



**association of american
medical colleges**

**AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES**

ADMINISTRATIVE BOARD

WEDNESDAY, SEPTEMBER 10, 1986

6:00 P.M. - 8:00 P.M.

MONROE ROOM WEST

8:00 P.M. - 9:30 P.M.

MONROE ROOM EAST

THURSDAY, SEPTEMBER 11, 1986

8:00 A.M. - 12:00 NOON

WASHINGTON HILTON HOTEL

WASHINGTON, D. C.

FUTURE MEETINGS

Administrative Board/Executive Council

January 21-22, 1987	Washington Hilton
April 15-16, 1987	Washington Hilton
June 17-18, 1987	Washington Hilton
September 9-10, 1987	Washington Hilton

CAS Spring Meeting

March 18-20, 1987	The Woodlands Inn, Houston, Texas
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AAMC Annual Meeting

October 25-30, 1986	New Orleans, Louisiana (CAS meets October 26-37)
November 7-12, 1987	Washington, D. C.

COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

Washington Hilton Hotel
Washington, D. C.

September 10, 1986

- 6:00 p.m. CAS Administrative Board Meeting
Monroe Room West
- 8:00 p.m. CAS Administrative Board Reception
Monroe Room East
- 8:30 p.m. CAS Administrative Board Dinner
Monroe Room East

September 11, 1986

- 8:00 a.m. CAS Administrative Board Meeting
Chevy Chase Room
- 12:00 noon Joint Board Lunch
Hemisphere Room
- 1:00 p.m. Executive Council Meeting
Military Room

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel
September 11, 1986

I. ACTION ITEMS

- A. Approval of the Minutes of the June 18-19, 1986 Meeting of the CAS Administrative Board..... Y1
- B. Membership Application: Ambulatory Pediatric Association..... Y9
- C. Amendment of the CAS Rules and Regulations: Representatives' Terms..... Y12
- D. Ambulatory Care Training Act..... B22
- E. NIH Centennial..... B19
- F. AAMC Position on NBME Score Reporting..... B21
- G. California Ballot Proposal..... B20

II. DISCUSSION ITEMS

- A. Discussion with Dr. Petersdorf
- B. Background for Consideration of AAMC Position on NBME Score Reporting..... Y13

III. INFORMATION ITEMS

- A. Program for 1986 CAS Annual Meeting..... Y24
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Y = Yellow Agenda Book
B = Blue Agenda Book

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 18-19, 1986
Washington Hilton Hotel
Washington, D. C.

PRESENT: Board Members

David H. Cohen, Chairman
Joe D. Coulter
William F. Ganong
Ernst R. Jaffe'
A. Everette James, Jr.
Gordon I. Kaye
Douglas E. Kelly
Jack L. Kostyo
Frank G. Moody
Virginia V. Weldon*

Staff

David Baime
James Bentley*
Terry Bryll*
Christine T. Burris
John A. D. Cooper*
Carolyn Demorest
Charles Fentress*
Paul Jolly*
Robert Jones*
Karen Mitchell*
David B. Moore
Nancy Seline*
Elizabeth M. Short
August G. Swanson*
Kathleen Turner*

Guests

Vicki Darrow*
Spencer Foreman*
Donald G. Langsley
Kirk Murphy
Richard Peters*
Robert G. Petersdorf*

* Present for part of the meeting

I. ACTION ITEMS

A. The minutes of the April 9-10, 1986 meeting of the CAS Administrative Board were approved as submitted.

B. 1986 CAS Nominating Committee

Dr. David Cohen reported on the meeting of the CAS Nominating Committee. The Committee met by conference call on June 2, 1986 and selected the following slate of nominees for membership on the CAS Administrative Board to be presented at the Annual CAS Business Meeting in October:

CHAIRMAN-ELECT

Douglas E. Kelly, Ph.D., Association of Anatomy
Chairmen, Los Angeles, California

3-YEAR TERMS

Lewis Aronow, Ph.D., American Society for Pharmacology and Experimental Therapeutics, Bethesda, Maryland

Herbert Pardes, M.D., American Psychiatric Association, New York, New York

2-YEAR TERM

William F. Ganong, M.D., Association of Chairmen of Departments of Physiology, San Francisco, California

1-YEAR TERM

S. Craighead Alexander, M.D., Society of Academic Anesthesia Chairmen, Madison, Wisconsin

C. Revision of the CAS Rules and Regulations

Dr. Cohen reviewed the recommendations that resulted from the Administrative Board's discussion in January of issues related to CAS representation. The Board had recommended that the public affairs representatives to the CAS be eliminated, that the length of term for society representatives to the Council be left to the discretion of the individual societies, and that each society be limited to one vote in the Council. On the basis of the Council's discussion at the Spring Meeting, the Board decided to continue the current system of each CAS representative having a vote in the Council.

ACTION: The CAS Administrative Board voted unanimously to strike the recommendation that each society be limited to one vote in the Council.

The Board also decided that the length of terms for the CAS representatives should be left to the discretion of the individual societies, but that the terms should be concurrent with the AAMC year; i.e., they should begin and end at the time of the AAMC Annual Meeting. This way, the representatives' terms will begin and end the same time as the terms for the CAS officers and Administrative Board members.

D. Criteria for the Flexner Award

The Administrative Board discussed a proposal to limit the number of times an individual can be nominated for the Flexner Award. After discussing the advisability of such a restriction and the problems associated with its implementation, the Board was in general agreement that this proposal was inappropriate.

ACTION: The CAS Administrative Board voted unanimously to disapprove the proposed revision in the nomination criteria for the Flexner Award.

E. Revision of the General Requirements Section of the Essentials of Accredited Residencies

Dr. Swanson explained that the COTH objected in April to a proposed revision of the General Requirements regarding residents' stipends. The revision, which had been proposed by the AMA, would have added a statement to section 1.3 that "adequate financial support for residents' stipends is an essential component of graduate medical education." The COTH felt that such a stipulation was not appropriate for an accreditation document. As a result of COTH's objections, the Executive Council tabled the revision.

The current alternative revision, according to Dr. Swanson, was an attempt to convey a sense of concern about unpaid residents. The proposal, which would be added to section 5.3, does not mandate financial support, but provides a warning that appointing unpaid residents is not condoned and implies that such appointments will have to be justified to the residency review committees and the ACGME. Dr. Swanson noted that this proposal met with some resistance at the recent ACGME meeting, particularly from the AMA representative, who felt that the wording was not strong enough. It was also pointed out that the AHA also might not approve this change.

ACTION: The CAS Administrative Board voted unanimously to accept the alternate revision.

F. Report of the MCAT Review Committee

Dr. Swanson reviewed the MCAT Review Committee's conclusions and recommendations. The committee found the MCAT to be a useful instrument in the selection of medical students and recommended that the AAMC continue to monitor and upgrade the examination. Dr. Swanson noted that there was considerable discussion about what should be done with the four science subtests. He explained that admission committees are advised that these tests form a diagnostic profile and their scores should not be added, but that admission committees still lump the scores together. He added that the AAMC staff has been considering how to approach a study that would result in a single science subtest.

One of the major issues the committee considered was whether the MCAT contributes to the "pre-med syndrome." The committee concluded that there are many factors involved and that the elimination of the MCAT would not ameliorate the situation. The committee did recommend that course requirements for medical schools be coordinated and that "suggested" courses be eliminated from the AAMC Admissions Requirement Handbook.

Dr. Kelly, who was a member of this committee, characterized this report as a good working statement identifying a number of areas for further study. He said that the committee considered the MCAT essay a useful development.

Karen Mitchell, who is with the AAMC Division of Educational Measurement and Research, explained that the Association recently surveyed admission committees on their use of the MCAT and this data will be available in the near future. She said that the committee urged the Association to provide educational guidelines related to valid uses of the test, adding that the committee felt that one of the best uses of the MCAT was to establish minimum qualifications for applicants.

ACTION: The CAS Administrative Board voted unanimously to endorse the report of the MCAT Review Committee.

G. Report of the GME Transition Committee

The AAMC ad hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency was charged to report to the Executive Council what steps the Association might take to address the "pre-residency syndrome." Dr. Swanson explained that, if approved, the committee's preliminary report would be distributed as a working document.

In examining the problems associated with the transition to residency, the committee decided that it should also consider the issue of institutional responsibility for graduate medical education. The committee felt that local institutional governance would ease many of the problems associated with the transition to residency training. The committee also recommended that the ACGME establish a separate institutional review committee, which would periodically review compliance with the General Requirements by institutions sponsoring graduate medical education. The decisions of this ACGME committee would be binding on the individual residency review committees (RRCs). Spencer Foreman, chairman of the committee, said that the committee was advocating an institutional review that could jeopardize the accreditation status of every graduate medical program within the institution. He also noted that the committee was recommending institutional responsibility without defining what the institution is.

The committee also addressed the content of the fourth year in medical school, recommending that the core electives be completed first at the student's home school and that other electives be under the supervision of a faculty member to assure that they are not merely a collection of apprenticeships designed to win a residency

position. The Board discussed extensively the recommendation to limit the availability of standardized test scores in the resident selection process.

The committee recommended that the deans' letters should more accurately reflect the true abilities of the student, making the letter more useful in the selection process. The committee advocated that the NRMP match deadline be moved to March 1 and that the length of time needed for confirmation be shortened to one month. This would allow the release date for deans' letters to be moved to November 1. All specialties were urged to negotiate to use the NRMP match.

The committee also proposed a strategy to facilitate implementation of the report's conclusions, including a discussion of the report at the AAMC Annual Meeting. Dr. Cohen suggested that a subcommittee of the Administrative Board examine the Transition Committee's recommendations in detail and report to the Board in September.

ACTION: The CAS Administrative Board voted unanimously to adopt the preliminary report of the ad hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency as a working document.

H. Medicare Physician Payment Changes under Consideration

James Bentley and Nancy Seline, from AAMC's Department of Teaching Hospitals, reviewed a possible attempt by Representative Fortney (Pete) Stark (D-CA) to incorporate payments for hospital-based physicians (e.g., radiologists, anesthesiologists, pathologists, and emergency physicians) into the hospital's DRG payments. Rep. Stark has asked his subcommittee staff to outline a proposal to implement this change and to estimate the cost savings associated with such a move.

In the absence of a specific proposal, most physician-based groups are monitoring the development of this issue and positioning themselves for action once a formal bill emerges from subcommittee. Staff recommended that the AAMC Executive Council consider the ramifications of the Stark proposal for physicians, hospitals, and academic medical centers, and that the Executive Council oppose the incorporation of hospital-based physician payments in hospital DRG payments. Dr. Bentley noted that the Council of Teaching Hospitals opposed Rep. Stark's position on this issue, but did not want the Association to actively lead the opposition.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council oppose the incorporation of hospital-based physician payments into hospital DRG payments.

I. Organ Transplantation

Nancy Seline reviewed the recommendation of the Task Force on Organ Transplantation that the Health Care Financing Administration (HCFA) designate centers for kidney, heart, and liver transplants and adopt minimum criteria for these centers' facility and staff requirements, transplant volume, and minimum patient and graft survival rates. The Administrative Board discussed the AAMC's earlier position that the Secretary of Health and Human Services may specify medically relevant criteria to identify centers and physicians eligible to be paid under Medicare for transplantation services. Concern was expressed that any criteria developed by the Secretary would include geographic or political considerations. The Board agreed that criteria should relate only to quality, and that these criteria should be determined by professionals in the private sector. The Board also agreed that the AAMC should explore ways to assist the private sector in formulating these criteria.

ACTION: The CAS Administrative Board voted unanimously to reject the Association's earlier position on the specification of transplant criteria by the Secretary of Health and Human Services. The Administrative Board voted unanimously to recommend that the Association adopt a position that focuses on the quality of both the professional services and the environment for transplants and that the Association assist with the development of these criteria by transplantation professionals.

J. Reporting of NBME Scores

Robert Jones, AAMC Director of Institutional Studies, reviewed the Council of Deans recommendation for pass-fail reporting only for Parts I and II of the NBME. This would include pass-fail reporting for individual discipline subtest. He noted that this proposal had originated with the students. Rick Peters, president of the AAMC Organization of Students Representatives (OSR), explained that students felt that the current emphasis on the NBME has a profound effect on the curriculum in medical schools. The students also objected to the use of NBME scores, particularly the Part I scores, by program directors to assess candidates for residency positions.

The Administrative Board discussed the use of standardized tests developed by the individual disciplines to evaluate curriculum. The Board agreed that specific discipline tests are more useful in terms of faculty and curriculum development than the NBME.

ACTION: The CAS Administrative Board voted unanimously to endorse the OSR proposal for reporting NBME scores on a pass-fail basis only.

II. DISCUSSION ITEMS

A. Trends in Medical School Applicants

Paul Jolly, director of the AAMC Division of Operational Studies, reviewed several recent trends in the numbers of applicants to medical school. He said that there was a substantial drop in the number of applicants in 1985, and he predicted that the number will drop an additional 5 percent to 7 percent in 1986. He added that concerns that the academic qualifications of the applicants might decline as their numbers decrease so far are unfounded. MCAT scores and grade point averages for both applicants and matriculants did not decline significantly in 1985.

Dr. Jolly said that the COD had requested at its Spring Meeting that staff study the question of declining interest in medical careers among college students. He explained that staff had identified 1,549 individuals who took the MCAT in 1985 and averaged at least 9, but did not apply to medical school. This group was surveyed regarding their career plans and reasons why they did not apply to medical school. A total of 539 individuals (41 percent) responded. Among the respondents, 177 (33 percent) indicated that they did not plan to attend medical school. The subsequent analysis was directed at these individuals. Reasons identified for deciding against a career in medicine included a perception that the individual's scientific interests would be better fulfilled in another discipline, the high cost and indebtedness associated with medical education, and loss of independence by physicians. In addition, almost 30 percent of those deciding against a medical career indicated that they had been discouraged by a physician.

B. Follow-up on COD Spring Meeting Discussions

The Administrative Board discussed the recommendations from the Council of Deans Spring Meeting related to the attractiveness of medicine as a profession, the institutional responsibility for medical education, the institutional responsibility for graduate medical education, and the transition to residency education. It was noted that many of the COD's recommendations on the latter two issues were incorporated into the report of the ad hoc Committee on Graduate Medical education and the Transition from Medical School to Residency.

C. Role of the AAMC in the Promotion of Academic Medical Centers to the Public

Dr. John A. D. Cooper described the background of this issue. He said that it arose out of COTH's concern with identifying the teaching hospital's place in the community. He added that the COTH is not interested in the

AAMC mounting an advertising campaign for teaching hospitals.

Charles Fentress, AAMC director of public relations, reviewed the activities of the AAMC Group on Public Affairs (GPA) in this context. The GPA conducted a lengthy discussion last June on the issues surrounding advertising and the academic medical centers. This discussion was later summarized in a booklet that was distributed to members of the CAS, COD, and COTH. In May, the GPA conducted a survey of its members to ascertain the volume of advertising at academic medical centers and teaching hospitals.

Dr. Cooper said that he supported the formation of an AAMC task force that would explore methods for more effective dissemination of information related to the role and contributions of the academic medical center, not only in terms of health care, but also to the economic well-being of the community. The Administrative Board enthusiastically endorsed the formation of such an AAMC task force.

MEMBERSHIP APPLICATION:
AMBULATORY PEDIATRIC ASSOCIATION

The application of the Ambulatory Pediatric Association for membership in the Council of Academic Societies was received in June 1986. This application has been assigned to Drs. Coulter and Jaffe' for review. At present, the CAS has three pediatric societies: the American Pediatric Society, the Association of Medical School Pediatric Department Chairmen, Inc., and the Society for Pediatric Research.

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: Mr. David Moore

NAME OF SOCIETY: Ambulatory Pediatric Association

MAILING ADDRESS: 1311A Dolley Madison Boulevard
McLean, Virginia 22101

PURPOSE: The objective in the APA is the promotion of improved patient care, teaching and research in general pediatrics through the forum provided by its annual meeting, its regional meetings, its Newsletter, public recognition of outstanding teaching programs and special workshops on teaching and research methodology.

MEMBERSHIP CRITERIA: APA members must be involved in teaching those learning to deliver child health services and also be involved in either patient care or research in general pediatrics.

NUMBER OF MEMBERS: 1200

NUMBER OF FACULTY MEMBERS: 1100

DATE ORGANIZED: 1960

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

Revised 4/30/81 1. Constitution & Bylaws

May 6-9, 1986 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

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?

 501(c)(3)

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.

 L. J. Berkelhammer, MD
(Completed by - please sign)

 6/6/86
(Date)

REVISION OF THE CAS RULES AND REGULATIONS

In January, the Administrative Board recommended that the length of term for CAS representatives should be left to the discretion of the individual members' societies. Currently, CAS representatives are elected to 2-year terms, and individual representatives may serve up to four terms (or a total of 8 years). The Administrative Board felt that societies should be encouraged to appoint at least one representative to a term of sufficient length to allow the individual time to develop expertise with the issues of importance to the Council and the governance process of the Association.

This recommendation met with approval by the Council at the Spring Meeting. In June the Administrative Board agreed to modify the proposal so that the terms of the society representatives would begin at the same time as those of the Administrative Board members; i.e., following the Annual Meeting in the fall.

This recommendation requires the following amendment of 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. Terms for representatives shall begin and end at the time of the Association's Annual Meeting. 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.*

Recommended Action:

The Administrative Board should approve the proposed amendment of Section II.1 of the CAS Rules and Regulations.

REPORTING OF NBME SCORES

The original discussion piece which appeared in COD and CAS agenda materials for the June 18-19, 1986 meetings is attached. Since there was some confusion at those meetings about current and proposed NBME score reporting policies, the following additional information is provided.

	<u>Current</u>	<u>Proposal for the Comprehensive Exam</u>
Individual student total scores for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student pass-fail status for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student discipline scores for Parts I and II	Yes, to students and schools	No, only group mean to schools
Individual student item keyword performance feedback	No	Yes, upon request to students and group performance to schools
Separate subject (shelf) examination program	Yes	Yes

Although there are various new features to the NBME's proposed "comprehensive" examination program, the major score reporting change is the abandonment of discipline scores for individual students. This is apparently a consequence of the content flexibility desired in the new examinations as well as the recommended reduction in number of questions. However, a school mean score by discipline may be derived and reported and item keyword performance feedback is introduced.

The NBME Study Committee for Parts I and II recommended the changes in score reporting for the comprehensive examination. At present the process for developing the comprehensive Parts I and II examinations are just under way. The committees selected to steer the development will meet in September. Thus far, the NBME has not made a firm policy decision on how the results of the examinations will be reported either to the examinees or the medical schools. We are informed that this decision will most likely occur in 1987.

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

REFERENCES

Association of American Medical Colleges. Physicians for the Twenty-first Century: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine. Washington, D.C.: AAMC, 1984.

Association of American Medical Colleges. External Examinations for the Evaluation of Medical Education Achievement and for Licensure. Washington, D.C.: AAMC, 1981.

Hubbard, John P., Measuring Medical Education. Lee and Febiger, Philadelphia, Pennsylvania, 1978.

Jones, Robert F. and J.A. Keyes, Jr., The LCME's Use of NBME Examination Results. Draft report for the Association of American Medical Colleges, 1985.

Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. LCME, 1985.

Wagoner, Norma E. and J.R. Suriano, Resident Selection: Process and Factors. Preliminary results of a national survey of residency program directors, 1984.

SUNDAY, OCTOBER 26
2:00 - 4:30 p.m.
Versailles Room

CAS ANNUAL MEETING

SPECIAL GENERAL SESSION
"Graduate Medical Education and the Transition
from Medical School to Residency"

Moderator:
Edward J. Stemmler, M.D.
*Chairman-Elect, AAMC
Executive Vice President and Dean
University of Pennsylvania School of Medicine*

Institutional Responsibility

Commentator:
Spencer Foreman, M.D.
*Chairman, AAMC ad hoc Committee on Graduate
Medical Education and the Transition from
Medical School to Residency
President, Montefiore Medical Center*

Reactors:
Frank A. Riddick, M.D.
*AMA Member of ACGME
Ochsner Clinic*

C. Rollins Hanlon, M.D.
Director (emeritus), American College of Surgeons

Problems at the Transition

Commentator:
Joseph S. Gonnella, M.D.
*Dean and Vice President
Jefferson Medical College*

Reactors:
Robert B. King, M.D.
*Chairman-Elect, ABMS
Chairman, Department of Neurosurgery
SUNY Upstate Medical Center at Syracuse*

Ture W. Schoultz, M.D.
*Chairman, AAMC Group on Student Affairs
Associate Dean and Director, Student Affairs
University of Arkansas College of Medicine*

5:00 - 7:00 p.m.

CAS RECEPTION

MONDAY, OCTOBER 27
12:00 noon - 1:30 p.m.
CAS Suite

CAS ADMINISTRATIVE BOARD LUNCHEON

1:30 - 5:00 p.m.

CAS BUSINESS MEETING

5:00 - 6:00 p.m.
CAS Suite

INFORMAL RECEPTION FOR NEW ADMINISTRATIVE BOARD
MEMBERS

1987 CAS SPRING MEETING

The Woodlands, Texas
March 18-20, 1987

Wednesday, March 18

5:00 - 7:00 p.m.	Registration and Reception
7:00 - 9:00 p.m.	Dinner and Keynote Address

Thursday, March 19

7:45 - 8:30 a.m.	Breakfast
8:30 a.m. - 12:30 p.m.	Plenary Session
12:30 - 2:00 p.m.	Luncheon
7:00 - 9:00 p.m.	Dinner Speaker: Robert G. Petersdorf, M.D.

Friday, March 20

7:45 - 8:30 a.m.	Breakfast
8:30 a.m. - 12:00 noon	Business Meeting