



**association of american
medical colleges**

**AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES**

ADMINISTRATIVE BOARD

WEDNESDAY, JUNE 18, 1986

6:00 PM - 10:00 PM

LINCOLN AND MONROE ROOMS

THURSDAY, JUNE 19, 1986

8:00 AM - 12 NOON

JACKSON ROOM

**WASHINGTON HILTON HOTEL
WASHINGTON, DC**

one dupont circle, n.w./washington, d.c. 20036

FUTURE MEETINGS

CAS Administrative Board Meetings

September 10-11, 1986 Washington Hilton Hotel

CAS Spring Meeting

March 18-20, 1987 The Woodlands Inn, Houston, Texas

AAMC Annual Meeting

October 25-30, 1986 New Orleans, Louisiana (CAS meets Oct. 26-27)

November 7-12, 1987 Washington, D.C. (CAS meets Nov. 8-9)

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel
Washington, D.C.

June 18, 1986

6:00 pm	Joint Administrative Boards Reception and
Lincoln and Monroe Rooms	Dinner for John A. D. Cooper, M.D., Ph.D.

June 19, 1986

8:00 am - 12 noon Jackson Room	CAS Administrative Board Meeting
12 noon - 1:00 pm Hemisphere Room	Joint Administrative Boards Luncheon
1:00 pm - 3:30 pm Military Room	Executive Council Business Meeting

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel
June 18-19, 1986

I. ACTION ITEMS

- A. Approval of the Minutes of the April 9-10, 1986 Meeting of the CAS Administrative Board Y1
- B. CAS Nominating Committee Handout
- C. Revision of CAS Rules and Regulations Y6
- D. Criteria for the Flexner Award B17
- E. Revision of the General Requirements Section of the Essential of Accredited Residencies B18
- F. Report of the Ad Hoc MCAT Review Committee B20
- G. GME Transition Committee Report Separate Attachment

II. DISCUSSION ITEMS

- A. Trends in Medical School Applicants B29
- B. Follow-up on COD Spring Meeting Resolutions B45
- C. Role of the AAMC in Promotion of Academic Medical Centers to the Public B27
- D. Discussion of NBME Scoring Policies Y9

III. INFORMATION ITEMS

- A. MEDLOANS B57
- B. Status Report on Animals Y
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- D. Legislative Report Handout

Y = Yellow Agenda Book
B = Blue Agenda Book

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

April 9-10, 1986
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

David H. Cohen, Chairman
Gary W. Hunninghake
Ernst R. Jaffe
A. Everette James, Jr.
Gordon I. Kaye
Frank G. Moody
Virginia V. Weldon*

Staff

David Baime
Christine T. Burris
John A. D. Cooper*
Carolyn T. Demorest
David B. Moore
John F. Sherman*
Elizabeth M. Short
August G. Swanson*
Kathleen Turner*

Guests

Donald G. Langsley
Robert G. Petersdorf*
Edward J. Stemmler*
Richard Wilbur

* Present for part of meeting

I. BUSINESS MEETING

A. ACTION ITEMS

1. Approval of Minutes

The minutes of the January 22-23, 1986, meeting of the CAS Administrative Board were approved as submitted.

2. Membership Application

Drs. Kaye and James recommended that the American Association of Pathologists be admitted to membership in the Council.

ACTION: The CAS Administrative Board voted to approve the application of the American Association of Pathologists for membership in the CAS and to forward this application to the Executive Council.

3. Review of the AAMC ad hoc Committee on Federal Research Policy

Dr. Short presented the draft of the final report of the AAMC ad hoc Committee on Federal Research Policy. She explained that this draft had been discussed at the Spring Meetings of both the CAS and the COD. As a result of these discussions, the Committee had agreed to several minor changes in the text.

The Administrative Board discussed the format and distribution of the final report. Dr. Short noted that the report would be delivered to the printers as soon as it receives approval by the Executive Council, and every effort will be made to have the final printed copies ready for the Fuqua Task Force on Science Policy before they begin their draft report in May. Dr. Short said that this report will also be sent to key individuals at NIH/ADAMHA, the NAS/IOM, and the other congressional committees that have jurisdiction over the federal biomedical research effort.

ACTION: The CAS Administrative Board voted unanimously to approve the final report of the AAMC ad hoc Committee on Federal Research Policy and to recommend it for approval by the Executive Council.

4. Tax Reform Update

Dr. Short reviewed the tax reform bill currently under consideration by the Senate Finance Committee. She explained that this bill, which was proposed by Finance Committee Chairman Robert Packwood (R-OR), addresses many of the concerns of medical schools and teaching hospitals, such as tax exempt bonds. At the same time, however, the Packwood bill still contains a number of provisions from the House bill, including caps on 403(b) elective deferrals and limits on IRAs. The overall effect of these provisions would make academic medical center pensions less competitive.

The Administrative Board discussed the need for individuals to contact members of the Senate Finance Committee to thank them for the changes that have been made and to urge them to further modify the bill to address the Association's remaining concerns. The Board also reviewed the positions on tax reform taken at the January 1986 meeting.

ACTION: The CAS Administrative Board unanimously reaffirmed the positions on tax reform taken by the Association in January 1986.

5. Revisions of the General Requirements Section of the Essentials of Accredited Residencies

Dr. Swanson explained the background regarding the two revisions proposed for the General Requirements section. These revisions, which were requested by the AMA, were adopted by the Accreditation Council for Graduate Medical Education (ACGME) at its February meeting. Revisions of the General Requirements must be ratified by the ACGME sponsors. To date, these revisions have been approved by the AMA, ABMS, and CMSS.

Dr. Swanson said that the first revision, which calls for "adequate financial support for residents' stipends," is in response to institutions taking on unpaid, unsupported residencies. It was noted that the COTH Administrative Board

opposes this revision as an intrusion into the accreditation of institutions.

The COTH Administrative Board also modified the second revision to stress "the importance of cost effective medical practice" as a part of all residency training programs.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council ratify the first revision as originally proposed and the second revision as modified by the COTH Administrative Board.

6. Changes in GME Training Requirements

The Administrative Board discussed two issues related to the procedures to change graduate medical education training requirements. The first was a proposal by the American Board of Medical Specialties (ABMS) to provide an open forum, through its Committee on Certification (COCERT), to review proposed changes in training requirements for certification. These forums would be used to evaluate the impact of such changes on the educational programs in other specialties, on hospitals and medical schools, and on health care costs. Member Boards would notify the ABMS of proposed changes in their certification requirements at least 180 days prior to implementation. The proposal would be referred to COCERT, which will arrange a forum open to other boards, Residency Review Committees, representatives from the ACGME, ABMS public and associate members, and other interested professional groups. COCERT will prepare a report on the proposal and its impact. Final responsibility for establishing certification requirements would remain with the Boards. The Administrative Board considered several options related to the ABMS proposal.

ACTION: The CAS Administrative Board unanimously approved a recommendation that the Executive Council take no further action on this issue until the open forum procedure proposed by the ABMS has been tried. In addition, the Board voted unanimously against a recommendation to require that changes in the special requirements be ratified unanimously by the five sponsoring organizations of the ACGME.

The Administrative Board also discussed the action of the ACGME in regard to the request of the Residency Review Committee (RRC) in Anesthesiology to approve changes in its special requirements that would eliminate the option of substituting two years of practical experience for a fourth year of formal training. All candidates would have to have one broad clinical year and three years of anesthesiology training in an accredited program. Based on a finding that this change would require approximately 1,000 additional positions, a finding that the Anesthesiology RRC disputes, the ACGME deferred action and requested that definitive data on the impact of this proposal on educational resources be provided at the June 1986 meeting. The AAMC supported this motion.

Dr. Cohen explained that the Society of Academic Anesthesia Chairmen support the proposed change in the Board requirement and submitted a statement by Dr. Robert Epstein, their representative, at the CAS Spring Meeting on March 27, 1986. The CAS representative of the Association of University Anesthetists, Dr. Philip Larson, has also written urging the AAMC to support this proposal.

ACTION: The CAS Administrative Board voted unanimously to recommend that the four AAMC delegates to the ACGME (Kay Clawson, Spencer Foreman, Haynes Rice, and David Sabiston) be informed of the CAS discussion of the Anesthesiology proposal. The Board also instructed Dr. Cohen to contact Drs. Epstein and Larson regarding this action.

7. Finance Committee Interim Report

Dr. Virginia Weldon, chairman of the AAMC, accompanied by Dr. Edward Stemmler, chairman-elect, and Dr. Robert Petersdorf, president-designate of the Association, discussed the interim report of the AAMC Finance Committee. Dr. Weldon explained that the Committee has developed a series of preliminary principles for review by the individual Councils. She noted that although membership dues for the medical schools and teaching hospitals will have to be raised to generate the additional revenue that these principles will require, there will probably be no dues increase for CAS societies other than inflationary increases.

ACTION: The CAS Administrative Board voted unanimously to endorse the principles developed by the Finance Committee.

8. Report of the AAMC Committee on Financing GME

Nancy Seline, from the AAMC Department of Teaching Hospitals, presented the draft of the final report of the Committee on Financing Graduate Medical Education. This report makes a number of recommendations to modify existing Association policy related to financing residency training in response to increasingly constrained fiscal resources on the part of teaching hospitals. In particular, the report recommends that limits should be placed on the length of residency training supported by patient care revenues to teaching hospitals, but that this support should extend at least until individuals are capable of the independent practice of medicine.

ACTION: The CAS Administrative Board voted unanimously to approve the report of the AAMC Committee on Financing GME.

B. DISCUSSION ITEMS

1. Current Proposals on Reimbursement of Indirect Costs

Dr. Cohen reviewed the current status of the OMB proposal to cap the administrative component of indirect costs. He noted that this limit, which was originally scheduled for April 1986, has been postponed until July 1986. Dr. Cohen also described the

alternative developed by the Council on Government Relations (COGR). This plan, which has been endorsed by the AAMC, would freeze each university's current administrative rate throughout fiscal 1987, eliminate the practice by NIH of adjusting indirect cost rates throughout the year, and reexamine the departmental administrative component of the indirect cost rate. COGR has appointed a negotiating team, which will be headed by Dale Corson, who is chairman of the NAS Government-University-Industry Research Roundtable.

2. Interpreting the AAMC Policy on the Treatment of Irregularities in Medical School Admissions

The Administrative Board discussed two issues that have arisen related to the interpretation of the Association's recently revised policy on admissions irregularities. The first was whether the Association should forward irregularity reports to non-member institutions or organizations dealing with non-MCAT irregularities. The second was whether the Association should honor the request of the Federation of State Medical Boards to forward certain categories of irregularity reports. It was noted that the National Board of Medical Examiners (NBME) no longer expunges records of irregular behavior and makes this information available to state licensure boards upon request or at the instigation of the NBME.

It was the sense of the Board's discussion that disclosure of such information under the proper circumstances is not only appropriate, but a responsibility. The Board felt that the Association should inform the appropriate organizations that it has this information and that it will make it available upon request. The Board agreed that more information is required on the legal implications of unsolicited disclosures. Efforts should be made to minimize the liability to the Association, to insure due process, and to inform the student of this process. The Board further agreed that these reports should be restricted to Association members, with the exception of MCAT irregularities, which could be reported to all institutions and organizations that use the MCAT.

3. 1986 CAS Annual Meeting Program

Dr. Short suggested that the Sunday plenary session at the CAS Annual Meeting be devoted to a consideration of the declining quantity and quality of applicants for both medical school and graduate programs in the biomedical sciences. Among the possible topics for this session would be the impact on future numbers of both physicians and faculty/researchers, changing perceptions of medical practice and research as careers, the ultimate need for recruiting students, the undergraduate system of advisors, and the cost of medical and graduate school. The session would feature one or more panels of speakers, with an open discussion, similar to the recently concluded Spring Meeting.

REVISION OF THE CAS RULES AND REGULATIONS:
REPRESENTATION OF MEMBER SOCIETIES

In January the Administrative Board discussed the representation of individual member societies within the Council of Academic Societies. This discussion produced the following recommendations:

- 1) The position of Public Affairs Representative (PAR) should be discontinued. The Board felt that the current public policy and legislative issues facing faculty are inseparable from other academic issues.
- 2) The length of the term of CAS representatives should be left to the discretion of the individual societies. Currently, representatives are elected to 2-year terms, and individual representatives may serve up to four terms (or a total of 8 years). Societies should be encouraged to appoint at least one representative to a term of sufficient length (4 to 8 years) to allow that individual time to develop expertise with the issues of importance to the CAS and AAMC and the governance process of the Association.
- 3) Each society should continue to be represented by two individuals appointed by the society. However, each society should have only one vote in the Council rather than the current one vote per representatives.

Recommendations 2 and 3 require the following amendments to the CAS Rules and Regulations:

Section II. Representatives

1. The Council of Academic Societies shall consist of no more than two representatives from each member Academic Society of the Association of American Medical Colleges. These representatives shall be designated by each member Society. ~~for a term of two years; provided, however, no representatives shall serve more than four (4) consecutive terms.~~ *The length of term for each representative shall be left to the discretion of each member Society. Member Societies are encouraged to appoint at least one representative to a term of sufficient length to become acquainted with the issues facing the Council. Each member Society shall be informed one year in advance of the expiration of the term of its representatives, asking for the names of the representatives for the subsequent term. It is the responsibility of each member Society to inform the Association of the names of the individuals designated to represent the Society and their terms of office.*
2. Voting. Each representative of a member Academic Society shall have one (1) vote in the Council. Members-at-large shall have no vote.

These recommendations were discussed by the Council at the Spring Meeting on March 27. Recommendations 1 and 2 met with general approval. There was considerable discussion related to Recommendation 3. Several representatives felt that this recommendation would limit the breadth and diversity of opinion within the Council. Supporters of the recommendation noted that it is the society that holds membership in the Association and that individuals are representing their society and not themselves when they participate in the Council. On the other hand if there is only one vote, member societies may not support the attendance of two representatives to Council meetings.

Recommended Action:

- 1) The Board should approve the proposed amendment of Section II.1. of the CAS Rules and Regulations.
- 2) The Board should discuss the proposed amendment of Section II.2. of the CAS Rules and Regulations.

REPORTING OF NBME SCORES

Issue: Should the AAMC take a position favoring the reporting of NBME examination scores solely on a pass-fail basis?

Background

Discussion and debate concerning the effect of NBME examinations on medical student education has centered on the score reporting system, particularly for Part I. The OSR has requested that the Board consider the question proposed above and has submitted the attached background piece for the discussion. The issue has been discussed in various reports (including GPEP) and forums over the past several years and may be well known to Board members. Here we only sketch the basic arguments.

Proponents for a pass-fail only scoring system assert the following:

- 1) The historical purpose and chief value of the NBME examinations is the licensure of physicians. Scale scores make no contribution to this decision.
- 2) The reporting of scale scores tends to have various detrimental effects on medical education.
 - a) It reinforces the tendency for the examination to drive the curriculum. For example, it focuses the faculty's attention on the competencies and skills measured by the exam at the expense of other competencies of equal or greater importance. Also, the examination format tends to promote an emphasis on memorization and information recall.
 - b) The need to make distinctions among a very able group of medical students invariably results in questions focusing on knowledge of minutia having only very indirect clinical implications.
 - c) Internal pressures to produce high scores stifle curriculum innovations.
 - d) It encourages faculties to abrogate their evaluation responsibilities to an external agency.
- 3) Scale scores are too easily abused. By the NBME's own assessment, the examinations evaluate only 25 percent of the competencies expected of graduating students. Yet these scores are viewed by the LCME as evidence of institutional effectiveness. Also, at times political bodies such as state legislatures request score information as a way of evaluating the institutions they support. Under such pressures it is difficult to decrease the emphasis placed on maximizing performance on the examination.

The counter-arguments presented include the following:

- 1) While licensure is the NBME's primary purpose, the examinations can serve other purposes, e.g., student evaluation, program (curriculum) evaluation, and institutional self-study.
- 2) Whatever disagreements exist about the importance of the material tested, the questions are written by medical school faculty members. Thus, it is not an external agency but our own faculties which are making judgments about the relevance of the material.
- 3) If abuses occur in the uses of the scores, the proper remedy is improved education on appropriate and inappropriate uses.
- 4) NBME scores are the single dependable numerical measure of competence and achievement available to program directors who must assess a large number of applicants to residency positions.
- 5) In the final analysis, each medical school faculty has the prerogative to determine institutional policy regarding the use of NBME scores. The information provided by scale scores should not be denied them.

Recently the National Board has embarked on a change in policy regarding the NBME examinations, to improve their value and, no doubt, to respond to the criticisms which have been levelled against them. In the proposed changes, individual discipline scale scores are no longer provided. However, the National Board stopped short of eliminating the reporting of an overall scale score.

Questions for Discussion:

- 1) Does the reporting of an overall scale score on the NBME examinations have such a deleterious effect on medical education that any benefits are outweighed by negative consequences?
- 2) Do internal and external pressures to achieve high NBME scores at the departmental or institutional level substantially undermine faculty freedom to decide the examination's use and value?
- 3) Does the LCME overemphasize institutional mean scores on the NBME examinations in its accreditation review? Is there a perception that it does so?
- 4) Are there alternatives to program directors' reliance on NBME scores to assess applicants to residency positions?
- 5) Is the proposition that NBME scores should be reported only on a pass-fail basis one on which the AAMC can achieve a consensus among its members?
- 6) If AAMC advocacy for eliminating the reporting of scale scores is not advised, are there other steps the AAMC can take to eliminate abuses in the use of the examination, improve its value to students and schools, and mitigate any adverse effects on medical education?

SCORE REPORTING FOR NATIONAL BOARD EXAMINATIONS
OSR ADDENDUM

The Administrative Board of the Council of Deans has requested discussion of Pass/Fail score reporting for National Board Part I and Part II examinations. Interest in exclusive Pass/Fail score reporting was highlighted by a COD Plenary discussion on the National Boards at the 1985 AAMC National Meeting, and by the publication of the Report of the Panel on the General Professional Education of the Physician (GPEP) and College Preparation for Medicine (AAMC, 1984) and new Liaison Committee on Medical Education (LCME) standards for accreditation Functions and Structure of a Medical School (LCME, 1985). The GPEP Report is critical of an overreliance on multiple choice examination techniques in the evaluation of medical student performance, and the new LCME standards were written so as to exclude any direct reference to, or reliance upon, the National Board Examination Scores in the accreditation process.

When founded in 1915, the original purpose of the National Board of Medical Examiners (NBME) was to produce a voluntary certification process of such high quality that an NBME certificate would become acceptable as evidence of proficiency to all state jurisdictions responsible for physician licensure. The NBME achieved that goal initially with the development of comprehensive essay examinations and then with development during the 1950's of multiple choice examinations (Hubbard, 1978). Further refinement and development is currently underway by the NBME towards development of new examinations that are interactively directed towards accessing decision making skills. The NBME has consistently maintained that its examinations are principally for licensure. It has long recognized and facilitated the use of its examinations for other than licensure, but has formally provided recommendations and cautions to medical schools regarding the use of NBME examination scores. Individual schools can and do use the examinations for purposes of individual student evaluation or curriculum evaluation. The responsibility for that use currently rests with each school.

Under the current scoring system for National Board examinations, subscores are provided to the test subjects and their institutions for each discipline covered using a 200-800 scale with five point score intervals. Actual passing standards are referenced to the performance of a selected group of examinees from the previous four years. Under this system it is theoretically possible for all examinees, in any given year, to pass Part I or II, although this has not occurred. Pass/fail rates on Parts I and II have remained relatively constant.

Currently, 47 percent of U.S. medical schools require students to achieve a passing total score on Part I for promotion and/or graduation, while 38 percent require a passing grade on Part II (Table 1). These figures have been stable over the past five years. Only 11-12 percent of medical schools use scores from Parts I or II in the determination of final course grades. This is a significant reduction from the number four years previously for Part I but reflects stability for Part II. Results of the NBME examinations are currently used by half of the medical schools in the U.S. for educational program evaluation, with no substantive change in this frequency of use over the past five years.

Table 1
 USE OF NBME EXAMINATIONS BY
 U.S. MEDICAL SCHOOLS - 1980-81 to 1984-85

	1980-81*		1981-82		1982-83		1983-84†		1984-85	
	No. (N=125)	Percent	No. (N=126)	Percent	No. (N=126)	Percent	No. (N=127)	Percent	No. (N=127)	Percent
STUDENT EVALUATION										
Use of the NBME exam, Part I										
Exam optional	31	24.8	32	25.4	31	24.6	29	22.8	29	22.8
Student must record score	35	28.0	33	26.2	34	27.0	35	27.6	35	27.6
Student must record total passing score . .	58	46.4	59	46.8	57	45.2	59	46.5	59	46.5
Student must record passing score in each section			3	2.4	4	3.2	3	2.4	3	2.4
Scores used to determine final course grades	31	24.8	29	23.0	11	8.7	18	14.2	14	11.0
Use of selected sections of NBME exam, Part I, by departments to evaluate students										
Anatomy	12	9.6	10	7.9	8	6.3	8	6.3	4	3.2
Behavioral sciences	7	5.6	5	4.0	5	4.0	2	1.6	2	1.6
Biochemistry	14	11.2	12	9.5	10	7.9	9	7.1	9	7.1
Microbiology	23	18.4	20	15.9	15	11.9	12	9.5	9	7.1
Pathology	21	16.8	17	13.5	12	9.5	11	8.7	10	7.9
Pharmacology	19	15.2	16	12.7	10	7.9	9	7.1	6	4.7
Physiology	18	14.4	15	11.9	11	8.7	8	6.3	4	3.2
Use of NBME exam, Part II										
Exam optional	36	28.8	39	31.0	38	30.2	36	28.4	35	27.6
Student must record score	37	30.4	36	28.6	42	33.3	41	32.3	41	32.3
Student must record passing score to graduate	47	37.6	46	36.5	44	34.9	48	37.8	48	37.8
Scores used to determine final course grades	16	12.8	17	13.5	14	11.1	16	12.6	15	11.8
CURRICULUM EVALUATION										
Based in part on										
Results of the NBME exams	65	52.0	67	53.2	61	48.4	62	48.8	63	49.6

* This compilation includes 1978-79 data for Louisiana State-Shreveport and 1979-80 data for California-Los Angeles (UCLA)

† This compilation includes 1982-83 data for Georgetown.

Critics argue that these uses by the schools of the NBME examinations have a deleterious effect on medical education in two ways. First, a focus on the competencies assessed by the NBME examinations may devalue other competencies of equal or greater importance. Second, the adoption of the NBME examinations as a national standard for achievement in various disciplines, may induce faculties to abandon their responsibility to exercise independent judgement in the design of the curriculum and the identification and evaluation of important learning objectives.

The first concern can be viewed in the context of the range of competencies that comprise the goal of undergraduate medical education. In the planning and development of enhanced Part I and II examinations, the NBME identified five characteristics important in student evaluation: knowledge and understanding, problem-solving and judgement, technical skills, interpersonal skills, and work habits and attitudes. By applying these five characteristics to ten identified physician tasks, the NBME produced a 50 cell matrix that correlates with competence expected of MD graduates entering graduate medical education (Figure 1). Implicit adoption of this analytical framework by the AAMC is indicated by its appearance in an AAMC position paper on external examinations (AAMC, 1981). Only 12 of these 50 cells represent areas amenable to assessment by current NBME test questions. The argument is made that focus by the school on NBME results tends to overemphasize the areas of competence that NBME examinations cover, at the expense of other competencies. The evaluation method also has a concomitant effect on the teaching methods used. Information recall methods of evaluation tend to promote information transfer methods of teaching. These problems stem in part from the lack of objective measures available to assess the 'other' areas of competence. NBME scores are thought to fill a vacuum created by an absence of other methods of assessment.

Even within the sphere of competencies that the NBME examinations purport to address, a second concern has been expressed about its influence on the content of what is taught in the medical school curriculum. Decisions about the content of the curriculum have always been regarded, within very broad limits, as the prerogative of the medical school faculty. Critics have charged that in seeking the approbation that NBME scores have come to represent, faculties have in effect delegated that authority to the NBME. 'Teaching to the Boards' may have become more commonplace, resulting in a greater emphasis on the transfer of information useful for test performance. This has come at the expense of learning care concepts together with the development of problem-solving and self directed learning skills. The dynamics of test construction itself may, in fact, lead away from core concepts because of the inclusion of more difficult questions designed to produce the desired spread of scores. Medical school proponents of the examinations have countered that the detailed information provided by the NBME on student performance has been useful in identifying gaps in the medical school curriculum. Relatively poor performance by students on one or another segment of the examination may highlight subject matter not learned or inadequately taught.

The use of National Board mean scores and failure rates by the LCME in the accreditation process of U.S. medical schools was actively discussed during the drafting of new accreditation guidelines last year (Jones and Keyes, 1985). By LCME consensus, and in actual fact during the review process, the LCME's principal focus is on a given school's failure rate. A relatively high failure rate signifies a potential problem for a school to produce licensable graduates. It also indicates that a number of students do

FIGURE 1

PROPOSED MATRIX OF PHYSICIAN COMPETENCIES *

ABILITIES TASKS	A Knowledge & Understanding	B Problem-Solving & Judgment	C Technical Skills	D Interpersonal Skills	E Work Habits & Attitudes
1. Taking a History	NBME	NBME			
2. Performing a Physical Examination	NBME	NBME			
3. Using Diagnostic Aids	NBME	NBME			
4. Defining Problems	NBME	NBME			
5. Managing Therapy	NBME	NBME			
6. Keeping Records					
7. Employing Special Sources of Information					
8. Monitoring & Maintaining Health	NBME	NBME			
9. Assuming Community & Professional Responsibilities					
10. Maintaining Professional Competence					

* Cells filled by NBME represent those areas currently assessed by NBME multiple-choice test questions.

not possess a minimal fund of basic and clinical science information deemed relevant by the community of accredited medical schools. Mean scores on NBME examinations currently receive a secondary focus.

Another use of NBME scores that has drawn the ire of some medical educators is the use by residency program directors in the selection of house officers. The perception that this use is on the rise stems from two factors: a 'buyers' market created by the increasing number of graduates competing for quality residency positions; and, the use of pass/fail grading systems by a number of schools which make it difficult for program directors to discriminate among applicants by some simple measure of academic performance. Concern is expressed that this is contributing to the replication in medical students of a set of behaviors in pre-medical students described as 'pre-med syndrome.' This 'syndrome' is seen as a highly competitive and inappropriate focus on the acquisition of a database of extremely detailed information at the expense of mastery of more fundamental understanding, knowledge, skills and attitudes.

A recent national survey of residency program directors sheds some light on this issue (Wagoner and Suriano, 1984). Preliminary results of this survey are shown in Figure 2. NBME Part I scores are seen to rank eighth in importance in a list of ten academic criteria, with Part II scores ranking fifth, although generally not available in time for the application review process. It is noted that 86 percent of program directors would not rank an applicant who has failed Part I, but 75 percent would rank a candidate who had an Part I score in the 380-450 range, which is the lowest ten percent of passing scores.

State licensure boards require a passing score on NBME Parts I, II and III, but do not look at individual subject or total scores. At the COD Plenary session at the 1985 AAMC national meeting it was noted that the state licensure boards consider the NBME scores only a fraction of the actual criteria for licensure. The principal criteria are the possession of a valid MD degree and the successful completion of an accredited PGY-1 year of clinical training.

The charge that medical education has become a process of information transfer at the expense of skill development should not obscure the fact that medical students need to learn and understand core concepts in biomedical science and bring to patient care a basic fund of clinical information. While no absolute agreement may ever exist on the parameters of this core material, the NBME examination content specifications, designed by test committees composed of medical school faculty members, are presumed to approximate well the topics covered in the curricula of U.S. medical schools. Passing the NBME examinations reflects therefore some minimum level of knowledge of basic and clinical science information and skills in applying this knowledge deemed relevant by U.S. medical schools. In addition, passage of NBME examinations is still a major pathway to licensure.

Against this background, discussion by the Councils within the AAMC is requested by the OSR Administrative Board concerning the implications and feasibility of requesting a change in score reporting by the NBME limited to a PASS/FAIL designation only.

FIGURE 2A

RESIDENT SELECTION: PROCESS AND FACTORS *

Norma E. Wagoner, Ph.D., and J. Robert Suriano, Ph.D.
October 31, 1984

A national survey of residency program directors was conducted in order to determine the degree of importance which cognitive factors, letters of recommendation, and interview criteria played in the selection of candidates by each specialty. A stratified random sample of programs was selected and 405 questionnaires were mailed to program directors. A return rate of 59% was achieved for an N of 237. Some of the results are detailed below:

PERFORMANCE: THE ACADEMIC RECORD

The program directors were asked to select the degree of importance for ten cognitive criteria using a five point rating scale: (1) = unimportant; (2) = some importance; (3) = important; (4) = very important and (5) = critical. The mean ratings are rank ordered below:

	\bar{X}	s.d.
1. Grades in clerkships of program's specialty	3.9	0.9
2. Grades in elective of program's specialty	3.6	0.9
3. Grades in other clerkships	3.5	0.7
4. Rank order in class	3.5	0.9
5. NBME II scores (assuming availability)	3.2	1.0
6. Membership in AOA	3.2	1.2
7. Grades in other electives	3.1	0.8
8. NBME I scores	3.1	1.0
9. Grades in preclinical courses	3.0	0.8
10. Research activities	2.7	0.9

The program directors were also asked to respond in a yes/no manner to a series of questions relating to cognitive criteria. These responses are rank ordered below by magnitude of agreement:

1. 86% give preference in ranking to students who have done well in an elective in the program director's specialty and hospital.
2. 86% would not rank an applicant who has failed NBME I.
3. 75% would rank a candidate with an NBME I score in the 380-450 range.
4. 55% select applicants to interview primarily on academic records.
5. 55% think that HONORS grades in preclinical courses are more important than NBME Part I scores.
6. 54% would favor an applicant who had taken and passed Part II of NBME by the time the candidates are ranked.

*Preliminary results of a survey conducted of program directors in specialties of: Internal Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, Psychiatry, Emergency Medicine, Family Medicine, Otolaryngology, Orthopedic Surgery. Survey date: 9/84

FIGURE 2B

LETTERS OF RECOMMENDATION: DEGREE OF IMPORTANCE OF VARIOUS TYPES OF LETTERS

Program Directors were asked to choose the type of letters which were most often found useful in the selection and ranking of candidates. Using the rating scale listed on the previous page, the choices are listed in rank order:

	\bar{X}	s.d.
1. Chairman's letter	3.9	0.8
2. Clinical letter/your hospital/your specialty	3.9	0.8
3. Clinical letter/your specialty	3.6	0.8
4. Dean's letters	3.6	1.0
5. Clinical letters/other specialties	2.9	0.7

DEAN'S LETTERS: CONTENT AND POLICY/STYLE

Program Directors were asked to rate a number of specifics which could be included in the Dean's letters using the same rating scale listed on the first page. The results are listed in rank order below:

	\bar{X}	s.d.
1. Hints of underlying problems	4.0	0.9
2. Consistency of performance	3.9	0.7
3. Negative comments	3.8	0.9
4. Highly laudatory comments from members of your specialty	3.7	0.9
5. Overall "bottom line" rating based on all students in the class.	3.7	1.0
6. Personal comments about candidate from Dean's letter writer	3.4	0.9
7. Narrative description of academic performance in each clinical rotation	3.4	0.9
8. Delineated rank order of candidate	3.4	1.0
9. Completion of curriculum in prescribed time	3.3	1.0
10. A signed waiver indicating student has not viewed the letter	2.3	1.3

INTERVIEW CRITERIA

Program Directors were asked to rate the importance of a series of individual criterion in the areas of Interpersonal Relationships, Communication Skills, and Work Performance on the one to five scale noted previously. The results are rank ordered below:

	\bar{X}	s.d.
1. Compatability with your program	4.5	0.6
2. Ability to grow in knowledge	4.4	0.6
3. Maturity	4.3	0.6
4. Commitment to hard work	4.3	0.7
5. Fund of Knowledge	4.1	0.6
6. Ability to solve problems well	4.1	0.7
7. Willingness to seek help from others	4.0	0.7
8. Ability to articulate thoughts	4.0	0.7
9. Sensitivity to other's psychosocial needs	3.9	0.8
10. Realistic self appraisal	3.8	0.8
11. Ability to listen	3.8	0.8

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UPDATE ON ANIMAL RESEARCH ISSUES

The Association has been actively involved in several recent issues related to the use of laboratory animals in biomedical research. The following report describes the current status of each these issues.

NIH Vigil

On April 27, several animal rights groups, led by the People for the Ethical Treatment of Animals (PETA), began a vigil at the NIH campus in Bethesda, MD, to secure the release of 15 research primates currently under NIH custody. In addition to increasing media sympathy for this cause, including two editorials by syndicated columnist James J. Kilpatrick, these groups have succeeded in generating considerable congressional support for the release of the animals. To date, over 150 Congressmen and over 50 Senators have co-signed letters to NIH Director James B. Wyngaarden urging the release of the monkeys and protesting the expenditure of NIH funds (approximately \$30,000 per year) for the continued care and housing of the animals.

Conversations with several members of Congress who have signed these letters suggest that many of them may be unaware of several important factors in this case:

- These animals are the subject of a pending lawsuit brought by animal activist groups to gain legal standing to sue for the custody of these animals.
- A research protocol for the completion of the project for which these animals were originally used has been judged meritorious by the NIH peer review system; thus disarming a major argument by the animal activists that no institution or individual is willing to undertake the completion of this research.
- Eight of the fifteen monkeys have been deafferented and require continued veterinary care. There is concern that the private sanctuary in Texas to which PETA is seeking the release of these animals will be unable to render the necessary care.

On April 30 the Association, along with 27 other organizations (including 9 CAS societies), sent a letter to all members of the House and Senate endorsing the NIH position on the release of these animals. In part, this letter stated that:

- There is an ethical obligation to complete the research so that the contributions made to science by these primates are not wasted.
- The animals are presently owned by the Institute for Behavioral Research -- the original grantee institution -- and not the NIH. Any arrangements for the completion of the research are currently constrained by the pending litigation.
- There is no choice but for the primates to remain at the NIH, where they are receiving excellent care, until the legal process is complete.

Both the CAS and the COD have been alerted and asked to contact their Congressmen and Senators regarding the specific facts and implications of this issue. On June 2 Dr. Wyngaarden sent a letter to the co-signers of the congressional requests for the release of the animals reiterating the NIH position that the IBR is "the appropriate organization to direct the disposition of the primates..."

Amicus Brief

The court case pending in the U.S. Court of Appeals for the Fourth District is a request by various animal activist groups to reverse a lower court decision against the provision of legal standing to non-owners to bring litigation regarding animal use or disposition. The AAMC and 69 other organizations -- including 45 CAS societies -- joined in filing an amicus curiae brief to present the scientists' side of this case. The brief provided information about the importance of animals in research, current laws regarding animal use and legal standing, the consequences of a decision to grant standing in this case. Oral arguments were presented on May 8 in Richmond, VA, and the three-member panel of judges appeared wary of reversing the precedents against standing in such cases. It is uncertain when the court will render its decision.

APHIS Regulations and Funding

The Association responded to a request by the U.S. Department of Agriculture's Animal and Plant Health Inspection Service (APHIS) for assistance in promulgating new regulations mandated by the recently amended Animal Welfare Act. These regulations cover the exercise of dogs, the psychological well-being of primates, procedures that require anesthetics, analgesics, or tranquilizers, and experiments that involve multiple operations. The AAMC stressed that the new regulations should allow flexibility based on the expertise and professional judgement of researchers and veterinarians involved in daily research activities, and should recognize differences among research facilities and protocols. These comments also urged that the new regulations should be consistent with the recently revised PHS Policy on the Humane Care and Use of Laboratory Animals by Awardee Institutions and the NIH Guide on the Care and Use of Laboratory Animals. A recent AAMC survey of medical schools and several research-intensive teaching hospitals reveals that it might cost as much as \$18.7 million to fulfill the administrative, capital, training, and oversight requirements contained in the Animal Welfare Act amendments.

The AAMC co-signed a letter from almost 100 animal protection and scientific organizations -- including 25 CAS societies -- supporting increased funding for APHIS in fiscal 1987. The letter, sent to both the House and Senate Agriculture Appropriations Subcommittees, urged an appropriation of \$6.6 million, which is an increase of approximately 11 percent over fiscal 1986. The president had requested no funds for APHIS in fiscal 1987.

Pending Legislation

H.R. 4535, introduced on April 9, would allow ordinary citizens to sue the government, on their own behalf or on behalf of an animal, to compel enforcement of the Animal Welfare Act. Sponsors of this bill include Representatives Charles Rose (D-NC), Rod Chandler (R-WA), Joe Moakley (D-MA), Barbara Boxer (D-CA), Robert Smith (R-NH), G. William Whitehurst (R-VA), Patricia Schroeder (D-CO), and Tom Lantos (D-CA). It supposedly does not

authorize suits against universities, research facilities or any alleged violators of the Animal Welfare Act. Another bill, H.R. 4871, would prevent NIH grant funds from being used to obtain pound animals for reserach purposes. It was introduced May 21 by Representative Robert Mrazek (D-NY) and referred to the House Committee on Energy and Commerce.