aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

FRIDAY, APRIL 15, 1988

9:00 A.M. - 12:00 NOON

BAYVIEW ROOM
SAN DIEGO PRINCESS HOTEL
SAN DIEGO, CALIFORNIA

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

COUNCIL OF ACADEMIC SOCIETIES
1988 SPRING MEETING SCHEDULE

Wednesday, April 13, 1988

3:00 - 6:00	Registration	Pacific Foyer
6:00 - 7:00	Keynote Address Edward J. Stemmler, M.D.	Royal Room
7:00 - 8:00	Reception	Bayview Room
8:00	Dinner	Bayview Room

Thursday, April 14, 1988

8:00 - 11:30	Council Plenary Forum	Bayview Room
11:30 - 1:30	Breakout Groups	
	Basic Research/Medical Ed	Executive Suite #706
	Faculty Development	Bayview Room
	Faculty Entrepreneurism	CAS Suite
	Faculty Med. Ed. Forum	Executive Suite #710
6:00 - 7:00	Discussion Groups Reports	Royal Room
7:00 - 8:00	Reception	Bayview Room
8:00	Dinner	Bayview Room

Friday, April 15, 1988

9:00 - 12:00	CAS Business Meeting	Bayview Room

DATES TO REMEMBER

November 12-17, 1988	AAMC Annual Meeting	Chicago, Illinois
March 15-17, 1989	CAS Spring Meeting	Orlando, Florida
October 28 - November 2, 1989	AAMC Annual Meeting	Washington, D. C.
March 14-16, 1990	CAS Spring Meeting	San Antonio, Texas

COUNCIL OF ACADEMIC SOCIETIES
SPRING BUSINESS MEETING

Friday, April 15, 1988
9:00 a.m. - 12:00 noon
Bayview Room
San Diego Princess Hotel
San Diego, California

AGENDA

I. Chairman's Report -- *Douglas E. Kelly, Ph.D.*

II. President's Report -- *Robert G. Petersdorf, M.D.*

III. Action Items

IV. Discussion Items

V. Information Items

MINUTES

1987 ANNUAL MEETING

OF THE

COUNCIL OF ACADEMIC SOCIETIES

November 9, 1987
Washington Hilton Hotel
Washington, D. C.

I. CAS CHAIRMAN'S REPORT
Frank G. Moody, M.D.

Dr. Moody convened the meeting by introducing the CAS Administrative Board, and presenting the outgoing Board members, Drs. David Cohen, Everette James and Frank Yatsu, with certificates of appreciation. He also announced that Dr. Cohen and Dr. Virginia Weldon, both former CAS Chairs, were elected to Distinguished Service Membership in the AAMC. Dr. Douglas Kelly was introduced as the incoming CAS Chair, and he encouraged all CAS Representatives to attend the CAS Spring Meeting in San Diego, April 13-15, 1988. The topic for that meeting will be medical education, and the meeting location is conducive to the inclusion of spouses and fun in addition to a thorough exploration of current issues in education.

III.A.-B. ACTION ITEMS

The minutes of the Spring Meeting were approved as submitted, and the election of officers and Administrative Board members confirmed the selections of the Nominating Committee. Douglas E. Kelly, Ph.D., University of Southern California and American Association of Anatomists, will succeed Dr. Moody as CAS Chairman following today's meeting. Chairman-Elect will be Ernst R. Jaffe', M.D., Albert Einstein College of Medicine and American Society of Hematology. Elected to 3 year terms on the Board are Myron Genel, M.D., Yale University School of Medicine and the American Pediatric Society; Vivian W. Pinn-Wiggins, M.D., Howard University, Association of Pathology Chairmen; and Joel Sacks, M.D., University of Cincinnati and the American Academy of Ophthalmology. S. Craighead Alexander, M.D., University of Wisconsin and Society of Academic Anesthesia Chairmen, was re-elected to a two-year term, and Glenn C. Hamilton, M.D., Wright State University, Society of Teachers of Emergency Medicine, was elected to a one-year term.

III.C. Report of the Ad Hoc Committee on Housestaff Participation

Dr. Alexander, who served on this committee, presented the conclusions of its deliberations. The Ad Hoc Committee recommended that an Organization of Resident Representatives be formed,

parallel to the Organization of Student Representatives. Housestaff representatives to the group would be selected by the teaching hospitals in which they are serving. Those hospitals will be responsible for paying the costs of their ORR representatives. The mechanism for selection will be left up to the hospitals, but it was the intention of the committee that a variety of disciplines should be represented. The ORR would also have an Administrative Board, whose activities will be funded by the Association. Although the ORR would relate primarily to the COTH, they will also have a formal linkage with the CAS Administrative Board. Consideration of Executive Council representation will be deferred until the ORR has become functional and attendance and interest by residents are clearly demonstrated.

ACTION: The Council of Academic Societies unanimously endorsed the report of the Ad Hoc Committee on Housestaff Participation.

IV. Special Presentation

Drs. Richard Weinshilboum and David Nierenberg gave a thorough and enlightening presentation on instruction in clinical pharmacology and therapeutics for medical students. This presentation was sponsored by the 3 CAS pharmacology societies, and discussed the importance of educating medical students in a very rapidly changing discipline, as well as the need to consider mechanisms by which one could revisit the principles of a basic science discipline in the context of its clinical application.

V. Discussion Items

A. AAMC Task Force on Physician Supply

Frank C. Wilson, M.D., former CAS Chairman, led a thoughtful and fruitful discussion by the Council on the deliberations of AAMC's Physician Supply Task Force. The Task Force posed a series of questions to the CAS and COD at this meeting. Thoughts and opinions were solicited to aid the Task Force in its ongoing deliberations.

Question #1 related to the attractiveness of medicine as a profession, the character of the profession and the public image of the medical doctor. Among the concerns expressed by CAS representatives were that commercialism and preoccupation with income are overtaking the importance of patient care. Teaching values to medical students is a difficult yet vitally important task which has been pushed aside by the voluminous increases in the amount of technical knowledge students must acquire during their time in medical school.

Question #2 asked how a more balanced distribution of physicians by specialty might be accomplished. Dialogue ensued over whether the needs of the teaching hospital drive the production of specialists. Other causes for the student's selection of specialty may include their faculty role models and the attractiveness of a narrowed focus and procedural stability in the face of the vast amount of information students must now absorb.

Question #3 addressed the issue of training in the biomedical sciences. The need for increased financial and psychic rewards for research training and support were stressed. The CAS was also concerned that obtaining an MD/PhD degree is getting more difficult, as MD training requires too lengthy a separation from the laboratory, and cannot accommodate the need for a basic scientist to maintain continuous contact with his scientific roots. Modification of that system to allow a year in research or other flexibility for the medical student would be a valuable experiment.

Question #4 asked about treatment of foreign medical graduates. Proposals to alter or delete the FMGEMs examination have been made, and more equitable assessment of FMGs is under discussion. The Council would remind the Task force of the continuity and standards of education inherent in LCME accreditation, and how important it is to residency training programs to be able to depend on obtaining residents of the calibre produced by LCME-accredited medical schools.

B. President's Report - Housestaff Hours

Dr. Robert G. Petersdorf spoke to the Council on an issue of crucial importance -- housestaff hours. Prompted by the death of an 18 year old woman at a major New York teaching hospital, a grand jury recommended that the New York State Commissioner of Health investigate working conditions and supervision of housestaff in teaching hospitals. The Commission produced a report with very specific recommendations, and the AAMC has felt it essential to take a public position in response to the Commission, as well as encourage our constituency to reconsider whether their particular housestaff teaching programs have duty schedules that encourage optimal patient care in the context of a quality learning environment. Dr. Petersdorf, working with Dr. James Bentley, AAMC Vice President for Clinical Services, prepared a draft AAMC policy document recommending not only this reevaluation, but also specific guidelines that residents not work more than 80 hours per week averaged over a four week period. This policy paper strictly defines the differences between working hours, on-call hours, and hours away from patient care. Responsibility and accountability of the teaching hospitals are stressed, as are the differences between hospitals and disciplines, and therefore the need to approach the housestaff hours issue with a thoughtful, cautious attitude. Debate ensued on the specifics of the policy paper as well as the overview. The Council concluded that the Association should position itself and thereby American medical education on this critical and timely topic. The tenor of opinion was towards making as few specific recommendations about hours as possible, consistent with countering recommendations from New York or other jurisdictions which were too restrictive. Faculty expressed the opinion that the latent issue here was proper supervision of trainees more than hours worked.

C. Legislative/Regulatory Update

Dr. Richard Knapp, Senior Vice President of the AAMC, addressed several of the issues presented in the Legislative/Regulatory Update. Of primary importance to the medical schools is funding of biomedical and behavioral research by the Congress. Although Dr. Knapp feels that there is strong support for research on Capitol Hill, the larger budgetary and economic pressures on the government are making it very difficult to see real increases in research support. NIH reauthorization will be on the legislative calendar in 1988, as will animal rights, fetal research, and Title VII reauthorization. Dr. John Sherman joined in the discussion of the animal rights issue, stressing the political activism of the animal rights movement.

Dr. Knapp also discussed the formation of a Government Relations Representatives Group, jointly organized between AAMC and AAHC. This will not be a policy-making body, but will provide a forum for the dissemination of information on issues important to the whole community. Any CAS society which is interested in participating may do so.

D. CAS Participation in the Group on Medical Education

Ernst R. Jaffe', M.D., led the discussion of the role of CAS societies in the Group on Medical Education. Essentially, the GME was considering elimination of CAS participation in their affairs, and had asked whether the CAS was still interested, as CAS participation in GME has been minimal. A thorough discussion over the role of faculty in medical education and curricula ensued. It became quite clear that the CAS representatives have very strong feelings on this subject, and that they would welcome more active and meaningful participation in the GME. This topic will be discussed further at the CAS Spring Meeting.

E. Transition from Medical School to Residency

Dr. Jaffe' asked for input from the CAS about how the November 1 date for release of Deans' Letters to residency programs worked this year. Discussion indicated that the quality of the Deans' letters did not improve this year. As to the timing of the letters, a few disciplines expressed difficulty with the logistics inposed by interviewing between mid-November and mid-January, but most felt that adequate time was provided for the selection process. Concern was expressed that programs not select candidates for interviews on the basis of incomplete information. Generally it was felt that the schedule change could not be evaluated yet because the process had only begun the week before with the release fo recommendation letters, and that the new schedule should be evaluated after March 1988.

VI. Information Items

Written materials were furnished on the following subjects as a matter of information for representatives.

1. Deferment of Student Loans
2. JCAH's Proposed Survey Guidelines for Academic Medical Centers
3. Changes in the Examination Sequence for Licensure

In conclusion, Dr. Douglas Kelly presented Dr. Frank Moody with an engraved speaker's bell as a tribute for his noteworthy leadership as CAS Chair, and again urged that all representatives attend the CAS Spring Meeting. There being no new business, the Council adjourned to its annual reception.

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: American Association of Chairmen of Plastic Surgery

MAILING ADDRESS: %Stephen H. Miller, M.D.; Oregon Health Science University; Plastic Surgery; 3181 S.W. Sam Jackson Park Road; Portland, OR 97201

PURPOSE: To promote education in plastic surgery and to benefit plastic surgery programs in the United States and Canada.

MEMBERSHIP CRITERIA: Voting Membership must be the Director or Acting Director of a residency training program. Associate Membership: Individuals interested in teaching of plastic surgery at the resident level.

NUMBER OF MEMBERS: 189

NUMBER OF FACULTY MEMBERS: 189, full-time and clinical faculty

DATE ORGANIZED: 4/28/85

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

accepted 10/12/85 1. Constitution & Bylaws

Minutes from meetings on----
4/28/85
10/12/85 and 5/4/86 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?

✓ 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?

___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.

[signature] Pres. 5/14/86
(Completed by - please sign)
[signature] Secy-Treas 5/20/86

_____
(Date)

NOTE: 501(c)(3) status was granted by the IRS on November 6, 1987.

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

ATTENTION: Jane Donovan

NAME OF SOCIETY: Association of Anesthesiology Program Directors

MAILING ADDRESS: AAPD
515 Busse Highway
Park Ridge, IL 60068

PURPOSE: The principal purpose of the Association of Anesthesiology Program Directors is to provide a forum for the discussion and development of educational, financial, and administrative policies concerning graduate medical education in anesthesiology.

AAPD Bylaws - Preamble

MEMBERSHIP CRITERIA: Program Directors of anesthesiology residency programs in the United States that have been approved by the Accreditation Council on Graduate Medical Education ("ACGME") shall qualify for membership in the Association.

AAPD Bylaws - Article II, Section 2.1

NUMBER OF MEMBERS: 140

NUMBER OF FACULTY MEMBERS: 140

DATE ORGANIZED: 10/24/86

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

1. Constitution and Bylaws 7/14/86
2. Program and Minutes of Annual Meeting 1986-87 (enclosed)
3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code 7/31/87 (enclosed)

1/5/88
Date Completed

James J. Richter
Completed by - Signature

James J. Richter, M.D., Ph.D.
Completed by - Please Print

Secretary-Treasurer
Title

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

ATTENTION: Jane Donovan

NAME OF SOCIETY: Association of Pediatric Program Directors

MAILING ADDRESS: Robert S. Holm, M.D., Secretary-Treasurer
SMAHEC, Stryker 4
1521 Gull Road
Kalamazoo, Michigan 49001

PURPOSE:
The Association is formed to advance medical education by benefitting and aiding the medical education programs of those hospitals located in the United States of America and the Commonwealth of Puerto Rico that are accredited by the Accreditation Council for Graduate Medical Education and those hospitals in Canada approved by the Royal College of Physicians and Surgeons to provide residency training programs in Pediatrics.

MEMBERSHIP CRITERIA:

Any accredited Pediatric Residency Program in the United States or Canada may join. Membership is by the Program Director or Department Chairman.

NUMBER OF MEMBERS: 248

NUMBER OF FACULTY MEMBERS: Not applicable (248)

DATE ORGANIZED: February 12, 1986

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

1. Constitution and Bylaws 2/12/86 Bylaws - No separate constitution
2. Program and Minutes of Annual Meeting April 27, 1987
3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code July 16, 1986

12/23/87
Date Completed

Edward O Reiter MD
Completed by - Signature

Edward O. Reiter, MD
Completed by - Please Print

President, Assoc Ped Prog Dir
Title

1988-89 CAS NOMINATING COMMITTEE

Representatives from CAS member societies are reminded that the nomination process for the CAS Administrative Board and the position of chairman-elect of the Council are open. The CAS Nominating Committee will meet via conference call in late May. Individual representatives are encouraged to submit recommendations regarding possible Board members. These recommendations may be submitted directly to members of the Nominating Committee or to the CAS office prior to the conference call. This year, the Nominating Committee will select a basic scientist as chairman-elect and will select nominees for three other positions on the Board.

Members of the 1988-89 Nominating Committee are:

Ernst R. Jaffe', M.D., Chairman - *American Society of Hematology*
William R. Drucker, M.D. - *American Association for the Surgery of Traums*
Douglas E. Kelly, Ph.D. - *American Association of Anatomists*
Thomas C. King, M.D. - *American Association for Thoracic Surgery*
Beverley Rowley, Ph.D. - *Association for the Behavioral Sciences and Medical Education*
Stanley Schultz, Ph.D. - *Association of Chairmen of Departments of Physiology*
Eleanor Z. Wallace, M.D. - *Association of Program Directors in Internal Medicine*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #88-12 March 8, 1988

TO: Council of Academic Societies
Council of Deans
Council of Teaching Hospitals
Organization of Student Representatives

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: AAMC Recommendations on Housestaff Supervision and Hours

During this decade, changes in the medical care system have had major effects on the environment of teaching hospitals. Very ill patients requiring close attention are hospitalized for tightly scheduled, short periods. This has increased the physical and intellectual demands on residents, and incidents of apparent lapses in the quality of care in teaching hospitals have focused public attention on residents' schedules and their supervision by the faculties. Medical schools and their teaching hospitals have been called upon to review and evaluate the policies and procedures for resident assignments and supervision.

As the organization representing medical schools, faculties, and teaching hospitals, the AAMC has taken this responsibility seriously. In September 1987 the Association's Administrative Boards and Executive Council considered a draft report and made a substantial number of suggestions for changes in the paper. Revised recommendations were subsequently discussed at the November meeting of the Executive Council; Annual Meeting sessions of the Councils of Academic Societies, Deans, and Teaching Hospitals; and the AAMC Officers' Retreat held in December. On February 25, 1988 a further revision was presented to the Association's Administrative Boards and Executive Council where it was revised and adopted.

Throughout the development and discussion of this issue, the AAMC has worked diligently to balance concerns for quality patient care and quality residency education. The attached recommendations--on the role of the resident, graded supervision of residents, hours assigned to residents, policy monitoring and evaluation, and the implications of changes in present practices--reflect the balancing of concerns and interests. Please read the complete statement and the recommendations and consider the need to review and evaluate institutional and program policies.

RESIDENT SUPERVISION AND HOURS:

Recommendations of the Association of American Medical Colleges

During the past decade the health service delivery system has accommodated to dramatic changes in medical technologies, patient expectations, and payment systems. Adjustments to these changes that affected teaching hospitals and their medical staffs include a greater use of preadmission and preoperative work-ups and a shift of postoperative care to the outpatient setting. Some patients who used to be admitted to hospitals are now treated only as outpatients. As a result, the patient admitted to a teaching hospital has a shorter length of stay during which the patient receives numerous diagnostic and treatment services compressed into a very few days.

These new patterns in the ways patients are cared for in teaching hospitals have significant implications for residency training programs. Residents participating in the admission of patients often see more patients, order and coordinate more ancillary and treatment services, perform more procedures and experience more calls to assist in the care of patients. This makes it appropriate to reassess the traditional operating characteristics of residency programs and to develop guidelines which may be used to evaluate current practices.

The Executive Council of the Association of American Medical Colleges (AAMC) has developed these recommendations and guidelines: (1) to help ensure high quality patient care and to preserve the high quality of residency programs, (2) to address the issues raised by changes in physician practice patterns and hospital characteristics, (3) to guide its members in responding to the issues raised by these changes, and (4) to alert policy makers and payers to the financial implications of changing resident supervision and hours. The policy statement is

presented in five sections: the role of the resident, graded supervision of residents, hours assigned to residents, policy monitoring and evaluation, and the implications of changes in present practices. Each of these sections contains recommendations designed to guide the AAMC constituency, including institutional executives, program directors, and external review bodies.

THE ROLE OF THE RESIDENT

To enter independent medical practice, an individual must complete the general professional education provided by medical school and a specialty education in an accredited residency program. During the residency, the physician occupies a unique position as both a learner and a provider of services. This combination is achieved by involving the resident in the care of patients under the supervision of more experienced physicians.

While the resident is both a student in training and a provider of medical services under supervision, residency programs should be established and conducted primarily for educational purposes. The educational purpose, however, must not be allowed to diminish the quality of service received by patients. Therefore, the AAMC recommends that:

EVERY TEACHING HOSPITAL HAVE GOVERNANCE AND OPERATIONAL MECHANISMS TO INSURE THAT RESIDENCY PROGRAMS NOT ONLY HAVE INHERENT EDUCATIONAL VALUE BUT ALSO ENHANCE THE QUALITY OF CARE PROVIDED TO PATIENTS.

THE SUPERVISION OF RESIDENTS

The objective of a residency program is to prepare physicians for the independent practice of medicine. In the course of a residency program, the

physician must develop the capabilities to examine and evaluate patients, to develop diagnostic and treatment plans, and to perform specialized procedures according to such plans. At the beginning of the training program, the resident has the least developed skills and must be regularly and consistently supervised by more experienced physicians, including more experienced residents.

If the capability to practice independently is to be achieved, the resident must be allowed to progress from on-site and contemporaneous supervision to more indirect and periodic supervision. There is no simple or single path for this transition from direct supervision to more independent responsibility. The resident's capabilities must be regularly assessed by more senior physicians and the authority to practice under indirect supervision must be granted gradually as the resident demonstrates competence.

Supervising and assessing the competence of each individual resident imposes a heavy responsibility on the more senior physicians. They must judge the clinical capabilities of the resident, provide the resident with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires both significant time and commitment.

While the progression from directly to indirectly supervised participation in the care of patients is based on the capabilities of the individual resident, supervisory decisions need to be made in the context of an institutional commitment that will assure patients that residents have adequate and appropriate supervision from more senior residents and medical staff physicians. Therefore, the AAMC recommends that:

TEACHING HOSPITALS AND RESIDENCY PROGRAMS HAVE POLICIES AND PROCEDURES SPECIFYING THE LEVEL OF SUPERVISION WHICH

FACULTY AND OTHER SUPERVISING PHYSICIANS EXERCISE OVER RESIDENTS AT EACH LEVEL OF TRAINING.

RESIDENT HOURS

Residency programs are very intense learning experiences. While each of the specialty disciplines may impose different requirements on its residents, the resident benefits by being exposed to patients throughout the course of their illnesses. This allows observation of both the natural history of the illness and the impact of the medical intervention. To experience all of the learning opportunities, the resident would have to be on-duty seven days a week, twenty-four hours a day. Clearly, such a schedule is unrealistic and does not recognize the possible adverse impacts of fatigue or the resident's commitments to other activities and interests. Therefore, assignment schedules for residents must be balanced between competing objectives and constraints.

There is no single assignment schedule that is optimal for all specialty disciplines, residents, or hospitals. In developing residency schedules, program directors should recognize differences in the clinical competence of residents resulting from factors such as specialty and year of training. They should also ensure that the resident's ability to make decisions about the care of patients is not impaired by fatigue resulting from excessive assigned hours or from the intensity of assigned responsibilities. Finally, they should distinguish between "on-call" hours which allow the resident to leave the hospital or sleep for a significant period and "on-call" hours which become working hours because the resident is repeatedly required to return to duty on-site and participate in the care of patients. While these differences preclude a single, uniform assignment schedule for all residents, the AAMC recommends:

THAT EVERY TEACHING HOSPITAL ADOPT GENERAL GUIDELINES FOR RESIDENTS' WORKING HOURS ACCORDING TO SPECIALTY, INTENSITY OF PATIENT CARE RESPONSIBILITIES, LEVEL OF EXPERIENCE AND EDUCATIONAL REQUIREMENTS. IN ORDER THAT DECISIONS ABOUT THE CARE OF PATIENTS ARE NOT IMPAIRED BY FATIGUE, RESIDENTS HOURS ACTUALLY WORKED SHOULD NOT EXCEED 80 HOURS PER WEEK WHEN AVERAGED OVER FOUR WEEKS.

In recommending guidelines for resident hours and in suggesting a maximum of eighty working hours per week, the medical education community is foregoing a more rigorous training schedule to help preserve and protect the quality of the care provided to patients. This adjustment serves neither the interests of education nor patient care quality if the resident is fatigued because the personal time provided has been used for moonlighting in another hospital or provider setting. The AAMC recognizes that some residents moonlight to earn extra income and part of this motivation may result from increasing levels of medical student debt. Nevertheless, if it is inappropriate for a resident to work more hours in the residency program, it is equally inappropriate to allow the resident to moonlight in another hospital beyond the training hospital's guidelines for working hours. Therefore, the AAMC recommends that:

TEACHING HOSPITALS AND RESIDENCY PROGRAMS HAVE POLICIES WHICH PROHIBIT UNAUTHORIZED MOONLIGHTING. THE TOTAL WORKING HOURS FOR RESIDENCY AND AUTHORIZED MOONLIGHTING SHOULD NOT EXCEED 80 WORKING HOURS PER WEEK WHEN AVERAGED OVER FOUR WEEKS.

POLICY MONITORING AND EVALUATION

In recommending that teaching hospitals and program directors have policies

for resident supervision and assignments, the AAMC is emphasizing the historic and continuing responsibility of the medical education community for both its trainees and its patients. As a self-regulating profession, medical education must develop mechanisms to help ensure a regular and impartial review of the practices of individual hospitals and residency programs. The Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committees (RRCs) provide a framework for the necessary monitoring and evaluation. Therefore, the AAMC recommends that:

> THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION INFORM EACH RESIDENCY REVIEW COMMITTEE THAT IT MUST INCLUDE IN ITS PROGRAM SURVEYS AN ASSESSMENT OF THE POLICIES AND OPERATING PROCEDURES THAT PROVIDE FOR DIRECT AND INDIRECT RESIDENT SUPERVISION BY PROGRAM FACULTIES.

The AAMC further recommends that:

> SURVEYORS SHOULD EXAMINE RESIDENTS' SCHEDULES AND VISITING REVIEW COMMITTEES SHOULD INCLUDE AN ASSESSMENT OF THE WORKING HOURS ASSIGNED TO RESIDENTS IN DETERMINING A PROGRAM'S ACCREDITATION STATUS

IMPLICATIONS OF CHANGE

The aforementioned recommendations may require significant changes in present practices in many teaching hospitals. The implications of these changes for quality of patient care, access of patients to care, future physician supply, and costs of teaching hospitals must be understood and accepted if the recommendations are to be implemented.

Quality of Care

Teaching hospitals have a number of distinctive characteristics. One of the most significant is the presence of physicians on-site twenty-four hours a day. Traditionally, part of this complement of on-site physicians has been met by residents whose on-call assignment begins one day, concludes the next and may last from 32-36 hours. The guideline for resident hours in the previous section recommends limiting a resident's working hours. As a result, teaching hospitals adopting these guidelines may need to alter present staffing patterns, and teams of physicians may be responsible for the patient. To transfer responsibility from one physician or team of physicians to another, it will be necessary to provide adequate time for the physician going off duty to brief fully the physician coming on duty about the patients and their problems. This imposes an additional service requirement on resident physicians; however, the time must be made available and funded or the quality of patient services may decline. Because of the multi-faceted impact on quality of care resulting from changes in resident assignment practices, the AAMC recommends that:

CHANGES IN RESIDENT HOURS BE PHASED IN GRADUALLY, ENHANCING THE QUALITY OF PATIENT CARE AND PRESERVING THE EDUCATIONAL GOALS OF RESIDENCY PROGRAMS.

Access to Care

Some teaching hospitals are located in communities with a shortage of physicians. In this setting the hospital becomes the primary provider of both hospital and physician services. Patients in these communities may face substantial problems in obtaining access to medical services unless the implications of the recommendations for resident supervision and hours are matched by the personnel

resources necessary to maintain at least the present supply of patient services. Hospitals in this situation should work with representatives of the local community, government regulators, and third party payers to obtain the financial and other resources required to hire and retain the physicians and other personnel necessary to provide care to the community.

Future Supply of Physicians

Another matter that warrants consideration is the long-term implications for physician manpower inherent in these recommendations. The simplest solution to a limitation in resident hours is to increase the number of residents. If the recommendation to limit hours is met by increasing the number of residents, then consideration must be given to the impact on those residents who are trained in medical, surgical and support specialties that may be overpopulated. The ultimate effect of increasing the number of residents on the supply of practicing physicians at a time when that supply is already increasing disproportionately to estimated requirements must be carefully evaluated by hospitals considering this option.

Where hospitals conclude that increasing the number of residents is inappropriate, the requirements for patient services may be met by employing other health professions. Nurse anesthetists may be used in place of anesthesiology residents, surgical technicians may be used in place of junior surgery residents, and nurse practitioners may be used to see primary care ambulatory patients and to triage emergency patients. The precise type of health professional required must be determined by the needs of patients, the availability of alternative personnel, and the acceptability of such personnel to the medical staff. Even where all factors encourage the use of "physician extenders," time and effort are needed to plan, recruit, train and integrate them into a hospital which has

formerly used residents. Finally, it also seems likely that where tasks presently performed by residents can be performed by alternative clinical, technical or support staff, it is incumbent upon the hospital to provide such help. Such measures are likely to increase resident productivity and reduce the need for additional residency positions.

One option that might be considered is to utilize fully-trained physicians in place of additional residents. While, at first glance, this strategy appears to be much more expensive, it has been shown that in certain patient settings (emergency room, intensive care units and operating rooms) the use of fully-trained and licensed physicians who do not require supervision can be cost-effective. Certainly it merits a trial in some circumstances.

Some hospitals cannot or should not expand their residents in response to the recommendation on resident hours. They may respond by abolishing their residency programs altogether. Such a step would put a greater onus for patient care on attending physicians themselves. This is the modus operandi in many community hospitals that do not have residency training programs. Progressively, over the past 10 years, such hospitals have cared for sicker patients. The absence of residents implies that practicing physicians will need to assume progressively greater responsibility. Given the sophisticated graduates of specialty training programs, physicians in hospitals that discontinue their residency programs should be well qualified to assume these additional duties.

Cost Implications

The hours residents are assigned are busy hours. While learning, they are seeing and caring for patients. As a result, efforts to decrease resident hours, either by an internal hospital decision or by external regulation will leave tasks

which need to be done. Increasing the number of residents, hiring physician extenders, employing hospital-salaried physicians, or increasing the involvement of attending physicians are alternative responses to a reduction in resident hours. While the responses are different, they share the common element of increased costs.

Increasing the hospital's complement of residents, physician extenders or salaried physicians immediately and visibly increases academic medical center personnel costs. These costs can be met only through generating higher revenues, greater productivity using existing resources, or reduced hospital earnings. Increasing the responsibilities of attending staff also increases costs, albeit more indirectly because they may not show up on the hospital's books, since attendings derive their fees through services provided to patients. Where academic attending physicians spend more time caring for hospital inpatients, additional faculty physicians will be needed to perform the educational, research, or administrative services formerly performed by the attending physicians. These additional physicians need to be paid; it is likely that these costs will be shifted to other cost centers in the hospital, or, as seems more likely, the medical school. No matter what course is chosen to address the problem, the economic implications of limiting resident hours are clear: tasks previously performed by residents will need to be performed by others who must be paid. Therefore, the AAMC recommends that:

ALL PUBLIC AND PRIVATE PURCHASERS OF HOSPITAL SERVICES SUPPORT TEACHING HOSPITAL EFFORTS TO ENSURE HIGH QUALITY PATIENT CARE BY REIMBURSING THE HOSPITAL FOR ALL OF THE INCREMENTAL COSTS INCURRED AS A RESULT OF ALTERING RESIDENT

CONCLUSION

The AAMC supports examining and re-evaluating current practices on resident supervision and on the number of assigned hours. Many of our current practices have a long history and tradition. They have resulted in well-trained physicians able to make critical decisions about seriously ill patients. At the same time, the teaching hospital has experienced dramatic changes in the past few years: patient stays are shorter, more procedures and treatments are scheduled in a shorter period of time, and the less ill are often treated on an ambulatory basis. As a result, residents are called upon to make more decisions about sicker patients than their predecessors. Consequently, training practices that were appropriate in an earlier time may need to be re-examined to ensure that they meet sound objectives of both patient service and medical education

In making recommendations for hospital policies on resident supervision and assignment, the AAMC is appreciative of the different characteristics of individual teaching hospitals and the different requirements of individual specialty disciplines. Accordingly, the recommendations are presented as guidelines, not as formulas, which each hospital and program should consider and utilize in a manner appropriate to its setting, role, and resources.

Committee on AIDS and the Academic Medical Center

Jay Sanford, M.D., president and dean, Uniformed Services University of the Health Sciences, is chairman of the AAMC Committee on AIDS and the Academic Medical Center. The subcommittees, one on institutional policies (SIP) and a second on medical education (SME), have now each held two meetings toward fulfillment of the Committee charge. The SIP, chaired by Festus Adebonojo, M.D., chairman, department of pediatrics, Meharry Medical College, is developing guidelines and principles to assist institutions in their management of HIV-infected members of the academic community, and policy formulation regarding HIV-screening and admissions. The SIP has identified a number of recommendations for institutions in dealing with self-identified HIV-positive students and residents. Although the SIP has generally resisted the idea of a mandatory testing program, it does support a concerted effort to educate and inform applicants, students and residents of the relevance of HIV testing to their personal and career goals. The specific language detailing these recommendations is being drafted and will be discussed by the full Committee in the early spring. The Committee plans to issue an interim report this summer.

The SME, chaired by Richard Behrman, M.D., dean, Case Western Reserve University School of Medicine, is broadly charged with examining the implications of the HIV-epidemic for medical student and resident education. The SME has initially focused on data regarding expressed fears and prejudices of students and residents in treating HIV-infected persons. A statement of professional responsibility was drafted by the SME and endorsed by the AAMC's Executive Council on February 25, 1988. In addition, the SME has also considered curricular implications of the HIV epidemic. Although the SME does not believe that a major overhaul of the curriculum is mandated, it does feel that the epidemic highlights certain areas of the curriculum in need of renewed attention, including the psychosocial aspects of care, prevention and public health, communication skills in doctor-patient relationships, and ambulatory care experiences. The SME believes that AIDS education must be integrated and woven into the existing medical school curriculum. Finally, the SME is interested in the impact of AIDS on residency selection and is encouraging further data exploration of this issue. The SME's recommendations are also being drafted into report language for consideration by the full Committee.

association of american medical colleges

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AAMC Statement on Professional Responsibility In Treating AIDS Patients

The acquired immunodeficiency syndrome (AIDS) has had an impact on the medical profession far beyond its pathophysiology. All fields of clinical practice have been dramatically altered by this disease. It has posed a significant challenge to the nation's health care system in providing for both the financing and delivery of care to those afflicted. Moreover, this epidemic, which is unparalleled in the latter half of the twentieth century, has confronted the medical profession with numerous moral and ethical issues. A central concern, to which this statement is directed, is the physician's responsibility to provide care to all patients.

The Association of American Medical Colleges (AAMC) has taken special note of the fears and concerns of medical professionals and those in training regarding the care of patients infected with the human immunodeficiency virus (HIV). Data indicate that a physician's occupational risk of acquiring HIV infection is small. However, because of the lethal nature of the disease, many physicians are concerned about transmission of infection, especially in settings where invasive procedures are performed such as the operating room or cardiac catheterization laboratory.

Personal risk to the physician in the practice of medicine is not a new phenomenon even within this century, as the history of tuberculosis, poliomyelitis, influenza, and syphilis demonstrates. But scientific advances, especially the development of vaccines and antibiotics, have tended to lower consciousness of these continuing risks for an entire generation of younger physicians, medical students and residents. AIDS has brought this consciousness once again to the fore.

The AAMC's special concern is with those medical students and residents, now and in the future, whose preparation for entry into the profession is the responsibility of medical school faculties. Medical education cannot be narrowly conceived as simply the imparting of knowledge and skills. It has as its objective the development of professional men and women who are prepared to adhere to the highest standards of conduct and behavior asked of few members of our society. Entry into the medical profession is a privilege offered to those who are prepared for a lifetime of service to the ill.

(more)

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The HIV epidemic must serve to remind us of these basic principles and the fundamental responsibilities of those who aspire to the practice of medicine and those charged with preparing them for it:

> *Medical students, residents, and faculty have a fundamental responsibility to provide care to all patients assigned to them, regardless of diagnosis. A failure to accept this responsibility violates a basic tenet of the medical profession -- to place the patient's interest and welfare first.*
>
> *Faculty members have a special responsibility to model the professional behavior and attitudes expected of physicians in training in their own willingness to provide competent, sensitive, and compassionate care to all patients.*
>
> *Each medical school and teaching hospital must accept the responsibility to help medical students, residents, and faculty address and cope with their fears and prejudices in treating HIV-infected patients. This responsibility includes providing the following:*
>
> - *an accurate portrayal to medical school applicants of the personal risks involved in medical practice;*
> - *up-to-date information on the modes and risk of transmission of the virus;*
> - *training in protective measures to be employed in the clinical setting, monitoring compliance with them, and defining procedures to be followed in the event of potential exposure;*
> - *appropriate facilities, equipment, and personnel to avoid unnecessary risk;*
> - *counseling to those who continue to express reluctance to participate in education and patient care programs with HIV-infected individuals.*
>
> *Further, each medical school and teaching hospital should articulate a clear policy emphasizing the physician's responsibility to provide care to patients without regard to the nature of their illness.*

Drafted by the AAMC Committee on AIDS and the Academic Medical Center.

Approved and endorsed by the AAMC Executive Council, February 25, 1988.

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Misconduct in Science

Issues surrounding scientific misconduct, especially in the biomedical and behavioral sciences, continue to be discussed and analysed in a wide variety of settings. Yearly several cases of substantive fraud are meticulously reported in the scientific and lay press. Yet we have no clear sense of the incidence of significant abuse of the scientific code of conduct in biomedical research, whether misconduct is truly on the increase, and how we compare to other scientific disciplines. The biomedical research community is grappling with concerns ranging from the formulation of federal agency policies to how a due process investigation of alleged falsification of data or plagarism should be conducted at a research institution. At the same time, focus on misconduct issues is expanding beyond procedural questions toward a realization that a large gray area exists in current scientific practice where there is variance in behavior among responsible scientists. Such issues as authorship conventions, citation practices, monitoring of trainees, retention of primary research data, use of control data, and repetitive publication are most commonly cited. A new formulation of standards appropriate to the scale and complexity of modern biomedical research may be warranted and even desired by scientists themselves.

Significant activity is underway in the major area of 1) federal policy formulation, 2) due process investigative procedures and 3) formulating standards of conduct in areas beyond actual data fraud.

Federal policy will require granting agency involvement only for cases of falsification of data or plagarism, but NSF and NIH vary in what is expected of grantee institutions and internal agency actions during investigation. NIH guidelines are not final and deserve further input from the community.

Proper procedures and due process for the handling of allegations and the conduct of investigations at grantee institutions are still evolving. An AAS-ABA National Conference of Lawyers and Scientists in September 1987 focused on process issues and proceedings of this meeting are anticipated. The Inspector General's Office, HHS, as part of a comprehensive plan to audit many aspects of grantee responsibilities in research administration over the next two years, has requested an IG Analysis Office investigation of the adequacy of processes for fraud investigation at grantee institutions. The AAMC Division of Biomedical Research is obtaining the current science misconduct policies and procedures of all medical schools and working with schools to insure minimal compliance with the broad guidelines advanced by AAMC-AAU in 1982 and incorporated in the interim NIH guidelines. A similar effort to study policies of land grant and state universities (NASULGC) has led both associations to an awareness that grantee institutions might well benefit from further efforts to articulate the more subtle issues

and range of decision-making that are actually faced in such investigations.

The possibility of articulating community standards in the gray areas is receiving increasing attention. The IOM will sponsor a workshop on if and how such standards could be articulated. The International Committee of Medical Journal Editors is meeting to propose publications standards and to date has formulated a retraction policy (ann. Int. Med 108:304, 1988). The AMA is planning a conference in 1989 on publication practices. Developments in the articulation of scientific standards of conduct will require wide debate within the scientific community.

The CAS Board believes these issues warrant broad faculty discussion and involvement and plans to devote the CAS plenary at the Annual Meeting in Chicago on November 13, 1988 to Evolving Views of Misconduct in Science.

Faculty Salaries Under New PHS Grant Application Form

The PHS Grant Application Form (PHS 398) was revised in 1987. Issued last September, its use becomes mandatory with 1988 application cycles. Instructions for budgeting personnel costs have been reworded and appear to change the calculations for PI research effort and salary calculations on NIH grant applications. Inquires from schools and investigators prompted AAMC to meet with NIH grants policy officials and seek clarification of the new instructions.

NIH assures the research community that the revised instructions do not represent any effort to change NIH policy for faculty PI salary on grants calculations.

Where the prior PHS application form asked only for percent effort on the grant, the new form requests three pieces of information and the headings of the columns are confusing (the old and new grant and instruction pages are attached). The key to filling out this form is to place 1.0 in the first column (Type Appt.) if one is a full-time faculty member at the applicant medical school. (Persons who work part-time or a 9 month year will get into more convoluted calculations, but there are few of these in medical schools). A PI faculty member legitimately holds a full time (1.0) type of appointment if the appointment is a "unified" grantee institution appointment, regardless of what mix of duties, salary sources, and geographic locations comprise his/her actual faculty responsibilities. A unified appointment means that the varied components and locations of faculty duties constitute the job description for this faculty appointment at the grantee medical school or institution, and that the component institutions and the medical school are mutually responsible for that individual's total professional effort.

Once the Type Appt. column is assigned a value of 1.0, then the other two columns become understandable. The second column, confusingly labeled <u>percent of appointment</u>, is where the actual percent effort to be devoted to this research project (as a percent of full-time faculty duties = 100%) is displayed. The third column labeled <u>effort on project</u>, then becomes an accurate depiction of proposed PI effort on this project, since 1.0x percent effort = percent effort. Columns 2 and 3 thus provide the same information.

Salary calculations should be made using the full regular annual salary assigned by the medical school for all duties as the base salary. The base salary is multiplied by column 2 (which while labeled <u>percent of appointment</u>, should be that portion of 100% professional time to be devoted to this project). The salary calculation thus continues to be the familiar one of percent effort x salary.

Thus, for a full time faculty member at xyz medical school, planning to devote 40% of 100% professional effort to this research project, with a base salary of $100,000/year, the PI line becomes:

NAME	ROLE	TYPE APPT	% OF APPT	EFFORT ON PROJECT	SALARY
J. Smith	PI	1.0	40%	40%	$40,000

As was previously the case, if a lesser salary is requested for 40% effort because the PI has other salary support sources, this should be explained on page 5 of the PHS form.

Attachment 1

PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR: _____

DETAILED BUDGET FOR FIRST 12-MONTH BUDGET PERIOD
DIRECT COSTS ONLY

FROM | THROUGH

DOLLAR AMOUNT REQUESTED *(Omit cents)*

PERSONNEL *(Applicant organization only)*

NAME	ROLE IN PROJECT	1 TYPE APPT.	2 % OF APPT.	3 EFFORT ON PROJ.	SALARY	FRINGE BENEFITS	TOTALS
	Principal Investigator						
SUBTOTALS →							

CONSULTANT COSTS

EQUIPMENT *(Itemize)*

SUPPLIES *(Itemize by category)*

TRAVEL	DOMESTIC	
	FOREIGN	
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	

ALTERATIONS AND RENOVATIONS *(Itemize by category)*

CONSORTIUM/CONTRACTUAL COSTS

OTHER EXPENSES *(Itemize by category)*

TOTAL DIRECT COSTS FOR FIRST 12-MONTH BUDGET PERIOD *(Item 7a)* → $

PHS 398 (Rev. 9/86)

*Number pages consecutively at the bottom throughout the application. D

es such as 5a, 5b

Detailed Budget For First 12-Month Budget Period. List only the direct costs requested in this application. Do not include any items that are treated by the applicant organization as indirect costs according to a Federal rate negotiation agreement except for those indirect costs included in consortium/contractual costs. For a SUPPLEMENTAL application, show only those items for which additional funds are requested, prorating the personnel costs and other appropriate parts of the detailed budget if the first budget period of the application is less than 12 months.

Personnel. Whether or not salaries are requested, list the names and roles of all applicant organization personnel to be involved in the project during the 12-month budget period. Starting with the P.I., list all key personnel first and then support personnel. Key personnel are those individuals who participate in the scientific development/execution of the projects. This will generally include individuals with professional degrees, i.e., Ph.D., M.D., D.D.S., D.O., D.V.M., B.S.N., or B.S.E., but in some projects this may also include individuals with other degrees at the masters and baccalaureate levels. Support personnel are those individuals who provide administrative or technical assistance to the project, i.e., dishwashers, animal caretakers, histopathology technicians, electron microscopy technicians, and in some instances research technicians or associates.

Column 1 indicates whether the type of appointment at the applicant organization is full-time or part-time for each individual. A full-time 12-month appointment is coded 1.0. If an individual has outside commitments or concurrent appointments with other organizations, enter only that portion of 1.0 which is allocable to *this* applicant organization. If the 12-month year is divided into academic and summer periods, identify and enter on separate lines the types of appointment for each period.

For example:

Half-time appointment for 12 months (0.5 × 12/12) = 0.5
Full-time appointment for 6 months (1.0 × 6/12) = 0.5
Half-time appointment for 9 months (academic year) (0.5 × 9/12) = 0.38
Full-time appointment for 3 months (summer) (1.0 × 3/12) = 0.25

Column 2 indicates the percentage of each appointment at the applicant organization to be devoted to *this* project. Enter on the appropriate separate lines the percentages for the academic and summer periods. If an individual engages in other institutional responsibilities, such as teaching, the *total* percentage devoted to *all* research activities by the individual must be less than 100%.

Column 3 is the effort on the project. This is calculated for each line by multiplying Column 1 by Column 2 and expressing the result as a decimal.

Enter the dollar amounts for each position for which funds are requested. The maximum salary that may be requested is calculated by multiplying the individual's base salary, defined below, by the percentage of the appointment to be devoted to the project (Column 2). If a lesser amount is requested for any position, explain on page 5 (for example, endowed position, institutional sources, other support). Enter on the appropriate separate lines the salaries requested for the academic and summer periods. The monthly base for summer salaries is calculated by dividing the base salary for the academic period appointment by the number of months of that appointment.

Base salary is defined as the compensation that the applicant organization pays for the individual's appointment, whether that individual's time is spent on research, teaching, patient care, or other activities. Base salary excludes any income that an individual may be permitted to earn outside of duties to the applicant organization. Base salary may not be increased as a result of replacing institutional salary funds with grant funds.

Attachment II

PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR: _____

DETAILED BUDGET FOR FIRST 12 MONTH BUDGET PERIOD DIRECT COSTS ONLY

FROM | THROUGH

DOLLAR AMOUNT REQUESTED *(Omit cents)*

PERSONNEL *(Applicant organization only)*		TIME/EFFORT				
NAME	POSITION TITLE	%	Hours per Week	SALARY	FRINGE BENEFITS	TOTALS
	Principal Investigator					
	SUBTOTALS →					

CONSULTANT COSTS

EQUIPMENT *(Itemize)*

SUPPLIES *(Itemize by category)*

TRAVEL	DOMESTIC
	FOREIGN
PATIENT CARE COSTS	INPATIENT
	OUTPATIENT

ALTERATIONS AND RENOVATIONS *(Itemize by category)*

CONSORTIUM/CONTRACTUAL COSTS

OTHER EXPENSES *(Itemize by category)*

TOTAL DIRECT COSTS *(Also enter on page 1, item 7)* → $

PHS 398 (Rev. 5/82)

Item 15. Official in Business Office to be Notified if an Award is Made. Self-explanatory.

Item 16. Official Signing for Applicant Organization. Self-explanatory.

Item 17. Principal Investigator/Program Director Assurance. Self-explanatory.

Item 18. Certification and Acceptance. Self-explanatory.

(Form Page 2)
Abstract of Research Plan. Self-explanatory.

(Form Page 3)
Table of Contents. Self-explanatory.

(Form Page 4)
Detailed Budget for First 12-Month Budget Period. List the direct costs requested in this application only. All fiscal information contained in the application must conform with the most current institutional guidelines. Do not include any items that are treated by the applicant organization as indirect costs according to the DHHS rate negotiation agreement except for those associated with consortium/contractual costs. Do not show the cost-sharing contribution of the applicant organization. For a SUPPLEMENTAL application, show only those items for which additional funds are requested, prorating the personnel costs and other appropriate parts of the detailed budget if the first budget period is less than 12-months.

Personnel. List the names and positions of all applicant organization personnel involved in the project, both professional and nonprofessional, whether or not salaries are requested. Describe on page 5 the specific functions of the personnel.

Indicate the percent of time or effort, or hours per week, on the project for professional personnel; indicate the hours per week on the project for nonprofessional personnel. List the dollar amounts separately for each individual for salary and fringe benefits. Fringe benefits may be requested to the extent that they are treated consistently by the applicant organization as a direct cost to all sponsors. An applicant organization may request tuition remission as a direct cost in lieu of all or part of salary for work on a grant-supported project. When tuition remission is not included as part of the negotiated fringe benefit rate, itemize it in the "Fringe Benefits" or "Other Expenses" category. Provide an explanatory note on page 5 describing the percentage of tuition requested in proportion to the time and effort devoted to the grant-supported project.

For each professional, indicate the percent of time or effort, or hours per week, in relation to the total professional activity commitment to the applicant organization. It is important to note that the sum of the percentages of time or effort to be expended by each individual for all professional activities must not exceed 100 percent. In computing estimated salary charges, an individual's base salary represents the total authorized annual compensation that an applicant organization would be prepared to pay for a specified work period, whether an individual's time is spent on research, teaching, patient care, or other activities. The base salary for the purposes of computing charges to a PHS grant excludes income that an individual may be permitted to earn outside of full-time duties to the applicant organization. The base salary of a professional may not be augmented or supplemented by funds from a PHS grant except when the individual's full-time status and base salary are for a period of less than 12 months. This does not preclude compensation for consultation under the terms specified in applicable cost principles.

Group on Faculty Practice

The Executive Council approved the creation of a Group on Faculty Practice (GFP) in June 1987. The purpose of the Group is to provide professional development and educational programs for the leaders of faculty practice plans. The Executive Council's objective was to develop a group primarily focused on institutional concerns rather than departmental or disciplinary issues; thus, the dean of each LCME accredited medical school was asked to name two representatives to the Group on Faculty Practice:

- one holding a senior position in the plan's governance structure, and
- one holding a senior position in the plan's administrative operations.

The deans were asked to select the representatives from faculty practice plans comprised primarily of full-time faculty.

The Group met for the first time at the AAMC's Annual Meeting. Two speakers developing methods by which Medicare's physician payments could be reformed made presentations at the program. They were: Robert B. Fetter of Yale University who described his work in developing Ambulatory Visit Groups, which are a means of categorizing ambulatory patient visits that is conceptually similar to the DRGs, and Edmund R. Becker, Ph.D. of Harvard who discussed the methodology and current status of the study funded by Medicare to develop relative value scales that may be used in physician payment (Hsaio study). Following the program session, the Group held its first business meeting and luncheon. It was attended by approximately 125 appointed representatives. Edward R. Stemmler, M.D., outgoing chairman of the Association, announced the appointment of the Group's Organizing Committee. The members are:

William E. Easterling, Jr., M.D.
Associate Dean for Clinical Affairs
and Chief of Staff
University of North Carolina

Linda Gage-White, M.D., Ph.D.
Assistant Professor of Otolaryngology
LSU Medical Center School of Medicine
in Shreveport

Richard H. Greenspan, M.D.
Associate Dean for Clinical Affairs
Yale University

Benjamin F. Kready
Director, MSRDP
University of Texas Medical School

Cheryl Haze Luehrs
Administrator
Jefferson Medical College

Henry L. Nadler, M.D.
Dean and President
Fund for Medical Research/Education
Wayne State University

Donald B. Tower
Executive Director
Stanford University Clinic

The Organizing Committee met in Washington, D.C. on January 28-29. They drafted a set of bylaws including a nominating procedure which will be considered by the members at their next business meeting. The Committee also discussed the Group's first professional development/business meeting. They requested that it be held in August 1988 in a setting conducive to interaction among the members so that they may get acquainted with each other and form a commitment to the group. Topics under consideration for discussion at the meeting are: contract negotiations with managed care programs, the organizational structures of centralized and decentralized practice plans, and physician reward and incentive programs.

The staff of the Division of Clinical Services will support the new group. A directory of members will be distributed in early February and a GFP newsletter published by the end of the month.

association of american medical colleges

February 19, 1988

Dear Colleague:

The purpose of this letter is to seek your continued support of the efforts that were initiated last year to reduce the disruption of medical students' senior year. The cooperation of the vast majority of program directors in observing the November 1, 1987 uniform release date for deans' letters was gratifying. As you begin to formulate your plans for the 1988-89 residency selection process, I sincerely hope that we can again count on your cooperation to establish application deadlines and interview schedules that take into consideration the dean's letter date.

The AAMC Council of Deans, Council of Academic Societies and Deans of Student Affairs have reaffirmed their commitment to a uniform date, and have selected ~~Tuesday, November 1, 1988 as the dean's letter release date for the 1989 graduating~~ class. This commitment was reviewed and fully supported by the AAMC Executive Council.

As we know from last year's experience, one of the important components to a satisfactory system of observing November 1 by all parties is full and open communications between the schools and the program directors. This early notification of the November 1, 1988 release date is being sent to all program directors and should eliminate the misunderstandings that emerged last year.

The schedule for submitting final rank order lists for the 1989 NRMP match must await the review of the implementation of this year's computerized confirmation process. However, if the experience is successful, it is possible that the final rank order deadline for 1989 will be two weeks later than in 1988. This will provide additional time for program directors to evaluate candidates. The NRMP will announce the 1989 date within the next two months.

During the discussions that led to the approval of the November 1, 1988 release date, the following recommendations were made by the schools regarding the 1988-89 residency application process:

- o Program directors are requested to honor November 1 as the earliest date for ~~the receipt of all evaluative information.~~
- o Program directors are requested specifically to refrain from asking students to submit transcripts or other evaluative information prior to November 1.

Your cooperation in observing November 1 as the initial date for your selection considerations will be greatly appreciated.

The AAMC will continue to facilitate communication between program directors and the medical schools. In this regard, would you kindly complete the enclosed inquiry regarding your plans for interviewing candidates. I thank you in advance for your cooperation.

Very sincerely yours,

Robert G. Petersdorf, M.D.
President

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

Information for Residency Directors About the Use of Parts I and II NBME Scores as Factors in Residency Selection

The National Board of Medical Examiners (NBME) Parts I and II examinations are frequently taken by students during their medical education programs, either as a school requirement, or to comply with requirements of this voluntary pathway for licensure. In the residency application process, NBME scores may be included by students or requested by the programs as part of the selection database. The NBME is providing this information about the purpose of these examinations and interpretation of scores so that residency directors who use scores in the selection process can be fully informed regarding appropriate interpretations and limitations of the evaluation instruments.

National Board of Medical Examiners certification requires graduation from a Liaison Committee on Medical Education (LCME) approved school of medicine in the United States or Canada, successful completion of Part I, Part II, and Part III examinations and satisfactory completion of one full year in a graduate medical education program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or comparable Canadian accreditation. Approximately 80% of U.S. graduates are licensed by this mechanism which is endorsed by 51 of the 54 licensing authorities (except Texas, Louisiana, and the Virgin Islands).

Description of the Examinations

The Part I examination is a two-day multiple-choice examination composed of approximately 950 questions, covering the basic medical sciences in the subjects of anatomy, behavioral sciences, biochemistry, microbiology, pathology, pharmacology, and physiology. Each subject contributes approximately the same number of items to the examination. This examination is usually written at the end of the sophomore year. It is administered in June and September. The great majority of examinees take the June administration. The Part II examination is a two-day multiple-choice examination composed of approximately 900 questions, covering the clinical sciences and includes approximately the same number of questions in the following subjects: internal medicine; obstetrics and gynecology; pediatrics; preventive medicine and public

health; psychiatry; and surgery, each with related subspecialties. This examination is usually written in the senior year. The number of examinees taking the test in September is slightly greater than the number who take it in April. The Parts I and II examinations may be taken in either order. Candidates must have passed Part I and Part II before they are eligible to write the Part III examination.

The Part III examination is a one-day examination intended to measure a candidate's medical knowledge which is deemed appropriate for the unsupervised practice of general medicine. Part III consists of two components; the first containing standard multiple-choice items (approximately 300) of the type found in Part I and Part II; the second part contains patient management problems to evaluate knowledge and strategies in diagnosis and management. This examination is written during March or May of the PGY-1 year. The great majority of examinees take the test in March.

Use of the Examination Scores

The Part I and Part II National Board examinations are designed to be taken at specific nodal points in the student's educational career, at the end of the formal curriculum in the basic medical sciences and during the final year of the clinical educational program. The Part examinations are developed in accordance with detailed subject content specifications as determined by the several Test Committees of the National Board, selected from medical school faculties in the United States and Canada. These examinations are designed to evaluate student performance on content that is taught in most medical education programs of LCME accredited institutions.

Parts I and II National Board examinations provide measurements of the basic medical science and clinical science knowledge of individual students that may be helpful in the overall assessment of students. It is important to understand, however, that the examinations have not been developed for the purpose of assessing preparation for post-graduate education. Appropriate use of these test scores, for whatever purpose, also requires recognition of certain limitations (see Precision of Measurement below) of evaluation instruments of this type.

Standard Scores

Parts I and II scores are reported to students and their medical schools for the total Part and for each of the subjects within the Part. Standard scores are reported on a scale with a range of 5 to 995, with nearly all scores falling between 200 and 800. This scale has an average of 500 and a standard deviation of 100 for a Criterion Group of examinees. The Criterion Group for a given test consists of students who were tested during the four-year period prior to the year in which the test was administered and who were two years from expected receipt of the M.D. degree (for Part I) or in their final year of school (for Part II). In both Criterion Groups, the examinees are candidates for NBME certification and taking the test for the first time. Criterion Group norms are provided in Table 1.

For Part I, a total score of 380 or higher is required to pass; therefore, approximately 11% of the Part I Criterion Group would be expected to fail a Part I examination. (See Table 1). For Part II, a total score of 290 or higher is required to pass; therefore, approximately 2% of the Part II Criterion Group would be expected to fail a Part II examination. (See Table 1.) Pass or fail scores are not determined for individual subjects.

Precision of Measurement

Tests do not measure with as much precision (reliability) as certain instruments used in the physical and biological sciences. Reliability coefficients of .9 or greater are recommended for tests used for important decisions about individual examinees. For Part I, the reliability coefficients for recent total examinations are .97 and for individual subject tests range from .74 to .87 with an average of .83; for Part II, these data are .95 (total), .76 to .85 (range of subjects), and .82 (average of subject).

Standard Error of Measurement (SEM) values are determined for each Part and its subject tests and provide a useful interpretation of the reliability of the test(s). The SEM defines a range around the obtained score within which the examinee's true score is likely to lie. For example, the odds areapproximately 2 to 1 that an examinee's true score is within one SEM of his or her obtained score. The SEM for the entire Part I is approximately 20 standard score points and for the subject tests averages approximately 40 points. The SEM for the entire Part II is approximately 25 standard score points and for the subject tests averages approximately 45 points.

Interpretation of Scores

Program directors who use Part I or Part II scores as a factor in selecting residents, must recognize that these examinations are not designed for that specific purpose. In addition, policy regarding use of these examinations varies among individual schools, e.g., their requirement for candidacy status and utilization in promotion and graduation decisions, etc. These variables may be factors in performance. They also should recognize that an examinee's true score for a total Part is likely to be within a band of 20 points (Part I) or 25 points (Part II) above or below the obtained score. A subject examination score is likely to be within a band of 40 points (Part I) or 45 points (Part II) below or above the obtained score. Small differences in scores between individuals are therefore, not meaningful and should not be over-valued when making critical decisions about potential residents during the selection process.

Table 1
Criterion Group Norms
(Four-Year Group)

Score	Percentile
750	99
725	99
700	98
675	96
650	93
625	89
600	83
575	75
550	68
525	58
500	49
475	39
450	30
425	22
400	15
380	11
350	7
325	4
300	2
290	2
275	1
250	1

To register, contact Marcie Foster at 202-828-0522 or at the AAMC, One Dupont Circle NW, Suite 200, Washington, D. C. 20036.

There is an institutional conference fee of $6560.00 which covers five team members. This fee includes tuition, all study materials, two days' accommodations at single occupancy, two continental breakfasts, one lunch, one reception, and one dinner for five team members. For each additional team member, the fee will increase by $1312.00. You will receive an invoice from the AAMC Business Office. If you would prefer to be billed on an individual basis, please let Marcie know when you call to register. Air transportation is at your own expense. Hotel reservations will be handled through a rooming list. DO NOT contact the hotel.

MANAGING INSTITUTIONAL CHANGE:

INTRODUCING A PROBLEM-BASED LEARNING CURRICULUM

Rancho Bernardo Inn, San Diego
May 5 - 7, 1988

Hershey Hotel, Philadelphia
December 1 - 3, 1988

PURPOSE AND OBJECTIVES

The purpose of this workshop is to assist the leaders of our organizations in managing institutional change, specifically, adopting a curriculum change in the form of problem-based learning. Participants will learn how to analyze the culture and climate of their own institutions in determining readiness for change. During the workshop, attendees will interact with colleagues in like roles from other institutions and with the members of their own institutional team as they work through the case studies and exercises in an effort to develop an institutional plan.

Objectives

- To provide participants with an opportunity to experience the problem-based learning method and analyze the nature and process of the approach.
- To examine strategies for increasing the likelihood of the implementation of planned change.
- To understand the involvement of the leadership of the organization and the levels of their participation in the change.
- To analyze external forces impinging on change issues at the institution.
- To explore the costs associated with the problem-based learning approach and mechanisms for financing.
- To explore and discuss various methods for evaluating the curriculum and assessing students' abilities.
- To discuss ways of obtaining faculty commitment to change.

Managing Institutional Change:
Introducing a Problem-Based Learning Curriculum

AGENDA

DAY I

12:00 noon	Registration	
1:00 p.m.	General Session: *Opening Remarks* Introduction and orientation to the seminar.	*Staff*
1:30 p.m.	Introduction Exercise	
2:30 p.m.	Breakout Session: Participants will meet in inter-institutional teams and through the mechanism of a case study will identify and define the problems present at their own institutions that may hamper or delay the implementation of planned change.	
3:30 p.m.	Coffee Break	
4:00 p.m.	Breakout Session: *PBL Demonstration* In this session, participants will assume the role of medical students as they work through an actual problem-based learning case/exercise. Seminar faculty will serve as tutors.	*Faculty*
5:30 p.m.	Reception	
6:00 p.m.	Dinner	
7:30 p.m.	Evening Open - Independent Study	

DAY II

7:30 a.m.	Continental Breakfast	
8:00 a.m.	**Breakout Session:** *PBL Demonstration Continued*	*Faculty*
9:30 a.m.	Coffee Break	
10:00 a.m.	**General Session:** *Managing Institutional Change* During this session, a description and demonstration of a diagnostic tool designed to facilitate the organization and implementation of plans will be discussed. A process of priority setting and the assessment of institutional readiness for proposed changes will be described. Strategies for increasing the likelihood of successful implementation will be explored.	*Steven Ruma*
12:00 noon	Lunch on Your Own	
1:30 p.m.	**Breakout Session:** *Small Group Discussion* During this session, participants will meet with the members of their own institutional team to begin the first steps in developing an action plan.	
3:00 p.m.	**General Session:** *Panel Discussion* The faculty will discuss various issues encountered in implementing problem-based learning such as, program evaluation, student assessment, faculty development (tutor training) and financing based on their experience at their own institutions.	*Howard Barrows* *Gordon Moore* *Scott Obenshain* *Harold Paul* *William Shragge*
4:00 p.m.	Coffee Break	
4:15 p.m.	**Breakout Session:** *(Institutional Teams Continued)*	

6:00 p.m. **Resource Session:**
As participants continue to work in institutional teams, the faculty will be available to serve as a resource for specific problems addressed during the panel discussion.

7:00 p.m. Evening Open

DAY III

7:30 a.m. **Breakout Sessions & Continental Breakfast**
Participants will meet with their colleagues in like roles from other institutions to share progress and identify problems.

9:00 a.m. **General Session:** ***M. Brownell Anderson***
Plan for the Day

9:15 a.m. **Breakout Session:**
Participants will return to their institutional teams to further develop strategies for their action plans.

10:45 a.m. Coffee Break

11:00 a.m. **Resource Session:**
Faculty will be available to serve as resources.

11:30 a.m. **Breakout Session:**
Participants will return to small groups and conclude their work.

12:30 p.m. **Reports at Lunch:**
Each school will present a synopsis of its action plan.

2:00 p.m. Closing Remarks ***Staff***

2:15 p.m. Adjourn