graduating class. An average of 50% of the students at those 63 schools had completed the student questionnaire.

In any analysis of the responses, it is important to consider the probable characteristics of the respondent pool. It is unlikely that the respondents represent a random sampling of all graduating students since at most schools the questionnaires were distributed on matching day in conjunction with the distribution of match results. Therefore, many students who did not participate in NIRMP did not receive the questionnaire.

In regard to the section of the survey about the types of programs which pressured students to enter into advance agreements, a weakness in the survey methodology should be mentioned. Students were asked to cite the types of programs which had pressured them to make agreements outside NIRMP but were not asked specifically to indicate the number of times each type of specialty program had contacted them. When GSA members compiled the student responses, they may have indicated that twenty of their students reported being contact by program directors and that the types of programs involved were surgery and ENT. It was not possible to extract from the surveys returned to AAMC the precise numbers of violations initiated by each type of program. The list of specialties in the attached report should not, therefore, be interpreted as an accurate "ranking" of programs which are involved in NIRMP violations. It provides, rather, some indication of those program types which are most frequently cited by students as having put pressure upon them to enter into advance agreements outside NIRMP.

GSA-NIRMP SURVEY RESULTS

As of May 20, 1975, 63 schools had returned their GSA-NIRMP Questionnaires. Based on an approximate 60% school response and an average student response at each school of 50%, the following data has been compiled.

98% of students responding participated in NIRMP.

6% of students responding went through the motions of participating in NIRMP after having made a private advance agreement with a program director.

Of those students who did not participate in NIRMP:

11% were married or engaged students who opted to secure an appointment with spouse before matching day

54% secured a military hospital appointment

4% secured a Canadian hospital appointment

15% withdrew from NIRMP after having made a private advance agreement with a program director outside NIRMP

6% secured an appointment with an affiliated hospital that does not participate in NIRMP

1% secured an appointment with a non-affiliated hospital that does not participate in NIRMP

9% did not participate in NIRMP for other reasons (e.g., early graduation, no clinical plans, entering Ph.D. program, secured appointments in unfilled, affiliated slots, etc.)

444 students or 14% of students responding to the questionnaire were contacted by program directors to make a private, advance agreement. Of those 444, 62 were contacted in writing; 61 were contacted more than three times; 198 were subjected to follow-up pressure by mail; and 201 were required to notify programs of a decision by a specified deadline.

In response to the question regarding counseling systems, the following numbers of respondents indicated those systems which proved most helpful.

280	Dean's Office
75	Graduate Medical Education Advisory Committee
394	Individual Faculty Advisors
178	Reference Materials Compiled by School
438	Other (i.e., advise of housestaff, peers, externship experiences, interviews, etc.)

Students were requested to list those types of programs which put pressure on them to make a private, advance agreement outside NIRMP. The following numbers of schools listed the following programs at least once on the GSA-NIRMP Questionnaire:

30	Surgery
25	Psychiatry
24	Family Practice
19	Pediatrics
19	OB-GYN
17	Internal Medicine
13	Anesthesiology
10	Medicine
7	Pathology
6	ENT
6	Ophthalmology
5	Radiology
3	Orthopedics
2	Urology
2	PM&R

In question 5a of the GSA-NIRMP Questionnaire, schools were asked to indicate the types of programs with which students matched who had "gone through the motions" of participating in NIRMP after making an agreement with a program director. The following numbers of schools listed the following programs at least once on the GSA-NIRMP Questionnaire:

17	Psychiatry
14	Surgery
9	OB-GYN
9	Pathology
8	Pediatrics
7	Family Practice
6	Internal Medicine
5	Anesthesiology
4	Medicine
3	Ophthalmology
2	ENT
2	Radiology
2	PM&R
2	Neurology
1	Urology
1	Orthopedics

Of the students who responded to the questionnaire, 2% withdrew from NIRMP after having made a private, advance agreement with a program director. The average percentage of students who matched in the five choice categories was as follows: 58% - 1st choice/ 14% - 2nd choice/ 10% - 3rd choice/ 12% - 4th choice or lower/ 6% - No Match. This breakdown did not vary significantly according to the counseling systems used. At schools where "other" systems were reported as being most helpful, slightly fewer students "went through the motions" or withdrew from NIRMP after having made a private, advance agreement with a program director.

Monitoring Committee Information:

38 of the responding schools have some type of monitoring committee or mechanism.

16 of the responding schools have not established a monitoring committee or mechanism.

24 violations were reported to monitoring committees of the responding schools. The types of programs involved were as follows:

Surgery
Psychiatry
Internal Medicine
Pediatrics
Pathology
OB-GYN
Orthopedics

5/28/75 - DM

AAMC ANNUAL MEETING
November 2-7, 1975
Washington Hilton

SATURDAY
NOV. 1

Soc Univ Urologists
1:30 - 5:30 pm

SUNDAY
NOV. 2

Assn Anatomy Chmn
8 am - 5 pm

Assn Chmn Physiology
8:30 am - 3:30 pm

Soc Univ Urologists
9 am - 4:30 pm

Soc Gyn Investigation
9 am - 5 pm

Assn Prof Dermatology
9 am - 5 pm

Assn Pathology Chmn
9 am - 5 pm

OSR/GSA Program
8 pm - 10:30 pm

MONDAY
NOV. 3

Soc Univ Otolaryn
8:30 am - 1 pm

Assn Prof Medicine
8:30 am - 5:30 pm

COD/COTH PROGRAM¹
9 am - 11:30 am

Assn Prof Dermatology
9 am - Noon

CAS BUSINESS MEETING
9 am - 5 pm

COTH GENERAL SESSION
Noon - 5 pm

COD BUSINESS MEETING
2 pm - 5 pm

Assn Pathology Chmn
4 pm - 6 pm

INTERNATIONAL PROGRAM
8 pm - 10 pm

TUESDAY
NOV. 4

PLENARY SESSION²
9 am - Noon

AAMC ASSEMBLY
1:30 pm - 4 pm

MINORITY AFFAIRS PROGRAM
4:30 pm - 6:30 pm

WEDNESDAY
NOV. 5

PLENARY SESSION³
9 am - Noon

Assn Chmn Psychiatry
1 pm - 5 pm

Soc Teach Fam Med
1 pm - 10 pm

CAS/COD/COTH PROGRAM⁴
2 pm - 5:30 pm

RIME Symposia
1 pm - 5 pm

THURSDAY
NOV. 6

Assn Orthopaed Chmn
8:15 am - 5:30 pm

Assn Chmn Psychiatry
9 am - 5:30 pm

Soc Univ Otolaryn
9 am - Noon

Soc Teach Fam Med
9 am - 5:30 pm

GME PLENARY SESSION⁵
10 am - Noon

Soc Chmn Otolaryn
Noon - 3 pm

RIME Symposia
1 pm - 5 pm

1. "Consortia: New Patterns for Inter-Institutional Coordination"
2. "Excellence in Medicine: The Role of Medical Education"
3. "Presentation of Awards - The Alan Gregg Memorial Lecture"
4. "Maximum Disclosure: Individual Rights and Institutional Needs"
5. "Remote Site Education: The Case For and The Case Against"

DRAFT OF POSITION PAPER FOR AAMC CONCERNING CONTINUING MEDICAL EDUCATION

Prepared by: Alfred Jay Bollet, M.D.

As background for a AAMC policy on Continuing Medical Education the following facts should be noted:

1. The prevailing policy regarding undergraduate medical education generally in the United States and supported by the AAMC is one in which the students are prepared for continued professional growth through self-education throughout their careers. A statement made by Professor George A. Smart, Director of the British Postgraduate Medical Federation, is worth noting in this context: He pointed out that "to educate" is derived from the Latin "to lead out of," to develop one's full potential, in contrast to the word "to instruct," which means "to pile up inside -- or to stuff." Stuffing a certain amount of skills and knowledge in an individual leaves him fixed at that point in his development. A policy regarding continuing medical education should be a logical extension of this overall aim of undergraduate education.

2. Four states have adopted a requirement for evidence of having completed continuing education in order for physicians to renew their licenses each year (Kansas; Kentucky, Maryland and New Mexico); seventeen states have such a requirement for osteopathic relicensure. These developments are clearly indicative of mounting public pressures for consideration of the ability of each physician periodically rather than life-time licensure which has been the case in the past.

1 Smart, G.A., "What Do We Mean by Continuing Medical Education and Why Is It Important Now in the United Kingdom?" In Anglo-American Conference on Continuing Medical Education, April 8, 1974.

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3. Concomitantly there has been a vast increase in the number of educational programs available to physicians. These include organized postgraduate courses, self-educational audiovisual material, and a variety of less structured educational opportunities. Varying amounts of credit are given for each type of educational program by the AMA for its Physician Recognition Award, and by the state licensing boards and medical associations in fulfillment of their requirements for continuing education at the time of re-registration.

4. Recertification has been made mandatory in one specialty, the American Board of Family Practice, and voluntary in one, the American Board of Internal Medicine. Most of the other specialty boards are strongly considering or actually planning recertification on either a voluntary or mandatory basis (the policy statement adopted by the American Board of Medical Specialties regarding recertification on March 20, 1975 is attached). One recertification examination has been administered, by the American Board of Internal Medicine, and 3355 internists (over 20% of those eligible) took this first examination. Twelve state medical associations and several specialty societies have made a policy decision requiring continuing medical education as condition of membership.

5. Additional background includes the rapid development of mechanisms of audit of physician performance. Spread of the usage of the problem-oriented record has assisted the development of methods of audit of physician performance. Legislation requiring such audit in the form of PSRO's seems to make it imminent that continuing evalua-

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tion of physicians in terms of actual performance in their practice should become a reality. This development will permit analysis of specific types of educational needs by individual physicians or groups of physicians and provide the opportunity to design educational programs tailored to meet specific needs.

Suggestions for the AAMC policy include the following:

1. With the increasing public pressure for relicensure examinations of physicians, the AAMC should strongly support the principle of periodic relicensure examination for the basic state licenses to practice medicine and should endorse mandatory recertification examinations in the various specialties.
2. The AAMC should also support continuing education requirements for re-registration of state licenses in the interval between the periods of periodic mandatory re-examination.
3. The AAMC should support the principle of flexibility in type of educational experience which would be acceptable. Formally organized postgraduate courses, although the most frequent and popular, may very well be the least effective mechanism. Many people learn better on their own and evidence of having reviewed certain types of prepared textual materials should be acceptable, as well as other unstructured experiences such as preceptorships, attendance at medical school grand rounds, conferences, etc. Self-instructional mechanisms should be acceptable. Participation in teaching programs as the teacher should also be acceptable (perhaps on a double credit basis, giving credit for the time spent preparing a presentation).

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4. The AAMC should support the evaluation of physician performance through medical audit and the utilization of information derived in this fashion to determine specific educational needs of individual physicians.

5. Evidence of having attended postgraduate educational programs should not be considered sufficient to meet relicensure requirements. There should be evidence that the physician learned something as well. The requirement for continuing education and attempts to evaluate the effectiveness of such programs should attempt to include elements of physician performance beyond that of pure cognitive knowledge. Specifically skills, attitudes and other components of clinical competence should be evaluated, and attempts to modify these parameters in educational programs insofar as developing methods permit. Methods of evaluation of physician performance for purposes of relicensure, as well as determination of continuing education need, thus should include performance on cognitive type examinations, audit of records to determine actual performance, responses of patients to evaluate attitudinal aspects, and peer evaluation to determine clinical competence and skills.

6. As an alternative to mandatory relicensure a mechanism might be supported by the AAMC which would tie some type of reward system to achievement of continuing education goals. For example, the basis for remuneration or fee schedule could be tied to achievement level in this regard. In a full-time medical care system rank and salary could be tied in this fashion, as it is to a certain extent in the V.A.

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7. Recertification by a specialty board should satisfy the requirements for mandatory relicensure by states. We should try to avoid perpetuation of the system in which specialty certification cannot be used to satisfy general state licensing requirements.

- 21 -
American Board of Medical Specialties

RECOMMENDED GUIDELINES ON RECERTIFICATION FOR SPECIALTY BOARDS

1. Recertification should assure, through periodic evaluations, the physician's continuing competence in his chosen area of specialty practice.
2. Recertification should encourage certified physicians to continue those educational activities essential to the maintenance of competence in their specialties.
3. It is the prerogative of individual boards to elect voluntary or mandatory recertification; however a specialty board may not rescind initial certificates by recertification procedures unless a date of expiration was a condition of the original certification.
4. Similar intervals for recertification by the specialty boards are desirable; an appropriate interval appears to be six years but not more than ten.
5. Upon recertification, the listing of a specialist in the Directory of Medical Specialists will include the date of original certification and the dates of any recertifications.
6. Recertification may apply to any of the fields in which a specialty board grants certificates.
7. Member boards are encouraged to develop procedures for recertification that are most appropriate to the characteristics of their specialty practice. Evaluated participation in continuing education, oral or written cognitive examinations, skills and performance evaluations, practice audits and practice profiles are among the elements that should be considered and utilized as may be appropriate and with suitable emphasis or weighting.
8. Policies and procedures for recertification should be incorporated in the published requirements for certification provided by each specialty board.
9. In the light of rapid developments now taking place in examination and testing technics, Member Boards are also encouraged to review on a continuing basis the recertification procedures they may develop and adopt.
10. The design of recertification procedures requires close collaboration between specialty boards and their related specialty societies and other constituencies; however, the determination of policies and procedures affecting the recertification process is ultimately the responsibility of each primary or conjoint board.

PROBLEMS POSED FOR ACADEMIC MEDICINE BY
MAJOR EXPANSION OF CONTINUING EDUCATION FOR PHYSICIANS

1. Most administrative units for continuing education in the medical schools do not have a "hard money" budget with which to support staff and faculty.

2. Continuing education programs are expected to be self-sustaining from fees charged for courses. This tends to skew offerings toward popular subjects which will attract large audiences.

3. Medical school faculties do not believe that their normal compensation covers an obligation to teach in continuing education courses.

4. Courses sponsored by medical societies, professional colleges and private institutes offer honoraria and opportunities for travel which are attractive to faculty. Most faculty consider participation in these courses as part of their academic perquisites. Growing demand could divert faculty from regular academic duties.

5. Schools do not have mechanisms for evaluation of the quality of continuing education offerings and, in most instances, do not require student participants to demonstrate what they have learned or achieved. Growing demand in the face of inadequate resources could lead to slipshod courses inconsistent with the quality expected of accredited schools of medicine.

PROPOSED SOLUTIONS

Financial Support of Medical School Based Continuing Education

Schools desiring to become major resources for continuing education should have available to them "hard money" budget for the support

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of core staff and faculty. These funds should be generated by a formula \$ figure tied to either (a) State Medical Association dues or (b) to annual licensure fees.

Tuition for courses or fees for consultation should be charged in addition, to cover overhead expenses and the costs of faculty whose official responsibility does not include continuing education and for guest faculty from other institutions.

Participation in Continuing Education Courses by Fulltime Faculty

1. Policies establishing limits on either time away from normal duties or dollar limits on earnings a faculty participant in continuing education away from the medical school may earn may be necessary. Organizations or institutions desiring to use an institution's faculty may be expected to reimburse the institution for the faculty member's services.
2. Institutional policies regarding obligations of faculty to participate in continuing education programs of the institution with additional compensation may have to be defined.
3. Faculty members from key departments should be identified and recruited and have continuing education as their principal educational responsibility. They should be paid from the "hard money" resources of the continuing education unit.

Maintenance of the Quality of Programs

The administrative unit for continuing education should report to the dean and be responsible to an advisory committee empowered to

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evaluate the quality of course offerings and the appropriateness of those offerings, to the school's agreed goals in continuing education. Depending on the school's administrative system, this committee could also be advisory to the dean regarding recruitment of personnel, faculty participation policies and budget.

POSITION PAPER ON PREDOCTORAL AND POSTDOCTORAL TRAINING IN THE BASIC
MEDICAL SCIENCES

Leslie T. Webster, Jr., M.D.

National attention has recently focused on training in the basic medical and behavioral sciences primarily for socioeconomic reasons. This topic also concerns the CAS and AAMC because of the heavy involvement of the nation's medical schools. Questions debated have included the extent of support by the federal government, optimal mechanisms of training support and future needs for trained bioscience manpower. The National Research Act of 1974 mandated that the National Academy of Sciences make specific recommendations to the Secretary of HEW concerning manpower needs and training in the biomedical and behavioral sciences. A preliminary report by the Committee on a Study of National Needs for Biomedical and Behavioral Research Personnel has already been issued in June, 1975 under the aegis of the Commission on Human Resources, National Research Council acting in behalf of the National Academy of Sciences. This report recommends that a mechanism be established for the continuous appraisal of scientific manpower needs and that federal support for training be continued at present levels until more definitive data are collected and evaluated. It is a matter of record that the executive branch of our government has been trying to phase out federal support for training in the biomedical and behavioral sciences.

Rather than entering the above arena with more of the same rhetoric that has proved so unsuccessful in the past, I am proposing to address a

related issue which perhaps has been largely ignored. That is the question of the orientation and quality of research training. This is an area where the CAS has expertise, lots of strong opinions and possibly some ability to effect change.

It seems that two major objectives must be met by any good training program in bioscience. First, the program should provide a strong scientific research training in a given scientific discipline, e.g., biochemistry, physiology, etc. Second, it also must provide a sufficiently broad scientific education to permit the trainee to bridge known disciplines and respond to new ones. My hypothesis is that we succeed fairly well in achieving the first objective of providing good training within a given discipline but all too often fail to achieve the second goal of imbuing the trainee with the necessary flexibility to integrate the selected field with others. The requirement for scientific versatility should receive a high national priority in view of rapid shifts in the orientation of targeted research, the blurring of various scientific disciplines, the interdisciplinary approach required to solve complex biological problems and the need to produce broadly oriented basic science teachers in medicine.

How well are the dual objectives of producing simultaneously specialized and broad based bioscientists being met? My view is that the design of most current Ph.D. training programs and the postdoctoral experience are well suited to producing specialists. Predoctoral training is departmentally based and the quality of the product depends largely on the quality of the faculty of the given department and their commitment to training. Unfortunately, departments vary tremendously in the quality of their research, the course work they offer and their philosophy of research training such

that it is possible to obtain a "cheap" Ph.D. in almost any bioscience discipline, i.e., there is virtually no national standard for a Ph.D. Mechanisms of internal review, even when available, usually fail to correct this deficiency in weaker research environments. Thus, an external review or accreditation process, perhaps formulated and implemented by the various bioscientific societies, may ultimately have to be introduced.

The format of postdoctoral research training in the basic medical sciences (essentially a research apprentice system) does offer the new Ph.D. an excellent opportunity to develop into an independent investigator. Again the quality of training depends largely on the research mentor and the richness of the research environment. In addition to predoctoral research training based in university/medical schools, postdoctoral training may be carried out outside the university setting, e.g., research institutes or the NIH.

The success of Ph.D. training programs in producing broadly trained bioscientists is less spectacular. The strong departmental base of most Ph.D. programs is discipline-orientated and cooperation amongst basic science departments themselves, or basic science departments with other university departments in offering multidisciplinary or integrated bioscience coursework and thesis research leaves much to be desired. Bridging Ph.D. programs, although they are often drawn up to attract federal funding and may appear attractive on paper, usually fail to realize their full potential due to lack of departmental commitment.

If one accepts the proposition that the major failure of present bioscience training is to produce broadly-based bioscientists, then what can be done to improve the situation? Inevitably it appears that greater cooperation between basic science departments is essential whether they

are located on the medical school or university campus or both. Such cooperation, for example, might be greatly expedited by a respected Graduate School Committee, comprised of faculty from the various departments. This Committee and the Graduate School Dean, backed by appropriate resources, might admit graduate students, allocate tuition scholarships, stipends, etc. The Committee might also be charged with setting up and monitoring a multidisciplinary core (bioscience) curriculum to occupy the first year of conventional Ph.D. training. This core might also be elected as part of an advanced undergraduate curriculum for future bioscientists. The core would be followed by the more traditional discipline-oriented and department based Ph.D. program, thus permitting more advanced material to be presented in the discipline selected for the Ph.D. Obviously, this is only one mode for combining a wide exposure to the biosciences with in-depth disciplinary training. Site visiting teams for training grants might be encouraged to look for evidence of this type of training opportunity.

In summary, issues affecting bioscience and behavioral science research training today such as the optimal role of the federal government in providing support, the type of program to be supported, and the number and types of trained personnel to be produced are already being addressed by one mechanism or another which may or may not be influenced by CAS and the AAMC. The problem of producing more broadly based, as well as better trained, bioscientists has not received proper attention and potentially can be influenced by the constituency of the CAS and the AAMC. Training more versatile bioscientists might have strong national appeal in view of rapidly shifting priorities for targeted research.

ITEMS FOR POSSIBLE CONSIDERATION IN THE DISCUSSION OF RESEARCH TRAINING

1. In 1974 the Committee on National Medical Policy of the American Society for Clinical Investigation reached the following conclusions:

- the institutional training grant should be the key element in the biomedical research training programs of the NIH and NIMH.
- the support of training through individual fellowships lacks many of the advantages of the institutional training grant, although in the presence of a vigorous national training grant program, individual fellowships can serve as useful supplements to fulfill special needs.
- the research grant and contract are poor substitutes for stipend support through training grants.
- self-support by the trainee does not appear to be an acceptable method of financing biomedical training.
- the objective of the NIH and NIMH supported biomedical research training programs should be restricted to the development of future scientists and teachers.
- perceptive analyses of flow of personnel on the one hand, and of shortages in specific disciplines on the other, should lead to periodic decisions to launch new programs in the fields that need strengthening, and the curtailment of programs in others.

Do we support these conclusions?

2. Are new federal mechanisms needed to support biomedical research training? Is there any alternative to federal support in this area?

3. How many researchers should be trained? Should there be quotas and, if so, can the Commission on Human Resources reasonably be expected to set them?

4. How can special research manpower needs (e.g. anesthesiology, pulmonary, environmental health) best be met?

STUDY OF IMPACT OF RESEARCH FUNDING
ON ACADEMIC MEDICAL CENTERS

The President's Biomedical Research Panel was created by Congress in mid-1974 and appointed February 1, 1975. At its Spring Meeting the Council of Academic Societies formulated its opinions and presented testimony to members of the Panel. The CAS emphasized their concern for the instability of research funding, the need for support of research training programs and basic biomedical and behavioral research and the need for increased participation of the research community in the planning of future biomedical and behavioral research initiatives. Responding in part to this dialog, the President's Panel set up a number of study groups of scientists whose responsibility is to examine the state of the art of 12 clusters of research endeavor and to advise the Panel what steps should be taken to conduct research more effectively in each area. The Association took a leadership role with the staff of the President's Panel to assess the stability of research funding and the trends occurring in the pattern of federal involvement in the research effort. As a result, a study of the impact of federal research funding on the academic medical center has now been undertaken by a consortium of the AAMC, the American Council on Education and the Rand Corporation. It must be completed by January, 1976.

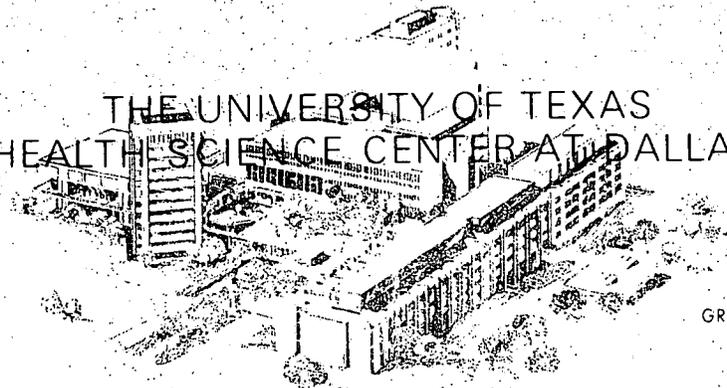
Work on the Impact Study was initiated at the end of June, 1975 with the assembly of a staff for the study. Most of our effort to date has been, and properly should be, the construction of a data base which will depict the dimension and trends in funding of academic medical centers in the past decade. Construction of the computerized data base for addressing questions about the impact of research funding on academic medical centers is now near completion. We have emphasized the construction of the data base because we believe that concrete data is the basis for sound analyses. The credibility of this study will be increased by making the analyses as firm as possible and relying as little as possible on subjective impressions. Our intention is to base analyses of the trends and impact of research funding on hard data and to rigorously test hypotheses about the impact of research funding on such data. In this way, we hope to distinguish clearly fact from inference.

Data on the size, complexity and organizational structure of medical centers is also being assembled. Similarly, data is being assembled as to the type, size and special attributes of medical education efforts at the various centers. The purpose of this effort is to allow the testing of hypotheses concerning the relation of research funding to academic medical center functions.

HEW SURVEY OF RESEARCH RISKS

For more than a year executives of the Department of Health, Education and Welfare have been concerned that no assessment of the type and number of bad outcomes of research in human subjects has been undertaken. There was further concern that no "mal-research" insurance is uniformly available. This concern led the Secretary to create a special Task Force in Spring, 1975, headed by Dr. Seymour Perry, Special Assistant To the Director, NIH. This Task Force has now initiated a telephone survey of 400 randomly selected clinical research project investigators. Intended to be voluntary and anonymous, the survey will seek to find the number and type of serious, moderate and minimal problems which have occurred in human research. The survey is being conducted now and the AAMC staff have serious concern as to the outcome of the study.

THE UNIVERSITY OF TEXAS
HEALTH SCIENCE CENTER AT DALLAS



R W ESTABROOK, Ph D
VIRGINIA LAZENBY O HARA PROFESSOR
CHAIRMAN, BIOCHEMISTRY DEPARTMENT

SOUTHWESTERN MEDICAL SCHOOL
GRADUATE SCHOOL OF BIOMEDICAL SCIENCES
SCHOOL OF ALLIED HEALTH SCIENCES

July 18, 1975

Dr. A. Swanson
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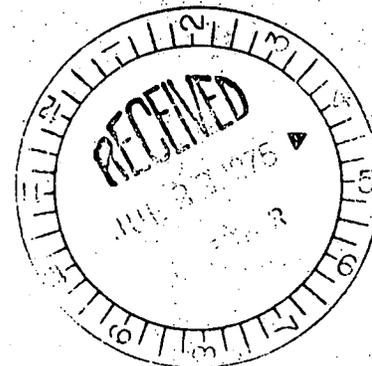
Dear Gus:

Enclosed you will find some old correspondence I received from Bruce Spivey of The American Academy of Ophthalmology and Otolaryngology concerning their program to define curriculum content and evaluation. I really see the day coming when each discipline will have to define a "minimum" expected for student teaching in medical schools. I would appreciate your inclusion of this topic for discussion at the next meeting of the Administrative Board of the CAS.

Best regards,

RONALD W. ESTABROOK, Ph.D.
Virginia Lazenby O'Hara Professor
Chairman of Biochemistry

RWE/mja
encl.



AMERICAN ACADEMY OF
OPHTHALMOLOGY AND OTOLARYNGOLOGY

CONTINUING EDUCATION
OPHTHALMOLOGY

EXECUTIVE OFFICE
15 SECOND STREET S.W.
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9 April, 1975

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Dr. Ronald W. Estabrook, Ph.D.
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RE: Curriculum Evaluation & National Standards

Dear Dr. Estabrook:

This letter is in response to what seemed to be a rhetorical question at the Council of Academic Societies meeting in Washington, on the morning of Tuesday, April 1, 1975. At that time, you questioned what is it that various disciplines or specialities are doing to develop external evaluation of individual schools' curriculum and student competency.

I am well aware, as I know you are, of the extreme resistance various training directors have to externally imposed or constructed examinations such as those of the National Board of Medical Examiners. It seems to me that if the various

specialities and disciplines are not willing to take the time and effort to construct curriculum content and evaluation mechanisms on a national scale (which each specialty or discipline could organize and control themselves), it undoubtedly will occur in some imposed form.

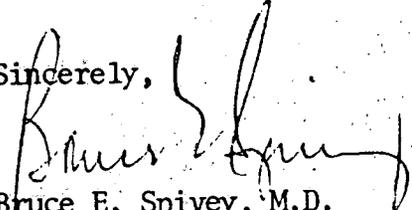
I am pleased to briefly outline the initial attempts of ophthalmology in regard to national standards. Based on a study of curriculum content that I made several years ago in cooperation with the national organization of ophthalmology departmental chairmen (Association of University Professors in Ophthalmology), we have been able to develop a national consensus. This has been validated by two additional studies. We have now taken the next step and developed curriculum materials in the form of a Study Guide (enclosed) and self-instructional materials which themselves have criterion-referenced evaluation. The Study Guide is not a means of supplanting textbooks, but of outlining the clinical problems that present themselves to individuals who are not ophthalmologists. Self-instructional materials have been developed by our group and others relating directly to the objectives that we have developed.

Dr. Ronald W. Estabrook, Ph.D.
RE: Curriculum Evaluation & National Standards
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Our next step will be to develop some means of national evaluation. We have circulated sample questions for use by training directors, and we are in the process of exploring the feasibility of a national examination. We have a multiple-choice examination available that could be utilized, but at this point, we are quite uncertain that it would be accepted by the schools and students. It is likely that some chief's of ophthalmology would object and others would like to utilize it. A greater problem seems to be the opportunity to get the class together or to get the administration to accept such an evaluation mechanism, even if the students could be persuaded of its desirability. The most important evaluation is one based on performance by measuring the knowledge, attitude and skills necessary to deal with patient problems outlined in our curriculum. This is not easily accomplished, as you well know, but we are in the process of considering how this might be done.

I would be happy to amplify any of my comments if you would like.

Sincerely,



Bruce E. Spivey, M.D.
Secretary, Continuing Education

BES/msb
enclosure
cc: Medical Student Education Committee
Continuing Education Committee
C.M. Kos, M.D.

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