association of american medical colleges

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

MONDAY, NOVEMBER 9, 1987

CAS, COD, COTH SPECIAL GENERAL SESSION
ON MANPOWER
BALLROOM CENTER
1:30 - 2:30 P.M.

CAS BUSINESS MEETING
JEFFERSON ROOM WEST
2:30 - 5:30 P.M.

CAS RECEPTION
MAP ROOM
5:30 - 7:30 P.M.

WASHINGTON HILTON HOTEL
WASHINGTON, D. C.

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

FUTURE MEETINGS

CAS SPRING MEETING	April 13-15, 1988 San Diego, California
AAMC ANNUAL MEETING	November 12-17, 1988 Chicago, Illinois

Administrative Board/Executive Council

February 24-25, 1988	Washington, D. C.
June 22-23, 1988	Washington, D. C.
September 7-8, 1988	Washington, D. C.

COUNCIL OF ACADEMIC SOCIETIES
ANNUAL MEETING

Monday, November 9, 1987
2:30 - 5:30 p.m.
Jefferson Room West
Washington Hilton Hotel
Washington, D. C.

AGENDA

CAS NOMINATION FOR DISTINGUISHED SERVICE MEMBERS

In June 1980 the CAS Administrative Board established a policy to automatically consider for nomination to the category of Distinguished Service Member in the AAMC any individual who has served as Chairman of the CAS, Chairman of the AAMC representing the CAS, or as a member of the CAS Administrative Board for two consecutive terms. Accordingly, the Board nominated:

David H. Cohen, Ph.D.	CAS Chairman, 1985-86
Virginia V. Weldon, M.D.	CAS Chairman, 1984-85 AAMC Chairman, 1985-86

The sections of the AAMC bylaws pertaining to Distinguished Service Membership and the current list of Distinguished Service Members from the CAS are shown below.

AAMC Bylaws

I.2.B - "Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC Representatives of any members described under Section 1."

I.3.E. - "Distinguished Service Members shall be recommended to the Executive Committee by either the Council of Deans, Council of Academic Societies, or Council of Teaching Hospitals."

CAS Distinguished Service Members

Robert M. Berne
F. Marian Bishop
A. Jay Bollet
Samuel L. Clark, Jr.
Carmine D. Clemente
Jack W. Cole
Ludwig W. Eichna
Ronald W. Estabrook
Harry A. Feldman
Patrick J. Fitzgerald
Robert E. Forster, II
Daniel X. Freedman
Robert L. Hill
Rolla B. Hill, Jr.
John I. Nurnberger
Thomas K. Oliver
Hiram C. Polk
Jonathan E. Rhoads
James V. Warren
Ralph J. Wedgwood
William B. Weil, Jr.
Frank C. Wilson

MINUTES

1987 SPRING MEETING

OF THE

COUNCIL OF ACADEMIC SOCIETIES

March 20,1987
The Woodlands Inn
The Woodlands, Texas

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

Dr. Moody welcomed the CAS to Texas and explained that his remarks would be given as part of the CAS Forum, "Sizing Up the Future of Medical Education".

II. Report of the President, AAMC
Robert G. Petersdorf, M.D.

Dr. Petersdorf began by describing in detail the recent reorganization of the AAMC. He said that the AAMC had conducted a constituent survey last fall, the first since the Cogshall Report fifteen years ago, and that the reorganization was based in part on responses to that survey. He explained that the reorganization would help the AAMC to be more responsive and helpful to its constituents. In particular, he said that the Council of Academic Societies would be staffed by the new Division of Biomedical Research, the Council of Deans will be staffed by the Division of Academic Affairs, and the Council of Teaching Hospitals will be staffed by the Division of Clinical Services.

Dr. Petersdorf then briefly listed the three principal items on the AAMC legislative agenda for 1987: (1) student financial assistance, (2) support for research and research training, and (3) reimbursement for patient services. Dr. Petersdorf discussed minority representation in medical schools. He said that minorities are underrepresented in applicants to medical schools, first-year enrollees, and faculty members. He posed the questions, "Why are there not more minority applicants, and what can we do about it?"

Dr. Petersdorf briefly mentioned the AAMC Task Force on Physician Supply (discussed later by Edward Stemmler, M.D.) and said that this issue would be the AAMC theme for 1987 and for the AAMC Annual Meeting. Dr. Petersdorf then reported on AAMC discussions with the Association of Academic Health Centers (AAHC). He said that AAMC had initially wanted to merge with AAHC, but that AAHC

had wanted to proceed slowly. It was decided that a forum of the AAMC/AAHC leadership would be formed to discuss issues on a regular basis.

III. Approval of Minutes

The minutes of the October 27, 1986 Annual Meeting of the Council of Academic Societies were approved as submitted.

IV. Discussion Items

A. CAS Nominating Committee
Douglas E. Kelly, Ph.D.
Chairman, Nominating Committee

Dr. Kelly introduced the members of the CAS Nominating Committee.

Paul Bianchi, Ph.D. - Association for Medical School Pharmacology
Paul Friedman, M.D. - Association of University Radiologists
Gordon Kaye, Ph.D. - Association of Anatomy Chairmen
Jack Kostyo, Ph.D. - American Physiological Society
Frank Moody, M.D. - Society of Surgical Chairmen
Joel Sacks, M.D. - American Academy of Ophthalmology

Dr. Kelly encouraged representatives of the CAS member societies to submit recommendations for openings on the CAS Administrative Board directly to members of the Nominating Committee or to Dr. Elizabeth Short. Dr. Kelly said that the Nominating Committee would meet via conference call on May 28 to select nominees. He said that this year, the Nominating Committee will select a clinical scientist as Chairman-Elect, and it will select nominees for three other positions on the Board.

B. Proposal from the Ad Hoc Group for Medical Research Funding; FY 1988 Budget Proposal for NIH/ADAMHA

Elizabeth M. Short, M.D., Deputy Director for Biomedical Research, AAMC

Dr. Short explained that for the past five years, a growing coalition of academic societies and voluntary health organizations interested in having strong funding for biomedical research, especially the budgets of NIH and ADAMHA, has been developing a counter budget proposal to the Administration's budget. This counter budget has been more realistic for at least maintaining current services, or possibly increasing the funding of biomedical research, so that award levels can be increased. Dr. Short explained that the Ad Hoc Group has a steering committee of individuals who are experienced in the political processes of budget and appropriations. The proposal of the Ad Hoc Group was printed in a glossy booklet to attract attention; Dr. Short distributed copies of the booklet to CAS members.

Dr. Short reported that the Ad Hoc Group had been successful in each of the past five years in getting appropriations increased over the Administration's budget. In each of those years, the

increase was a modest, current services budget to maintain current levels of funding. However, this year, the Appropriations Committees had asked the Ad Hoc Group to tell them what was really needed given the scientific opportunities at the present time. Thus, this year, the Ad Hoc Group proposed anappropriation for NIH of $7.452 billion, an increase of 20.5% over the FY 1987 appropriation, and 34.7% over the Administration's request.

To arrive at this figure, the Ad Hoc Group developed a five-year plan, which would achieve an award rate of 45-50% by 1992. The award rate is now about 30%; and for some institutes, it is only in the 20% range. NIH institute directors had said that they would like to maintain the current portfolio balance at NIH and the segment of the budget now occupied by RO1 and PO1 and individual investigator-initiated grants, which for NIH as a whole, is about 56% of the total spending portfolio.

Dr. Short encouraged member societies to work with the Congress to enact this proposed budget. She expressed hope that even if the total is not accepted by Congress, at least a substantial increase can be gained toward the goals established by the Ad Hoc Group of a 45-50% award rate. She reminded each society of the importance of their becoming formal signatories to the Ad Hoc proposal each year and a signing sheet was circulated.

C. Manpower Task Force - Edward J. Stemmler, M.D.
Chairman, AAMC Assembly

Dr. Stemmler reported that the AAMC Executive Council had approved the creation of a task force, sponsored by the AAMC, to examine the question of "physician supply." Dr. Stemmler explained that the task force would be careful to avoid using the terms "physician surplus" and "physician excess" but instead would be examining the issue of "physician supply." Dr. Stemmler reported that the task force would be guided in its study by a steering committee to be chaired by Daniel C. Tosteson, M.D., President, Harvard Medical Center, and Dean, Faculty of Medicine, Harvard Medical School. Other members of the steering committee had not yet been named.

Dr. Stemmler reported that three working committees would also be named to examine certain topics within the broad issue of physician supply.

1. Physician Supply and Demand - Chair, Saul Farber, M.D., New York University
   a. Medical student education
   b. Resident and fellow education and specialty distribution
   c. Special problems of minorities

2. Medical Scientists Supply and Demand -
   Chair - David Korn, M.D., Stanford University
   a. Basic science education
   b. Clinical scientist education

3. Foreign Medical Schools and Students - Chair, Richard Moy, M.D., Southern Illinois University

Dr. Stemmler reported that the members of the working committees had not yet been named. He said that the steering committee would be named and would meet first in May or June of 1987, and then again before the end of the year. He said that the expectation was that the task force would complete its work in about 18 months.

D. Fiscal 1987 NIH/ADAMHA Budget Update - John Sherman, Ph.D. Executive Vice President, AAMC

Dr. Sherman gave a report of the AAMC actions in response to an attempt by the Administration to "extend the availability" of $334 million of NIH funds and $5 million of ADAMHA funds from FY 1987 to FY 1988. Dr. Sherman described the sequence of events during the FY 1988 budget process leading to the development of this proposal. He explained that the NIH had been forced into this action by the OMB and the Department of Health and Human Services.

Dr. Sherman said that the AAMC recognized the need for a broad, collective strategy, the first part of which might involve a legal process, and the second and ultimate part, the necessity of a legislative decision. Final action regarding the Administration's proposal could reside only with the Congress. However, because the Congress moves at a very deliberate pace, and because NIH was already making reductions as though the Congress had already granted the Administration authority to follow through on its proposal, harm was already being done to some institutions and some grant supported investigators. Therefore, the strategy had a two pronged approach, first to stop the Administration from going ahead with implementation of its proposal, and second, uniting the community to bring pressure on the Congress to reject the Administration's proposal as decisively and promptly as possible.

Dr. Sherman explained that the legal route offered the most prompt possibility for stopping the Administration from continuing to implement this policy. He said that the AAMC, by itself, undertook exploratory work to determine the legal basis for action. He described the development of information showing harm to individuals and institutions resulting from actions already taken by the Administration. Dr. Sherman said that the legal case was judged to be first class.

Dr. Sherman said that two concerns had been felt about using the legal approach. First, there was concern about offending friends at the NIH. And second, there was concern about costs; a total of about $70,000 had been spent on legal costs. Dr. Sherman explained that the AAMC informed NIH of its action, and people at NIH understood that it was necessary. The AAMC also informed key staffers in the Congress.

Dr. Sherman reported that the legal part of the AAMC strategy had been successful. On the same day as the court date, James Miller, the Director of OMB, sent a letter to Secretary Otis Bowen of HHS directing the Department to cease implementing the policy. Dr. Sherman said that the AAMC now must work with the Congress to defeat the proposal legislatively.

E. Organization of Public Affairs Activities of Academic Societies: Panel Discussion

Myron Genel, M.D., American Pediatric Society
Herbert Pardes, M.D., American Psychiatric Association
David H. Cohen, Ph.D., Society for Neuroscience

Academic Pediatric Societies

Dr. Genel began the discussion by describing the organization and process used by the Academic Pediatric Societies in their public affairs activities. The Academic Pediatric Societies is composed of three organizations: The Association of Medical School Pediatric Chairmen, the American Pediatric Society, and the Society for Pediatric Research. A fourth organization, the Ambulatory Pediatric Association, may soon join the groups. These organizations have a small membership (about 1,800 academic pediatricians) and no staff. The executive councils of these organizations have formed a Public Policy Council to perform their public affairs functions, comprising two representatives from each organization. For effectiveness, these two representatives are the same two representatives from each organization to the CAS and to the Council on Government Affairs (COGA) of the American Academy of Pediatrics (AAP).

In order to gain leverage, the Academic Pediatric Societies work closely with the American Academy of Pediatrics, which has a sizeable and effective Washington office and a membership of about 30,000. The AAP furnishes a Washington coordinator for a small fee.

The Public Policy Council meets several times each year, at CAS meetings or at COGA meetings of AAP. The Council also has monthly conference calls and an electronic mail system. The Council communicates with academic departments through a Public Policy Forum, composed of representatives of each of the academic departments of pediatrics. The Council also writes an annual report for distribution to all pediatricians.

The Council maintains a key contact file of members who have relationships with members of Congress. The Council uses these key contacts as well as contacts with home state Senators and Congressmen to influence legislation, rather than using a "hired gun".

Academic Psychiatric Societies

Dr. Pardes first made several general comments about public affairs activities.

- Congress is much less forbidding than many people feel that it is.
- There are many organizations that are very active and very effective at lobbying.
- It is very helpful to establish good working relationships with Congressional staff.
- It is often helpful to form coalitions with other groups, particularly on a specific issue.
- It can be particularly beneficial to form a coalition with citizens groups.
- Letters really count because on many issues, there are not many letters.
- Before meeting with someone in Congress, it is important to visit relevant officials in the Executive Branch to become fully informed on the current status of issues.

Dr. Pardes then explained that Academic Psychiatric Societies work closely with the American Psychiatric Association (with 31,000 members) in order to gain leverage and assistance. Dr. Pardes described the very effective government relations office of APA and said that the academic societies try to get research and education issues on the agenda of APA in order to utilize their talents.

Dr. Pardes described several specific public affairs activities of Academic Psychiatric Societies. He said that the Association of Clinical Research Directors meets annually in Washington for a update on relevant issues and then fans out to meet with homestate Congressmen and Senators. He also said that arranging visits of key Congressional staff to academic centers had been very beneficial.

Society for Neuroscience

Dr. Cohen explained that the Society for Neuroscience has proceeded independently in its public affairs activities because it wanted to behave in a highly targeted fashion without diluting its desires as part of a larger coalition. He said that the Society recognized that its access and its influence might be diminished, but it had still chosen to remain independent. Dr. Cohen said that the Society does participate with coalitions on certain issues and in certain ways, for example, with the CAS, the Ad Hoc Group for Medical Research Funding, and the National

Committee for Research (NCR) in Neurological and Communicative Disorders, a coalition that supports the NINCDS appropriation.

Dr. Cohen said that the Society has a Government and Public Affairs Committee of seven members who are chosen based on their experience and "connectedness". He explained the importance of maintaining long-term stability of the membership of this committee and said that there is a constant struggle to convince Society members to keep the same members on the committee. He said that the members of the committee have certain functions and act quite independently of each other.

Dr. Cohen explained that public affairs activities are essential. The more scientific advances a society has appearing in the news, the better off it will be. He said that it is very important to get into the news, more helpful than lobbying the Congress. Dr. Cohen also endorsed the importance of working with citizens groups.

During the discussion following the presentations of panel members, the point was made that academic societies can work effectively with individuals from industry, especially if those individuals have influence with a particular member of Congress. However, academic societies should be cautious about participating in coalitions with industry.

F. Information Items

Written Materials were furnished on the following subjects as a matter of information for members, and to update them about legislative action in some of these areas.

1. Research Facilities Construction
2. General Clinical Research Centers (GCRCs)
3. Medicare Payment of Physician Services; Radiologists, Anesthesiologists, Pathologists (RAPs)
4. Catastrophic Care
5. AAMC Housestaff Committee
6. President's FY 1988 Budget--NIH, ADAMHA, VA, NSF
7. Transition to Residency: Schedule of NRMP Match 1988

ACTION: After discussion, the CAS unanimously approved November 1 as the date on which the deans' letters should be released.

G. Future Meeting Dates

The 1987 AAMC Annual Meeting will be held November 6-12, 1987, in Washington, DC. The CAS Business Meeting will be held on Monday, November 9, 1987.

The 1988 CAS Spring Meeting will be held April 13-15, 1988, in San Diego.

The 1988 AAMC Annual Meeting will be held November 12-17, 1988, in Chicago.

1987 CAS Administrative Board Meetings are as follows:

April 15, 16	Washington, DC
June 17, 18	Washington, DC
September 9, 10	Washington, DC

ELECTION OF MEMBERS TO THE 1988 ADMINISTRATIVE BOARD

The 1987 CAS Nominating Committee met by conference call on May 28, 1987 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from that meeting is as follows:

CHAIRMAN-ELECT:

Ernst R. Jaffe', M.D.
American Society of Hematology
Albert Einstein College of Medicine
Bronx, New York

THREE-YEAR TERMS:

Myron Genel, M.D.
American Pediatric Society
Yale University Medical School
New Haven, Connecticut

Vivian W. Pinn-Wiggins, M.D.
Association of Pathology Chairmen
Howard University College of Medicine
Washington, D. C.

Joel Sacks, M.D.
American Academy of Ophthalmology
University of Cincinnati School of Medicine
Cincinnati, Ohio

TWO-YEAR TERM:

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

ONE-YEAR TERM:

Glenn C. Hamilton, M.D.
Society of Teachers of Emergency Medicine
Wright State University Medical School
Dayton, Ohio

Information about the nominees appears on the following pages.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: ERNST R. JAFFÉ, M.D.

Present Location (School) ALBERT EINSTEIN COLLEGE OF MEDICINE

CAS Society: American Society of Hematology

Undergraduate School: University of Chicago

Degree: Bachelor of Science (Anatomy) Date: 1945

Medical School: University of Chicago Year Graduated: 1948

Also, Master of Science, Pathology

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern and Assistant Resident, Presbyterian Hospital, New York Medical Service 11/48 - 10/49; 11/49 - 12/50; 4/53 - 6/53; 7/54 - 6/55

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Research Fellow, Hematology, Albert Einstein College of Medicine, National Foundation for Infantile Paralysis, 1955-1957

Board Certification:

Internal Medicine 1957 (Specialty/Date)

Hematology 1972 (Specialty/Date)

Academic Appointments (With Dates):

All Albert Einstein College of Medicine.

Instructor, Department of Medicine 1956-1957

Assistant Professor, Department of Medicine 1957-1962

Associate Professor, Department of Medicine 1962-1969

Professor of Medicine, 1969-Present

Distinguished University Professor of Medicine, 1984-Present

Societies/Affiliations:

American Federation for Clinical Research, American Society for Clinical Investigation, Association of American Physicians, American Physiological Society, American Society of Hematology (President, 1983) International Society of Hematology, Society for Experimental Biology & Medicine, Corresponding (Honorary) Member of Italian Society of Hematology

Honors/Awards:

Phi Bet Kappa Scholastic Honor Society

Doctor of Humane Letters, honoris causa, Yeshiva University, 1987

Alpha Omega Alpha Honor Medical Society

Sigma Xi Honor Scientific Society

Distinguished Service Award, University of Chicago Medical Alumni Association - 1981

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Myron Genel, M.D.
Present Location (School) Yale University School of Medicine
CAS Society: American Pediatric Society
Undergraduate School: Moravian College
Degree: B.S. Date: 1957
Medical School: Univ. of Penn. Year Graduated: 1961

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Rotating Intern Mt. Sinai Hospital, NY, 1961-1962

Resident in Pediatrics, Children's Hospital of Philadelphia, 1962-64

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Pediatric Endocrinology, Johns Hopkins Hospital, 1966-67

Genetics and Inherited Metabolic Diseases, Children's Hospital of Philadelphia, 1967-1969

Board Certification:

Pediatrics 1967 (Specialty/Date)

Pediatric Endocrinology 1978 (Specialty/Date)

Academic Appointments (With Dates):

1969-71 Associate in Pediatrics, Univ. of Penn. School of Medicine

1971-76 Assistant Professor of Pediatrics, Yale Univ. School of Medicine

1971-85 Director, Section of Pediatric Endocrinology, Yale Univ. School of Med.

1971-86 Program Director, Children's Clinical Research Center, Yale Univ. Sch of Medicine

1976-81 Associate Professor Pediatrics, Yale University School of Medicine

See over for rest

Societies/Affiliations:

American Academy of Pediatrics, American Pediatric Society

American Diabetes Association, American Public Health Association

American Federation for Clinical Research, American Society for Bone & Mineral Research

Endocrine Society, Lawson Wilkins Pediatric Endocrine Society, Society for Pediatric Research

Honors/Awards:

1) Annual Award, CT Campaign Against Cooley's Anemia, 1979

2) Robert Wood Johnson Health Policy Fellowship, Institute of Medicine, National Academy of Sciences, 1982

Academic Appointment Continued

1981-present Professor of Pediatrics, Yale University School of Medicine
1985-present Associate Dean, Government and Community Affairs, Yale University School of Medicine

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Vivian W. Pinn-Wiggins, M.D.
Present Location (School) Howard University
CAS Society: Association of Pathology Chairmen
Undergraduate School: Wellesley College
Degree: B.A. Date: 1963
Medical School: University of Virginia Year Graduated: 1967

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Internship & Residency, Pathology, Massachusetts General Hospital, 1967-1970

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Board Certification:

Pathology 1973
(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

Teaching Fellow in Pathology, Harvard Medical School, 1967-1970

Instructor to Associate Professor in Pathology, Tufts University School of Medicine, 1970-1982

Professor and Chairman of Pathology, Howard University College of Medicine, 1982 - present

Societies/Affiliations:

AMA, ASN, IN, IAP, APC, New Eng. Soc. of Path., Wash. Soc. of Path., AAAS, AAP, Board of Trustees of NMA, NMF.

Honors/Awards:

Teaching Awards, Medical Students; (Tufts: 1974,76,77,78,79,80,81, 82,84,87; Howard: 1983,85,86,87); Sigma Xi ; AAMC, GSA-MAS(1982); NAMME (1985); + other community and organizational awards.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Joel G. Sacks, M.D., M.B.A.
Present Location (School) University of Cincinnati
CAS Society: American Academy of Ophthalmology
Undergraduate School: Northwestern University
Degree: Bachelor of Arts (Psychology) Date: 1960
Medical School: Northwestern University Year Graduated: 1963
Graduate School (1) Northwestern University, M.S. (Anatomy) 1962
Graduate School (2) University of Cincinnati, M.B.A. (Management) 1987

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern (Rotating) Chicago Wesley Memorial (Now: Northwestern Memorial) 1963-1964

Resident (Ophthalmology), Univ. California, San Francisco, 1964-1967

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

NIH Special Fellow in Neuropathology, Maryland Medical-Legal Found., Baltimore 1967-1968

Neuro-Ophthalmology, Johns Hopkins, 1968 - 1969

Board Certification:

Ophthalmology 1969 _____
(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

1969 - 1973 Assistant Professor of Ophthalmology and of Neurology, Northwestern

1973 - 1977 Associate Professor of Ophthalmology and of Neurology, Northwestern

1977 - Present, Ben and Louise Tate Professor and Director of the Department of Ophthalmology, University of Cincinnati

Societies/Affiliations:

American Academy of Ophthalmology, American College of Surgeons, Association of University Professors of Ophthalmology, Association for Research in Vision and Ophthalmology

Honors/Awards:

Phi Beta Kappa, Alpha Omega Alpha; Delta Mu Delta, Beta Gamma Sigma (both Business Honoraries); Honor Award, American Academy of Ophthalmology

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: S. Craighead Alexander, M.D.
Present Location (School) University of Wisconsin-Madison
CAS Society: Society of Academic Anesthesia Chairmen
Undergraduate School: Davidson College, Davidson, N.C.
Degree: B.S. Date: 1951
Medical School: University of Pennsylvania Year Graduated: 1955

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Internship - Philadelphia General Hospital, Philadelphia, P.A., 1955-56

Residency - Dept. of Anesthesiology, University of Pennsylvania, 1960-62

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Department of Anesthesiology, University of Pennsylvania, 1962-64

Board Certification:

Anesthesiology, 1963 (Specialty/Date) _____ (Specialty/Date)

Academic Appointments (With Dates):

Instructor, Dept. of Pharmacology, Univ. of Pennsylvania (1958-60); Instructor, Dept. of Anesthesiology, Univ. of Pennsylvania (1960-63); Associate, Dept. of Anesthesiology, Univ. of Pennsylvania (1964-65); Assistant Professor, Dept. of Anesthesiology, Univ. of Pennsylvania (1965-69); Professor and Chairman, Dept. of Anesthesiology, Univ. of Connecticut (1969-71); Professor and Chairman, Dept. of Anesthesiology, Univ. of Wisconsin (1971-present)

Societies/Affiliations:

Association of University Anesthetists, American Society for Pharmacology & Experimental Therapeutics, American Medical Association, American Society of Anesthesiologists, Society of Neurosurgical Anesthesia and Neurologic Supportive Care, Society of Academic Anesthesia Chairmen
CAS Administrative Board, 1986-1987.

Honors/Awards:

Pharmaceutical Manufactures Association Fellowship in Clinical Pharmacology (1959)
Career Development Award, U.S. Public Health Service, (1965-69)
Visiting Scientist, Bispebjerg Hospital, Copenhagen, Denmark, (1968-69)
Sigma Xi

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Glenn C. Hamilton, M.D.
Present Location (School) Wright State University School of Medicine
CAS Society:
Undergraduate School: University of Michigan
Degree: Bachelor of Science Date: May 1969
Medical School: University of Michigan Year Graduated: 1973

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern, Medicine, U.C.L.A. - Harbor General Hosp., 6/73 - 6/74
Resident, Internal Medicine, University of Michigan, 7/75-7/76
Resident/Chief Resident, Emergency Medicine, Denver General Hospital, 7/77-7/79

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Fellow - American College of Emergency Physicians 1983

Honorary Fellow - Australasian College of Emergency Medicine 1984

Board Certification:

American Board of Internal Medicine 9/12/79
American Board of Emergency Medicine 9/82
(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

Asst. Prof. of Emer. Med. & Clinical Med., Univ. of Cincinnati, 1979-1981

Assoc. Prof. of Emer. Med., Wright State Univ., 1982-1986

Professor of Emer. Med., Wright State Univ., 1986 - present

Assoc. Prof. of Internal Med., Wright State University, 1984-present

Societies/Affiliations:

Alpha Omega Alpha
Amer. College of Emer. Physicians.
Amer. College of Physicians
Society of Teachers of Emer. Med.
University Assoc. for Emer. Med.
Society of Critical Care Medicine

Honors/Awards:

Outstanding Senior Resident- Emer. Med./Class of 1979
Silver Tongue Orator Award, 1982 Annual STEM Debates, ACEP Scientific Assembly
Imagio Obscura Award, University Assoication for Emergency Medicine, 1983
Teaching Excellence Award, Emer. Med. Resident's Assoc., 1985
Academic Excellence Award, Society of Teachers of Emer. Med., 1986
Presidential Award for Outstanding Achievement as a School of Medicine Faculty
Wright State University, 1986

III. C. Report on Housestaff Representation

The attached report of the Ad Hoc Committee on Housestaff Participation was accepted by the Executive Council at its September meeting for transmission to each of the Councils.

The CAS, COD and COTH are asked to consider the report and advise their Administrative Boards on its acceptance.

REPORT OF THE

AD HOC COMMITTEE
ON
HOUSESTAFF PARTICIPATION IN THE AAMC

For a number of years, the AAMC has sought ways to increase the participation of physicians in residency training in the deliberations of the Association in areas germane to its mission to advance medical education. Association Ad Hoc Committees have included resident representatives who have thus contributed to the formation of Association policy. In 1978, a Special AAMC Committee on Housestaff recommended that the Association convene a conference of housestaff to identify generic issues of concern to housestaff appropriate for AAMC involvement. Four conferences were conducted, in 1980, 1981, 1983 and 1985, on topics ranging from evaluation of residents and of GME programs to clinical education of medical students. In November, 1986, the AAMC Constituent Survey showed support for formal involvement of housestaff in the Association. In May, 1987, the Ad Hoc Committee on Housestaff Participation was appointed to consider and make recommendations concerning the future role that residents should have in the Association.

A. Purpose

The Committee first addressed the purposes that would be served by resident participation, both for the Association and for the residents. They agreed that a formal mechanism for consistent, continuing communication between the Association and residents in the identification of issues and the formulation of policies to address those issues was appropriate. The Association would benefit from a structured system for interacting with the approximately 75,000 physicians in residency each year, thus closing a gap in its relationships with an important sector of the medical education community. Representation by residents would provide a means by which residents could express their views on issues identified by the Association and identify issues to be addressed by the Association. The Committee recognized the value to the Association of being exposed to issues and viewpoints of concern to residents.

The Committee identified several categories of issues that it anticipated would be a focus of shared concern.

o Issues related to the student role of residents; e.g., issues related to career decisions. The Committee felt that representation of residents in the Association might influence additional residents to choose academic/research careers.

- Issues related to the teaching role of residents; e.g., the development of methodologies by which residents enhance their teaching skills and evaluate medical students.

- Issues related to the patient care role of residents; e.g., the size of resident programs; the balance of service and educational goals.

- Issues related to the research role of residents; e.g., factors influencing clinicians entering clinical research careers.

- Issues related to the social and public health role of residents; e.g., the provision of care to AIDS patients.

- The Committee recognized that many more issues of mutual concern would arise as the relationship between residents and the AAMC evolved. Bearing in mind the missions of the AAMC, they stipulated that the focus of the relationship should be on educational and scholarly issues and not on economic or working condition issues of local jurisdiction.

B. Organization

The Committee discussed possible organizational forms for achieving representation by residents in the Association.

- Resident conferences - The Committee felt that this approach had been used in the past as a first step in developing representation by residents. Annual meeting programs and specific conferences would undoubtedly continue to be an appropriate forum for in-depth discussion of a number of the areas of mutual interest. However, this process would not meet the need for input from residents on all aspects of Association policy. The Committee felt that a more formal approach was needed at this time.

- Group on Resident Representatives - Although the Group model is widely and successfully used in the Association, the Committee felt that this form of organization did not fit well for resident representation. An AAMC group is a professional development and educational organization for permanent faculty and staff.

- Organization of Resident Representatives (ORR) - This organizational form would be consistent with the Organization of Student Representatives (OSR), which has been the mechanism for student representation in the Association since 1971. Either a separate ORR could be formed, or the OSR could be enlarged to include residents as well as students. The Committee felt that combining students and residents in a single organization would not be appropriate at this time because residents, with greater numbers and greater experience, might tend to dominate the students.

Recommendation: The Committee recommends that an Organization of Resident Representatives (ORR) be formed to represent residents within the Association. The ORR would be modeled after, and consistent with the OSR. In future years, if an ORR becomes viable, consideration should be given to the merits of a single organizational entity which would integrate and balance the interests of students and residents.

C. Selection of Resident Representatives

The Committee discussed selection of resident representatives to attend the annual meeting of the Association and to represent residents at that meeting. They examined selection through academic societies, through program directors, through medical schools, and through teaching hospitals. The Committee decided that the most rational locus from which to select resident representatives would be the teaching hospitals.

Recommendation: The Committee recommends that one resident representative be selected from each COTH full-member hospital, through a process determined by, and appropriate to that hospital. The Committee suggests, however, that consideration be given to selecting resident representatives for a period of longer than one year in order to gain some degree of continuity. Consideration should also be given to selection of residents representing a variety of disciplines.

D. Funding

Recommendation: The Committee recommends that the method of funding for sending resident representatives to the annual meeting be determined at each hospital. Funding for the activities of the Administrative Board of the ORR would be provided through the Association.

E. Organizational Relationships

The Committee recognized that residents relate primarily to the teaching hospitals, and the ORR would represent residents within the teaching hospitals. However, residents also have common academic interests and shared missions with academic societies.

Recommendation: The Committee recommends that the ORR report to the COTH and that its principal relationships be with the COTH. However, the Committee recommends that the ORR Board also have a formal linkage with the CAS Administrative Board.

F. Voting Representation

After discussion, the Committee declined to make a recommendation regarding voting representation, feeling that this decision was appropriately the prerogative of the Executive Council. The Committee suggested that consideration of Executive Council representation be delayed until the ORR has become functional and attendance and interest by residents have been clearly demonstrated.

G. Implementation

The Committee expressed some concern about the level of resident participation and interest and felt that a gradual evolution toward the full organizational form would be realistic. They also felt that, following initial Executive Council consideration of this report, the opportunity should be afforded for the membership of each Council to fully discuss and support its recommendations before final Executive Council and possible Assembly action.

INSTRUCTION IN CLINICAL PHARMACOLOGY AND THERAPEUTICS FOR MEDICAL STUDENTS

Dr. David Nierenberg and Dr. Richard Weinshilboum are making this presentation on behalf of The Council on Medical Student Education in Clinical Pharmacology and Therapeutics. The Council is comprised of Representatives from The American Society for Clinical Pharmacology and Therapeutics (ASCPT), The American Society for Pharmacology and Experimental Therapeutics (ASCPT), and The Association for Medical School Pharmacology (AMSP). All three are members of the Council of Academic Societies.

The Representatives making up The Council on Medical Student Education in Clinical Pharmacology are:

For ASCPT:
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Edward M. Sellers, M.D., Ph.D.
Richard Weinshilboum, M.D.

For ASPET:
Darrel Abernethy, M.D., Ph.D.
Terrence Blaschke, M.D.
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For AMSP:
Lewis Aronow, Ph.D.
Edward Carr, Jr., M.D.
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Results of 1985 Survey of Medical School Instruction in Clinical Pharmacology, and Summary of Discussion from January 1986 Dartmouth Workshop on Teaching Clinical Pharmacology to Medical Students

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The American Society for Clinical Pharmacology and Therapeutics (ASCPT), through its Medical Education Committee, has traditionally been active in promoting the teaching of clinical pharmacology, primarily in the spheres of educating postdoctoral fellows and enhancing the continuing medical education of practicing physicians. During the past year, the leadership of the Society proposed several actions which increased the Society's activities in the area of undergraduate medical education. After the March 1985 meeting, funds were approved to sponsor a survey of current teaching in clinical pharmacology at U.S. medical schools. That survey was conducted in October 1985. Dr. Lowenthal, immediate past president of the ASCPT, proposed holding a winter workshop to discuss teaching clinical pharmacology to medical students. That workshop was held at Dartmouth Medical School in January 1986. During the March 1986 meeting, the Society sponsored both a poster session and a symposium concerning the teaching of clinical pharmacology to medical students.

In this brief report, I will provide a brief overview of past efforts to teach clinical pharmacology to medical students; present the results of the survey on current teaching of clinical pharmacology at U.S. medical schools; and summarize the discussions and tentative conclusions of the workshop participants.

PAST TEACHING EFFORTS

That clinical pharmacologists must teach students at all levels "the basic concepts of an approach to rational therapeutics" is not a new concept (1). The preface from an early American textbook in clinical pharmacology specifically stated that the book was written to help medical

students understand a general approach to rational drug therapy, since almost all teaching in this area still occurred in a "hand-me-down" fashion (2). Furthermore, it was recognized that the discipline of clinical pharmacology required knowledge of, and prior training in, both basic medical pharmacology and basic clinical medicine.

In 1980, the Association for Medical School Pharmacology surveyed all 110 US medical schools concerning their clinical pharmacology programs (3). Of the 81 schools which responded, only 36 could identify clinical pharmacology as a separate teaching entity in the third or fourth years of the medical school curriculum. Teaching was performed in a variety of formats, and was either elective or required. Topics varied from subspecialty therapeutics (e.g. treatment of congestive heart failure) to concepts in general clinical pharmacology (e.g. adverse reactions to drugs). The next year, Peck and Halkin described an 18 hour course in therapeutic decision making for second year medical students, and documented both the intensive faculty time required, and the difficulty of teaching clinical pharmacology to second year students because of their unfamiliarity with clinical problems (4). Later, an editorial stressed that the best educator in clinical pharmacology would probably be "a physician, preferably one working in the classrooms and at the bedsides of university-based medical-student and house-staff training programs"(5).

In 1984, Spector and Roberts proposed a longitudinal plan for physician education about drug therapy, beginning in the second year of medical school and extending through the physician's professional life (6). The two parts of the plan which related to medical schools included continuing the basic pharmacology course in the second year, and introducing a required course in basic principles of clinical pharmacology

to be taught in the fourth year. Later that year, Ferguson and Vlasses described a four-week elective course which they offered to their fourth-year students, which included not only didactic lectures, but also case discussions, student presentations, and written case evaluations (7).

That same year, the Association of American Medical Colleges published the Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine, the "GPEP Report" (8). The report stressed that all students required a common foundation of knowledge, skills, values, and attitudes, regardless of their intended areas of specialization. Also, the report stressed the importance of integrating basic science and clinical education. While the report made many other recommendations, both of these concepts have direct application to undergraduate medical education in clinical pharmacology.

Most recently, Reidenberg discussed how the discipline of clinical pharmacology had moved two broad themes--the use of the scientific method to study the effects of drugs in man, and the individualization of drug therapy--into the mainstream of medicine. One of the roles of the clinical pharmacologist remained to teach about these two themes (9).

During the March 1986 meeting, the ASCPT sponsored both a poster session and a symposium concerning undergraduate medical education in clinical pharmacology. Thus, 1986 seems to be an appropriate year to reassess our current programs for teaching clinical pharmacology to medical students, and to summarize discussions on possible future endeavors.

SURVEY OF CURRENT TEACHING IN CLINICAL PHARMACOLOGY

In October 1985, a four-page survey was sent to all 127 American

medical schools. The survey was sent to the director of the clinical pharmacology program when such a person could be identified (10). When no such person was identifed, the survey was sent to the Dean of Academic Affairs at each medical school, with an appropriate cover letter. A second mailing was sent out 1 month later to all schools which had not responded. Eighty-eight schools responded (69.3% response rate). In the discussion below, the percentages of all responses to each question are listed. Most questions were answered by more than 60 of the 88 responders.

Basic pharmacology instruction: The average class size was 124 students. All schools offered a required course in basic medical pharmacology, usually taught in the second year (96%), but occasionally taught in the first year (4%). The average number of hours in this course was 114; a portion of these hours was spent on topics related to clinical pharmacology at 84% of the schools.

Required teaching in clinical pharmacology: Only 14% of schools offered required courses in clinical pharmacology; of those which did not, 87% taught material related to clinical pharmacology within other required courses. On average, 18.4 hours of required instruction in topics related to clinical pahrmacology were given before graduation. In years one through four, the time was apportioned as 0.4, 10.5, 3.1, and 3.8 hours respectively.

Of this average figure of 18.4 hours instruction, 12.0 hours were in the form of lectures, and 6.3 hours in conferences or seminars. These required hours were taught by the Department of Pharmacology (80%), Medicine (7%), or other (14%). The actual teaching was performed by PhD's in Pharmacology (32%), MD's in Pharmacology (36%), MD's in clinical departments (30%), or others (3%).

Elective courses in clinical pharmacology: Of the schools which responded, 60% offered an elective course in clinical pharmacology. The format was either classroom instruction (24%), a clinical rotation (46%), or other (30%). The average length of the elective course was either 55 hours or 3.8 weeks. The average number of students who took the elective during the previous year was 22 (average graduating class size was 124).

General clinical pharmacology: Topics which represented 17 areas of general "core" material in clinical pharmacology were included on the survey. Each responder was asked to state whether he thought these topics should be required and taught in an ideal curriculum, and whether present coverage in his medical school was adequate. These topics and results are listed in Table 1. Responders usually agreed (mean 92.3%) that these topics should be required and taught in an ideal curriculum. However, there was considerably less confidence (mean 57.4%) that such topics were being adequately covered in the present medical school curricula.

Specific areas of therapeutics: The survey also inquired about whether medical schools should teach (somewhere in the curriculum) material concerning therapeutics in 16 specific disease areas (see Table 2). Again, most of the responders (mean 93.6%) felt that this information should be taught in an ideal curriculum. Some responders were unsure whether this information was being adequately covered at present. Many of those who expressed an opinion felt that this material was not being adequately covered in their medical schools.

General conclusions: Several questions at the end of the survey were designed to explore future directions in teaching clinical pharmacology. Of those who responded, 87% felt that an ideal curriculum should include a required, separate course in clinical pharmacology. Those who favored

this idea felt that the course should be held in the third year (22%), the fourth year (64%), or either the third or fourth year (12%). Only 1% felt the course should be held in the second year; none felt that it should be held in the first year. Regarding course format, 54% felt that such a course should be classroom oriented; 19% felt it should be a clinical rotation; and 26% felt it should have another format, usually a combination of the two above. Of the medical schools which do not currently have a required course, only 11% indicated plans to implement such a course in the next few years. Finally, 62% of the schools which responded indicated that they presently had a section or division of clinical pharmacology, although several schools indicated that the section was vacant at present.

WORKSHOP ON TEACHING CLINICAL PHARMACOLOGY

In January 1986, at the suggestion of Dr. Lowenthal, an informal workshop was held at Dartmouth Medical School to discuss various issues related to teaching clinical pharmacology to medical students. Participants included Carl Peck (Uniformed Services University of the Health Sciences), Terrence Blaschke (Stanford University Medical Center), Edward Sellers (Faculty of Medicine, University of Toronto), Edward Carr (State University of New York at Buffalo), Richard Mamelok (Drug Studies Unit, University of California, San Francisco), Richard Weinshilboum (Mayo Clinic), Alexander Shepherd (Univerisity of Texas Health Sciences Center, San Antonio), David Lowenthal (Mount Sinai School of Medicine), and David Nierenberg (Dartmouth Medical School). The discussions were continued at a second informal meeting held during the March 1986 ASCPT meeting. A number of questions were addressed, and a summary of the consensus developed

about these points follows.

Past teaching practices: A review of past editions of several commonly used textbooks of both medicine and basic pharmacology revealed little emphasis on principles of rational therapeutics. Textbooks could have a very important role in this area, since most medical schools still do not have sections of clinical pharmacology, and those that do may have only one or two members within the section. Recent editions of textbooks of medicine (11) and pharmacology (12) have devoted considerably more attention to "core" material in clinical pharmacology. In addition, several new textbooks devoted to clinical pharmacology have recently been published (13,14).

Concern has been expressed among faculty members in clinical pharmacology that if much time is spent teaching medical students, this will harm career advancement, which is usually based predominantly upon academic achievement as measured by receipt of grants and publication in peer-reviewed journals. In any case, only 14% of medical schools offer required courses in clinical pharmacology; medical students receive on average only 18.4 hours of instruction in areas related to clinical pharmacology before graduation; and most of this instruction is done by basic scientists from Pharmacology departments during the second year. Thus most students are not exposed to teaching by clinician-pharmacologists, and are probably not required or urged to read relevant material in medicine, pharmacology, or clinical pharmacology textbooks.

Core information in clinical pharmacology: The group reached a consensus that there was a body of knowledge within the discipline of clinical pharmacology which could be considered "core" information, and

which should be taught at every American medical school. This information included all 17 of the topics listed in the survey (see Table 1). Other topics which were felt to represent "core" information included: 1)Principles of therapeutic decision making; 2)Generic drug use and economics of drug use and development; 3)Influences upon physician prescribing behavior; 4)Medicolegal issues relating to rational prescribing (e.g. informed consent, prescribing drugs for non-approved indications, restricted hospital formularies, etc.); and, 5)Use and abuse of over-the-counter drugs. This list of "core" topics included all of the topics proposed by Spector and Roberts in their paper (6). All of these topics are primarily related to the development of a rational approach to therapeutics, rather than to specific areas of therapeutics.

There was recognition that many of these same topics are considered necessary "core" topics by chairmen of medical school pharmacology departments. That group identified the minimum knowledge base in pharmacology which every student trained as an undifferentiated physician should have at the time of graduation from medical school (15). In their proposed "ideal" course of 133 hours, fully 18 hours of classes were proposed in the above areas. In addition, the 87 medical schools in that survey reported that their current second year pharmacology courses (averaging 89.5 hours of class time) included 13 hours in areas directly related to clincial pharmacology. Thus many of the content areas identifed at the workshop as representing "core" clinical pharmacology material had already been identifed by either clinical pharmacologists (6) or by Pharmacology Department Chairmen in medical schools (15).

The workshop participants discussed whether topics in specific areas of therapeutics (such as a rational approach to the treatment of

hypertension, or a rational approach to the treatment of sepsis) should be taught. The group reached a consensus that such teaching was essential in medical school, but that it could be done on clinical rotations in medicine, surgery, pediatrics, etc. While such topics did not appear to be part of an essential "core" curriculum in clinical pharmacology, their incorporation into such a course would certainly strengthen the course. However, their addition would also add hours to a course which might have difficulty obtaining those hours. Ultimately, if such topics were included in a required course, they should be used primarily to reinforce the basic therapeutic principles outlined in the core lectures, rather than attempting to describe detailed therapeutic options in a variety of specific diseases.

Timing of instruction: The participants of the workshop generally agreed that the best time to teach clinical pharmacology to medical students is in the fourth year. At that time, students will have had their second year course in basic pharmacology, and have completed required clinical rotations in their third year. They are thus prepared to tackle the more difficult issues involved in individualizing therapy. This conclusion was in agreement with the results of the survey previously mentioned.

The workshop group also recognized the difficulties of teaching such a required course in the fourth year. This is traditionally a year of electives for medical students; thus most students are scattered over many hospitals or even different states. It might be easier to develop a required course in the third year (in conjunction with medicine), or in the second year (as part of the basic pharmacology course). These alternatives were felt to be better than no teaching in clinical

pharmacology, but were also recognized as suboptimal. Teaching in the third year would superimpose even more material onto an already very crowded and compressed clinical experience. Teaching clinical pharmacology in the second year was felt to be suboptimal because those students would have little or no direct knowledge of clinical medicine, and therefore could not fully comprehend the material, as previously noted by others (4). Thus, in an ideal curriculum, most participants felt that a medical school would require all fourth-year students to return to the classroom for a period of time during the fourth year, to take one or more courses including a formal course in clinical pharmacology. Such an arrangement is already in place at several American medical schools (16,17).

There should be coordination between any required clinical pharmacology course and the basic pharmacology course at any medical school. Efforts should be made to make the second year course clinically relevant, without diluting the strength of the scientific approach to basic pharmacology. Also, it was recognized that some topics covered in the second year course in pharmacology (e.g. pharmacokinetics, drug metabolism, pharmacogenetics, drug abuse) formed the basis for subsequent lectures on the "same" topics in a clinical pharmacology course. Clearly a fourth-year lecture on pharmacogenetics would build upon, and be considerably more advanced than, a second year lecture on the "same" topic.

Required course format: There was agreement that no course format had been shown to be ideal, and that the actual format would have to be tailored to the circumstances at each medical school. Clearly, a lecture format would be most efficient, since most medical schools have very few faculty members in clinical pharmacology. However, active student

participation should also be required to stimulate problem-solving skills, and place proper emphasis on student-activated learning.

Such a course should be coordinated and primarily taught by a "general" clinical pharmacologist. Certain lectures could be taught by subspecialists, but the overall course thrust and coordination would require the expertise of a general clinical pharmacologist. It was recognized that such indivuduals are in short supply, that few new fellows are trained each year, and that the number of fellows may actually be dropping (16). In addition, some clinical pharmacologists might feel uncomfortable lecturing about some or all of these "core" subjects. However, clinical pharmacologists with adequate training in the field should be able to develop lectures on these topics and teach at a level conducive to learning by fourth year students. In fact, as standards for training programs for fellows and board certification appear more likely (19), clinical pharmacologists should feel more comfortable in their role as "generalists." The related issue of how to increase the number of medical residents interested in careers in general clinical pharmacology remains a chronic and difficult problem.

Other issues relevant to course format were discussed. At schools with few faculty members in clinical pharmacology, videotapes could be prepared to lessen faculty load, especially if a required course had to be repeated several times each year to include all students. The development of computer-assisted teaching devices would also serve a similar purpose. The month-long rotation on an active consultation service has been a valuable and popular way to teach fourth-year medical students, although its primary shortcoming is the ability to enroll only 1-3 students per month. In addition, such rotations are offered at a minority of medical schools.

The goals of teaching were also discussed. A required course in clinical pharmacology should help the student master essential facts, skills, and attitudes in the area of general clinical pharmacology. As previously suggested (8,13), the skills (e.g. searching reference sources for information, analyzing papers and clinical studies, solving basic pharmacokinetic problems) and attitudes (e.g. personal plans for future drug education, desire to apply scientific principles to therapeutic decisions) may be as important as the current factual base of the discipline. Details of current therapeutics will certainly change, but an approach to life-long learning and rational therapeutics should be valid over time. The transmission of facts, and especially skills and attitudes, seems to require an interactive style of teaching with direct faculty-student contact. An over-reliance upon computer assisted teaching and videotapes might shortchange students in these areas. Active student participation (for example, presenting analyses of drug advertisements or of clinical cases) was felt to be a desired course characteristic, and would clearly require close faculty-student contact.

Future role of the ASCPT: The workshop participants felt that the ASCPT should consider taking a formal position to support the required teaching of general clinical pharmacology at all American medical schools. While such a position relates to other important issues (e.g. shortage of trained "general" clinical pharmacologists, accreditation of fellowship programs, board certification, etc.), the workshop participants felt that such a formal position should be seriously considered by the Society.

Other ways in which the Society could involve itself were also suggested. First, the Medical Education Committee and the Subsection on Pharmacometrics are now considering the establishment of procedures for

evaluating software programs useful in the teaching of clinical pharmacokinetics to medical students. At present, there are several programs in the public domain, and several others offered by private companies. Their evaluation in a systematic fashion would be of considerable benefit to faculty members seeking an appropriate program to supplement their courses.

Second, the Medical Education Committee has been very active in supporting CME programs for licensed physicians. The Committee may wish to pursue the issue of how best to involve the ASCPT in any future attempts to improve the quality of undergraduate medical training in clinical pharmacology.

Third, it was clear that the American Society for Pharmacology and Experimental Therapeutics (ASPET) has been interested in the education of medical students in pharmacology for quite some time. ASPET has a Committe on Educational Affairs, a Subcommittee on Teaching and Evaluation Materials, and an Executive Committee of the Clinical Pharmacology Division. The Medical Education Committee of the ASCPT is now considering ways of working with the appropriate ASPET committees to coordinate plans to strengthen the teaching of clinical pharmacology within medical schools.

In summary, the workshop participants generally agreed that the discipline of clinical pharmacology has gained increasing visibility and respect from other medical disciplines. The student can practice rational therapeutics optimally only when he or she has mastered a "core" of material in general clinical pharmacology comprised of necessary facts, skills, and attitudes. Therefore, material which represents the "core

essentials" of clinical pharmacology should be taught in required courses in all medical schools. The shortage of trained "generalist" clinical pharmacocolgists, and the difficulty in changing medical school curricula, will make this an evolutionary process. Different solutions may be required at different medical schools. The relative merits of different formats and styles of teaching will have to be assessed, as well as the overall efficacy of our teaching endeavors upon medical student performance (1, 20). Nevertheless, as our Society moves forward with its efforts to define standards in training fellows and standards for board certification, it may also be time for the Society to consider taking a leadership role in bringing clinical pharmacology into the mainstream of medical school educational goals and required curricula.

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Table 1. Survey responses to topics in general clinical pharmacology. Each percentage represents positive responses from all those answering that question. Blank responses were not counted.

Topic	Should be required and taught	Present coverage adequate
Pharmacokinetics	98%	79%
Adverse drug reactions	95	73
Drug interactions	99	65
Therapeutic drug monitoring	91	45
Drug allergy	95	54
Pharmacogenetics	90	56
Prescription writing	84	74
Drug use in the elderly	97	50
Drug use in infants	97	38
Drug use in pregnant/lactating women	92	35
Drugs and the kidney	96	65
Drugs and the liver	96	59
Drug overdose/poisoning	95	71
Drug regulations	88	55
New drug development	72	45
Substance abuse	94	68
Learning about new drugs	90	44
Mean	92.3	57.4
SD	6.5	13.3

Table 2. Survey responses to topics in particular therapeutic areas. Tabulation of responses as in Table 1.

Topic	Should be required and taught	Present coverage adequate
Rx of obstetric conditions	88	28
Rx of pediatric conditions	91	39
Rx of surgical conditions	85	31
Rx of hematologic conditions	93	61
Rx of concologic diseases	94	70
Rx of cardiovascular diseases	97	77
Rx of pulmonary diseases	94	58
Rx of infectious diseases	97	69
Rx of rheumatologic diseases	96	67
Rx of renal conditions	94	58
Rx of neurologic diseases	96	61
Rx of gastroenterologic diseases	96	59
Rx of endocrine conditions	97	69
Rx of dermatologic diseases	90	41
Rx of allergic conditions	93	49
Rx of psychiatric diseases	97	59
Mean	93.6	56.0
SD	3.6	14.5

V. C. AAHC/AAMC Group of Government Relations Representatives

The attached proposal describes the plans and policies for the formation of a Government Relations Representatives (GRR) Group to be cosponsored by AAMC and AAHC and work with the AAMC Office of Government Relations (OGR).

Members would include:

1) Associate deans or other persons in the Deans' offices assigned the government relations portfolio.

2) Similar persons in the Vice Presidents for Medical Affairs Offices.

3) A representative from each CAS Society desirous of membership.

GRR members will receive only those memos sent to CAS, COD and/or COTH representatives. They will convene in Washington semi-annually to meet with Congressional staff and receive special briefings.

CAS Council Representatives should make their Societies aware of this opportunity. Since our Council decided to abolish the separate Public Affairs Representatives to Council and empower the regular CAS Council members to be the link between AAMC and their Societies for issues in the legislative arena, CAS Societies should consider the wisdom of appointing one of their two CAS Representatives to this Group to enhance coordination and integration on policy issues.

PROPOSED POLICIES FOR THE ESTABLISHMENT OF A JOINTLY SPONSORED AAHC/AAMC GROUP OF GOVERNMENT RELATIONS REPRESENTATIVES

Background Information

The Association of Academic Health Centers provides staff and logistical support to a group of individuals on the staff of AAHC member institutions who have responsibility for their institutions' governmental liaison in the area of health programs. These individuals report at various administrative levels of the university, and although the majority of them function within the academic health center, several operate at the overall university level and are involved in legislative liaison for other university programs outside the health arena.

However, the individuals in the group have been nominated by the academic health centers' chief executive officers. They have varying degrees of seniority, expertise, and operational responsibility, but generally, each is the contact person between the university and the staff of their state's congressional delegation. They carry out this legislative liaison function on behalf of their respective institutions.

The group has met at irregular intervals in Washington, D.C. The staff of the AAHC has helped the group with the distribution of information relevant to legislative issues, and has assisted with the logistics of the meetings. Staffing of the group is done by the AAHC as a whole, without personnel exclusively assigned to the function.

The group was initially constituted in response to the solicitations by AAHC members. Two factors were instrumental:

1. It was felt that a group of individuals knowledgeable about legislative issues of concern to the AAHC members could be of significant assistance in sharpening the perceptions of the AAHC Board and staff about legislative areas which should be given priority attention. Furthermore it was felt that it would be useful to know which institutions have a good rapport with congressional representatives and staff of key committees dealing with health policy.

2. Many of the individuals who participate in the group already knew each other and collaborated at various times within other groups informally constituted around single issues (for example, taxes, NIH, etc.). However, the leaders in these activities felt that they would be able to be more effective if they could meet from time to time with their colleagues from the other academic health centers to discuss legislative issues, compare their respective interests in them, and, particularly, help each other gain access to congressional staff in key committees.

The reasons given above still represent the purpose and objective for the group. The members of the group are constantly reminded that they are not to represent themselves as emissaries of the AAHC, but only of their own institutions, even in stituations when the institutional policies they pursue coincide with positions supported by AAHC.

In September 1986, at approximately the same time when the AAHC-supported group was forming, the AAMC asked each medical school dean and COTH chief executive officer to identify a person in their respective organization with government relations responsibilities. The response to this request produced two lists: a deans list of 85 individuals and a teaching hospital list of 123. Where duplicates were reported, they were removed from one or the other of these two lists.

All AAMC memoranda pertinent to government relations activities are sent to these individuals. The majority of those on the deans' list have full-time responsibility for government relations, although many of these people function out of the health science center CEO's office or have responsibilities which encompass general university interests. By contrast, the majority of those on the teaching hospital list do not have full-time government relations responsibilities. They tend to be directors of medical education (in some cases with a different title), chief financial officers, or administrators with other specific operating responsibilities.

Policy Directions

Shortly after the AAHC group began to meet, officers of the Association of American Medical Colleges approached the leadership at the AAHC to express concern that the group as constituted excludes many people with essentially similar functions and interests in institutions not members of AAHC but members of AAMC. Another reason given for the apprehension within the AAMC was that institutional policies advocated by individual group members might be construed by congressional staffers as representing positions advocated by AAHC. Should these be at variance with positions of the AAMC, the impression might be created that AAHC and AAMC differ on a given issue. The resulting confusion could be counterproductive to the efforts of the two organizations.

The views of the AAMC concerning the AAHC Government Relations Representatives group were given due consideration by the Board of Directors of the AAHC. The AAHC Board felt that while the AAMC's concerns about the advocacy of positions are understandable and had merit, ways to minimize these occurrences could be devised, and that the positive factors stemming from the group formation (dissemination of timely information, better visibility for the institutions, opportunities for the group members to learn from each other, etc.), outweighed the risks. In effect, the AAHC Board reaffirmed its support for the group of Government Relations Representatives.

At the same time, discussions between the AAHC and AAMC on this subject continued at the AAHC/AAMC FORUM. The outcome of these discussions was that the members of the FORUM recommended as a solution the creation of a

single group of government relations representatives to be sponsored jointly by both associations. Presidents Hogness and Petersdorf were asked to develop guidelines and operational details for implementing the recommendation, and to seek the approval of their respective governance boards for a joint sponsorship and staffing of the group.

Proposed Guidelines

Following are the guidelines for the operation of the jointly sponsored group:

1. The present group of Government Relations Representatives will continue in existence. Its name will be group of Government Relations Representatives (GRR) of AAHC/AAMC institutions.

2. The group will be expanded to include, in addition to the representatives nominated by academic health center CEOs,

   a) representatives nominated by the medical school deans
   b) representatives nominated by the Council of Teaching Hospitals chief executive officers.

3. In soliciting the nominations from medical schools and teaching hospitals the AAMC will stress the following:

   a) Members of the group should be individuals on the staff of the institution; as much as feasible they should be actually involved in the institution's legislative liaison activities. It is understood that not all institutions have such positions, thus there could be institutions without representation in the group.

   b) For those institutions that are part of an academic health center (where the medical school and/or the hospital relate administratively to a vice president for the health sciences or other such position) the dean(s) and the hospital CEO(s) will be urged to consult with the health center CEO and with each other to coordinate nominations. At the very least the academic health center CEO should be informed of the medical school and hospital nominations. A current roster of the AAHC group as presently constituted, and of the medical school and hospital lists of government liaison staff previously obtained by AAMC, will be provided to facilitate the consultations.

4. The AAHC will ask the academic health center CEOs to extend reciprocity of consultation to the dean and hospital CEO when appointing individuals to the group.

5. Membership in the group is at the discretion of the institutional officers making the nomination. The members of the group represent the individual who nominated them, thus it will be assumed that they speak with his/her knowledge and on his/her behalf. The group will not be a voting organization. It will not have a formal governance structure.

6. A new membership roster will be prepared as soon as practical and will be distributed to all members of the group and to all the AAHC members and respective AAMC council members.

7. Government liaison staff of national organizations representing universities and health professions schools will be routinely invited to attend and participate in the general meetings of the group. If representatives of the AAMC Council of Academic Societies' organizations wish to participate, they will be welcome to do so. ★

8. General meetings of the group will be scheduled at regular intervals during the year and the dates announced well in advance.

9. The present group of Government Relations Representatives is guided by a steering committee of six members. Two committee members complete terms and two begin three-year terms at the beginning of each calendar year. The selection of the two new members is made by the incumbent committee.

   Once these guidelines are adopted there will be a chairman and chairman designate, who serve for one year in each of these two capacities. In the new jointly sponsored group the steering committee will be expanded to a total of nine people. The three new people will be chosen from representatives nominated by the teaching hospitals' CEOs. The present steering committee already includes people who are also deans' representatives. Thereafter, the steering committee will strive for institutional balance in the selection of new committee members, as well as for geographic and other characteristics.

10. The functions of the steering committee are: to provide leadership for the group; to act as the operational interface between the group and the staff of the AAHC and AAMC; to plan the dates and the agendas for the group's meetings; to suggest items of information that ought to be brought to the attention of the group's members; to suggest and help organize special meetings, when warranted, of selected group members with selected congressional staff people.

    In addition, the steering committee will facilitate the organization of a "whip network" for those occasions when it is necessary to inform the members of the group of critical situations that are developing so rapidly that there is not sufficient time for mail communication. The AAHC and AAMC staffs will be responsible for activating the network, including the preparation of the message, based on the nature of the occurrence and the reason necessitating the activation.

11. All communications and information flowing to the members of the group will originate from the AAHC/AAMC staff delegated to work with the group.

12. Logistical support for the group will be shared by AAHC and AAMC. Each association will assign a staff person who will function as the association's contact with the steering committee and with the

group. These two staff persons will maintain very close liaison on all issues and activities which, directly or indirectly, affect the group. Both staff persons will attend meetings of the group and of the steering committee.

13. The secretariat functions (mailings, setting up of meetings, updates of membership rosters, etc.) will be performed by AAHC and AAMC staff on rotation in alternate years.

The direct costs of the following items will be shared by AAHC and AAMC in proportion to the numbers of their respective institutional constituents who can nominate members to the group:

a) Postage and telegrams.
b) Printing of material distributed to the group.
c) Charges for conference space and refreshments for general meetings of the group and meetings of the steering committee.
d) Cost of functions such as luncheons, dinners and receptions for the group and/or the steering committee, and for special meetings with congressional staff, when both associations have agreed in advance to underwrite these costs. Ordinarily it will be expected that group members participating in these functions will bear the entire cost of food functions. Shortfalls in the collection of these reimbursements will be shared by AAHC and AAMC. All travel expenses including those of the steering committee will be borne by the individuals.

14. Subject to the approval of the AAHC and AAMC respective governance bodies, these proposed guidelines will become effective January 1, 1988.

RECOMMENDATION:

That the Council approve the proposed policies for the establishment of a jointly sponsored AAHC/AAMC group of government relations representatives.

GROUP ON MEDICAL EDUCATION

Background

The AAMC Group on Medical Education (GME) sponsors the Research in Medical Education (RIME) Program at the Annual Meeting and is active in discussion of medical education and curriculum issues at four regional meetings during the year. Membership in the GME is currently open to representatives appointed by the medical school (usually the Associate Dean for Medical Education or Academic Affairs); by CAS Societies and by COTH member hospitals. The AAMC Task Force on Groups has recommended that membership in GME be limited to decanal appointees.

CAS representatives to GME (list attached) have expressed varied opinions. Some, although titularly representatives, have never been active. Others are active and would wish to continue membership. A number of Society representatives have expressed the concern that faculty as well as associate deans should be represented on curricular issues.

Recommendation

The Council should debate the issue of CAS representation in GME for those societies who wish to appoint a representative and make a Council recommendation to forward to the AAMC Task Force.

REPORT ON NOVEMBER 1 DEAN'S LETTER RELEASE DATE

With relatively few exceptions, the schools expended considerable effort in their observance of the decision of the Council of Deans, the Council of Academic Societies and the AAMC Executive Council not tc release deans' letters prior to November 1. Approximately 90 percent of the schools complied with the decision despite the lateness of the announcement of the uniform release date.

Status of Cooperation of Residency Program Directors

- Despite the efforts of the Association of University Professors of Ophthalmology to encourage cooperation, the majority of problems experienced by schools and students were related to ophthalmology programs. These were chiefly concerned with the refusal of some programs to accept letters as late as November 1 and the tone of communications from many other programs and the Ophthalmology Matching Program.

- While problems were encountered with some orthopedic and radiology programs, the vast majority of program directors revised their deadlines for deans' letters.

- During September and October, a number of NRMP participating programs began to request transcripts prior to November 1---posing a problem for institutions that held all materials until November 1.

Status of Medical Schools' Compliance with the November 1 Release Date

- The AAMC received reports of some type of violation of the November 1 release date by 17 schools.
- The types of violations include the inadvertant release of letters due to misunderstanding or problems in communication, the content of a dean's letter being provided in another form, and deans' letters sent by a few schools that chose not to comply with the November 1 date.
- AAMC staff and national GSA officers worked through the schools to remedy the violations.

Although problems existed during the first year of implementation, the performance of the schools indicates a strong commitment to the concept of a uniform release date for deans' letters. This year's experience has helped to identify problems that need resolution. Discussion should focus on what alterations are required to achieve compliance by all schools and programs with a uniform release date for all materials in support of a residency application in 1988-89 and decide whether November 1 is a feasible date for 1988-89.

The Experiences of 1987 Graduates in Obtaining a Residency

The following tables are derived from the responses of 10,988 graduates who planned to enter graduate medical education this year. The specialty designators show the number of respondents who had definitely decided to pursue certification in that specialty.

TABLE 1

Percentage of Respondents Who Reported on When They Decided on the Specialty or Subspecialty They Desire to Practice*

Specialty	Before Medical School	During Years 1 & 2	During Year 3	During Year 4	Still Undecided	No. of Respondents
Anesthesiology	4.9	8.7	61.2	25.1	0.2	510
Dermatology	8.9	11.8	54.8	23.7	0.0	135
Emergency Medicine	18.0	10.9	46.5	22.5	1.1	284
Family Practice	29.8	10.8	40.7	17.8	0.5	1425
Internal Medicine	11.7	9.0	54.9	22.5	1.2	943
Neurology	13.3	12.0	53.3	21.3	0.0	150
Neurosurgery	17.0	18.2	52.3	11.4	0.0	88
Obstetrics/Gynecology	11.5	8.6	62.6	16.8	0.6	524
Ophthalmology	10.1	23.1	55.7	10.1	0.3	316
Orthopedic Surgery	25.0	18.2	45.4	10.3	0.7	456
Otolaryngology	4.3	16.2	68.1	10.3	0.5	185
Pathology	11.0	10.5	59.7	18.2	0.0	181
Pediatrics	20.0	5.9	58.0	15.3	0.6	524
Psychiatry	20.5	7.7	52.5	17.9	0.6	507
Radiology	5.6	10.6	62.5	20.1	0.9	538
Surgery	23.0	8.6	57.1	10.7	0.2	665
Urology	3.4	4.0	71.8	20.7	0.0	174
All Respondents	14.9	9.3	53.3	18.7	3.1	10988

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category

SOURCE: 1987 AAMC Graduation Questionnaire

Over half of the respondents had decided on a specialty during their 3rd year. Almost 19 percent made a decision in their 4th year, and nearly 15 percent had decided on a specialty before entering medical school.

TABLE 2

Percentage of Respondents Reporting When One or More Programs Required Deans' Letters and Transcripts*

Specialty	Prior to July	During July	Aug	Sep	Oct	Nov	Dec	No. of Respondents
Anesthesiology	2.1	4.9	15.4	25.8	36.8	35.2	32.9	510
Dermatology	0.7	0.7	1.4	8.8	11.1	34.8	57.7	135
Emergency Medicine	1.0	1.4	8.8	26.7	38.3	39.0	39.7	284
Family Practice	0.5	1.9	4.9	13.5	21.9	37.9	53.5	1425
Internal Medicine	0.6	1.0	3.0	7.4	20.0	44.5	56.4	943
Neurology	0.0	4.0	6.0	22.0	22.6	40.6	20.6	150
Neurosurgery	1.1	3.4	37.5	64.7	36.3	9.0	2.2	88
Obstetrics/Gynecology	0.1	1.3	6.2	27.0	42.5	56.4	36.0	524
Ophthalmology	5.6	18.6	48.7	39.8	6.6	17.4	31.9	316
Orthopedics	2.6	6.3	50.2	83.3	72.8	35.5	14.4	456
Otolaryngology	6.4	23.7	78.3	72.9	34.0	10.2	5.9	185
Pathology	0.5	0.0	6.0	20.4	31.4	41.9	48.0	181
Pediatrics	0.9	1.3	4.0	8.5	13.3	37.4	57.2	524
Psychiatry	0.5	2.5	17.3	28.4	29.9	27.4	33.3	507
Radiology	1.3	4.8	17.6	44.9	46.2	35.5	27.6	538
Surgery	1.3	1.5	10.6	30.0	39.5	48.8	46.6	665
Urology	0.5	5.7	31.6	60.9	36.2	19.5	3.4	174
All Respondents	1.2	3.3	12.7	24.3	29.3	39.0	43.2	10988

*Percentages do not add to 100 because each cell excludes the percentage of nonresponses and the percentage of students reporting that programs did not require letters and transcripts in that time period.

SOURCE: 1987 AAMC Graduation Questionnaire

Early requests (July & August) for deans' letters and transcripts were most frequent from programs in neurosurgery, ophthalmology, orthopedics, otolaryngology and urology.

TABLE 3

Percentage of Respondents Reporting that One or More Programs Required National Board of Medical Examiners Scores*

Specialty	Part I	Part II	No. of Respondents
Anesthesiology	86.1	26.7	510
Dermatology	70.4	29.6	135
Emergency Medicine	85.9	25.0	284
Family Practice	72.8	25.0	1425
Internal Medicine	75.0	27.5	943
Neurology	72.0	20.7	150
Neurosurgery	88.6	26.1	88
Obstetrics/Gynecology	84.7	39.7	524
Ophthalmology	77.8	20.6	316
Orthopedic Surgery	88.8	28.9	456
Otolaryngology	88.6	29.7	185
Pathology	64.1	19.9	181
Pediatrics	65.3	21.4	524
Psychiatry	52.1	12.4	507
Radiology	83.8	30.7	538
Surgery	82.4	36.2	665
Urology	84.5	23.0	174
All Respondents	76.1	26.8	10988

*Percentages do not add to 100 percent because each cell excludes the percentage of nonresponses and the percentage of students who reported that programs did not require this type of NBME score.

SOURCE: 1987 AAMC Graduation Questionnaire

Over three-fourths of the respondents were asked to submit NBME Part I scores to one or more programs. Neurosurgery, orthopedic surgery and otolaryngology had the highest rates at 88 percent. NBME Part II scores were most frequently requested by OB/GYN programs.

TABLE 4

Percentage of Respondents Who Were Told by One or More Programs that They Were More Likely to be Selected if They Took an Elective in the Specialty at that Institution*

Specialty	Percent	No. of Respondents
Anesthesiology	34.9	510
Dermatology	22.9	135
Emergency Medicine	68.3	284
Family Practice	38.5	1425
Internal Medicine	33.1	943
Neurology	16.3	150
Neurosurgery	84.1	88
Obstetrics/Gynecology	60.1	524
Ophthalmology	25.3	316
Orthopedic Surgery	87.5	456
Otolaryngology	71.4	185
Pathology	18.8	181
Pediatrics	35.1	524
Psychiatry	34.9	507
Radiology	34.3	538
Surgery	51.4	665
Urology	64.9	174
All Respondents	42.7	10988

*The percentage of nonresponses and the percentage of students reporting that no programs made this suggestion are excluded.

SOURCE: 1987 AAMC Graduation Questionnaire

Over 60 percent of candidates for programs in emergency medicine, neurosurgery, obstetrics/gynecology, orthopedic surgery, otolaryngology and urology were told than an "audition elective" would be advantageous. At 87.5 percent, orthopedics had the highest rate of suggesting an audition elective.

TABLE 5

Percentage of Respondents Who Took Two or More Electives in the Specialty in Which They Planned to Take a Residency*

Specialty	At Own Institution	At Other Institution	No. of Respondents
Anesthesiology	25.5	11.2	510
Dermatology	33.4	11.1	135
Emergency Medicine	19.0	21.8	284
Family Practice	16.6	9.0	1425
Internal Medicine	70.7	22.9	943
Neurology	28.7	9.3	150
Neurosurgery	14.8	30.7	88
Obstetrics/Gynecology	26.5	21.8	524
Ophthalmology	32.8	19.1	316
Orthopedic Surgery	23.2	37.0	456
Otolaryngology	16.2	27.0	185
Pathology	34.8	7.2	181
Pediatrics	63.7	26.1	524
Psychiatry	27.4	15.8	507
Radiology	28.4	12.9	538
Surgery	35.8	24.1	665
Urology	20.7	18.4	174
All Respondents	39.2	19.2	10988

*Percentages do not add to 100 percent because the percentage of nonresponses, the percentage of students reporting one or no electives, and the percentage for whom the number was unclear are excluded.

SOURCE: 1987 AAMC Graduation Questionnaire

Two or more electives in the specialty planned for graduate medical education were taken by 39 percent of the respondents at their own institutions. This figure is inflated by the 71 percent and 64 percent who did electives in medicine and pediatric subspecialties. Candidates for neurosurgery and orthopedics had the highest frequency of electives at other institutio

TABLE 6

Percentage of Respondents Reporting That One or More Programs Programs Asked Them to Make a Commitment Before the Match*

Specialty	Percent	No. of Respondents
Anesthesiology	18.4	510
Dermatology	8.9	135
Emergency Medicine	3.8	284
Family Practice	6.6	1425
Internal Medicine	7.8	943
Neurology	11.4	150
Neurosurgery	7.9	88
Obstetrics/Gynecology	14.9	524
Ophthalmology	10.5	316
Orthopedic Surgery	28.7	456
Otolaryngology	8.1	185
Pathology	43.1	181
Pediatrics	6.7	524
Psychiatry	53.2	507
Radiology	36.5	538
Surgery	7.2	665
Urology	14.4	174
All Respondents	14.3	10988

*The percentage of nonresponses and the percentage of students reporting that no programs asked for a commitment before the match are excluded.

SOURCE: 1987 AAMC Graduation Questionnaire

Respondents' reports of being asked to make a commitment before the match ranged from a high of 53.2 percent for psychiatry to a low of 3.8 percent for emergency medicine.

TABLE 7

Number of Days Spent Away from Medical School Applying and Interviewing for a Residency Position*

Specialty	Percentage of Respondents Who Spent 0-7 Days	8-14 Days	15-21 Days	Over 21 Days	Average Days Spent	No. of Respondents
Anesthesiology	20.2	27.5	23.7	25.6	18	510
Dermatology	33.4	30.4	14.1	14.1	14	135
Emergency Medicine	16.9	23.6	25.7	30.7	19	284
Family Practice	27.9	31.4	19.2	16.4	15	1425
Internal Medicine	25.3	27.1	22.8	21.3	17	943
Neurology	20.0	28.7	20.0	28.7	18	150
Neurosurgery	11.4	19.3	27.3	34.1	22	88
Obstetrics/Gynecology	18.5	24.2	23.5	27.5	19	524
Ophthalmology	19.0	24.4	26.9	27.8	18	316
Orthopedic Surgery	16.4	18.6	30.7	29.2	20	456
Otolaryngology	15.7	21.1	27.0	31.3	20	185
Pathology	31.5	32.6	14.4	16.6	13	181
Pediatrics	25.2	29.6	22.3	18.3	16	524
Psychiatry	31.1	28.8	17.9	16.8	14	507
Radiology	17.9	23.4	23.2	32.6	19	538
Surgery	11.3	19.2	27.5	38.5	22	665
Urology	10.9	15.5	26.4	43.7	23	174
All Respondents	22.1	26.1	22.8	24.6	18	10988

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.

SOURCE: 1987 AAMC Graduation Questionnaire

An average of 18 days was spent applying and interviewing for a residency position. The highest number (23) was reported by candidates for urology. The lowest number (13) was reported by candidates for pathology.

TABLE 8

Number of Dollars Spent Applying and Interviewing for a Residency Position*

Specialty	Percentage of Respondents Who Spent $0-499	$500-999	$1,000-1,499	$1,500 or more	Average Dollars	No. of Respondents
Anesthesiology	23.7	22.9	17.5	33.3	1148	510
Dermatology	43.0	17.0	17.8	14.1	755	135
Emergency Medicine	18.7	19.4	16.9	42.3	1312	284
Family Practice	50.9	22.0	13.2	10.6	634	1425
Internal Medicine	36.8	23.3	17.5	20.1	903	943
Neurology	26.6	26.0	13.3	31.4	1144	150
Neurosurgery	3.4	11.4	12.5	67.1	1955	88
Obstetrics/Gynecology	27.1	22.5	16.6	29.8	1189	524
Ophthalmology	14.8	21.2	15.8	46.5	1547	316
Orthopedic Surgery	13.2	19.7	19.1	45.6	1478	456
Otolaryngology	10.2	16.8	17.3	51.9	1649	185
Pathology	35.9	23.8	12.2	22.6	924	181
Pediatrics	36.1	25.2	14.5	20.4	872	524
Psychiatry	33.2	24.3	16.8	20.9	967	507
Radiology	24.5	18.4	16.5	38.2	1234	538
Surgery	16.8	18.5	20.3	42.4	1468	665
Urology	9.1	19.5	21.3	48.2	1632	174
All Respondents	30.7	22.1	16.6	27.2	1064	10988

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.

SOURCE: 1987 AAMC Graduation Questionnaire

On average, respondents spent $1064 applying and interviewing for a residency position. Candidates for neurosurgery spent the most and candidates for family practice spent the least.

TABLE 9

Extent to Which Pursuit of a Residency Influenced Choice of Electives and Organization of Clinical Education*

Specialty	Primary or Major Influence	Minor or No Influence	No. of Respondents
Anesthesiology	76.6	22.3	510
Dermatology	70.4	29.6	135
Emergency Medicine	83.1	13.8	284
Family Practice	60.7	37.2	1425
Internal Medicine	64.9	33.5	943
Neurology	59.4	39.3	150
Neurosurgery	80.7	17.1	88
Obstetrics/Gynecology	71.2	25.8	524
Ophthalmology	84.2	14.5	316
Orthopedic Surgery	88.2	10.1	456
Otolaryngology	85.4	11.4	185
Pathology	61.3	35.9	181
Pediatrics	64.1	33.2	524
Psychiatry	60.2	36.9	507
Radiology	77.3	21.2	538
Surgery	77.7	21.1	665
Urology	85.1	13.7	174
All Respondents	70.1	27.8	10988

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.

SOURCE: 1987 AAMC Graduation Questionnaire

Seventy percent of candidates indicated that pursuit of a residency had a primary or major influence on their choice of electives and organization of their clinical education. For over 80 percent of candidates for emergency medicine, neurosurgery, ophthalmology, orthopedic surgery, otolaryngology and urology, pursuit of a residency was a primary or major influence.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #87-40

August 28, 1987

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

FROM: Robert G. Petersdorf, M.D.

RE: Update on Loan Deferments for the Guaranteed Student Loan (GSL) and Supplemental Loans to Students (SLS) Programs

* This memorandum concerns two issues related to loan deferments for the GSL and SLS programs. The first is a provision in the recently enacted Higher Education Technical Amendments Act of 1987 that specifies that residents are eligible for two years of loan deferment, but only if they are new borrowers on or after July 1, 1987. The second item relates to a recent ruling by the Department of Education which states that "a borrower who is enrolled in a residency program at an eligible institution, may, if he/she is considered by the school to be a full-time student, receive a deferment based on in-school status." Institutions may wish to evaluate current practices in this area as a result of this ruling.

Following Executive Council discussion and action, the Association sent out an advisory position on loan deferments for the GSL and SLS programs last February (Memorandum #87-7) and has continued to be active in the area. A number of significant developments have recently occurred.

First, the Higher Education Technical Amendments Act of 1987, enacted on June 8, explicitly stated that health professions residents are eligible for two years of post-degree deferment. This clarification had been sought by the AAMC and other health professions education associations in light of a November 10, 1986, final rule for the GSL and SLS programs. The final rule had required individuals seeking "internship" deferments to provide considerable documentation including a statement from the appropriate state licensing agency that such "internship" (in this case, residency) is required in order to begin "professional practice or service" in the state. This had the effect of reducing the previous two year deferment in many states. Furthermore, many licensing agencies have been unwilling to provide borrowers with the statements they need in order to receive deferments.

Unfortunately, the provision in the technical amendments did not achieve its full purpose. It is not retroactive, as Congress intended, but applies only to individuals who borrow a GSL or SLS for the first time after July 1, 1987. Therefore, this provision is of almost no help to our graduates, and we regret to inform you that the November 10 regulation remains in effect for virtually all M.D.s now entering repayment.

In light of the problem with the technical amendment and the continued applicability of the November 10 rule to many borrowers, the AAMC has offered to compile centrally a list of the licensure requirements for M.D.s in each state and have them disseminated by the Department of Education (ED) to lenders and state guarantee agencies so that they would know the appropriate length of medical residency deferments in each state. This would eliminate the need for individual borrowers to obtain the statements from the licensing boards. ED has accepted this offer (see Question #2 in the attached letter, as well as ED's response) and the AAMC will soon begin to contact licensing agencies. However, this process cannot be expected to be a speedy one; the AAMC will inform you when it is completed.

In addition, AAMC's legislative staff will attempt to alter the provision included in the technical amendments legislation so that it may apply to all GSL borrowers, regardless of when they received the loans. This will ensure that all residents receive at least two years of deferment. AAMC staff have already discussed with Committee staff the continued problems in this area.

On another important and related matter: In response to numerous concerns expressed about the effects on residents that the AAMC's advisory opinion on loan deferments would have had (if followed uniformly), AAMC staff met earlier this summer with representatives from the Department of Education (ED) to discuss how residents enrolled as students at "eligible" institutions of higher education, e.g., medical schools, should be treated for the purposes of loan deferments. The AAMC subsequently placed its understanding of ED's position on this subject in writing, and has now received a formal response from the Department. The AAMC's communication on this subject is to be found in Question #3 of the attached letter; ED's position is located on the bottom paragraph of the first page of its response. As you can see, ED has stated that "a borrower who is enrolled in a residency program at an eligible institution, may, if he/she is considered by the school to be a full-time student, receive a deferment based on in-school status." This opinion may be of considerable relief to schools and residents, and we commend it to your attention.

Attachments

cc: Deans for Student Affairs
Student Financial Aid Officers

aamc association of american medical colleges

July 16, 1987

Mr. Larry Oxendine
Acting Chief
Guaranteed Student Loan Branch
U.S. Department of Education
Regional Office Building #3, Room 4310
7th & D Streets, S.W.
Washington, D.C. 20202

Dear Mr. Oxendine:

First, we want to thank you and Mr. George Harris for spending so much time last Thursday speaking with Carolyn Henrich, Wendy Pechacek and us. The session was extremely informative and productive, even if there remain some areas in which it appears that our graduates will face complications. In order to minimize such situations, it would be enormously helpful if you could confirm our understanding relating to current and potential ED practices regarding deferments under the GSL and SLS programs. The fact that most internships and residency cycles began on July 1 means that the sooner we receive clarification on these items--and are thus able to inform our schools--the sooner the GSL and SLS programs can function smoothly in these areas (resulting, we hope, in a sharp drop-off in the incessant phone calls coming in to all of us on these matters).

1. The first clarification relates to the current regulation governing internship deferments for GSL and SLS loans. As you know, under this rule, state licensing agencies are required to certify that a borrower has a bachelor's degree before entering an internship or residency program. Unfortunately, state agencies are not able to provide this information, for two reasons. The first is that it is generally a medical or dental degree--M.D., D.D.S. or its equivalent--that is required to enter a residency program, not a bachelor's degree, and secondly, state licensing agencies simply do not gather information on whether individual residents have met these requirements. To do so would be an enormously time-consuming process. Therefore, we wish to clarify that this information does not need to be provided by licensing agencies in the case of medical or dental residents, who clearly have a level of educational achievement beyond the bachelor's degree in order to enter such programs.

2. The AAMC remains interested in reducing the administrative burdens associated with Sections 682.210 (g)(1) and (2) of the regulations for borrowers, state licensing agencies, and ED alike. The AAMC believes that the administration of this portion of the deferment regulations could be immeasurably streamlined, without in any way altering or diminishing its effect, if each individual state licensing agency were

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

simply required to specify to ED which types of internship and residency programs must be successfully completed by borrowers before they can be certified by the agency for professional practice or service. Under this proposed arrangement, a state licensing agency could simply articulate the conditions that must be met by all physicians in the state before they can be licensed to practice medicine; the information could then be communicated to guaranty agencies. Individuals wishing to obtain deferments could then provide documentation to lenders that they are in fact enrolled in a program that is required by the state for licensure. This mechanism would result in an "cleaner", simpler approval arrangement.

3. While residents in certain health professions programs (except new borrowers after July 1, 1987) may not qualify for deferments based on their involvement in residency programs, we wish to clarify our understanding that participants in residency programs based at institutions which are part of, or affiliated with, eligible institutions of higher education, can receive deferments based on their "in-school" status.

It is our wish to inform our schools about the Department's position on the items we have mentioned above as soon as possible. Currently, there are unanswered questions, and many of our financial aid administrators are confused because they have received conflicting information. In order to resolve the problems quickly, we ask that you return a signed copy of this letter if you agree with the understandings we have expressed. We thank you for your attention and response in this matter. If you have questions relating to our letter, or desire further clarification, please do not hesitate to call us at the telephone numbers noted below.

Sincerely,

David Baime

David Baime
Assistant Director, Office of Government Relations,
AAMC, 828-0525

Marty Liggett

Marty Liggett
Legislative Counsel and Director, Office of Government Affairs,
AADS, 667-9433

UNITED STATES DEPARTMENT OF EDUCATION
WASHINGTON, D.C. 20202

AUG 12 1987

Mr. David Baime
Assistant Director
Office of Government Relations
Association of American Medical Colleges

Ms. Marty Liggett
Legislative Counsel and Director
Office of Government Affairs
Association of American Dental Schools

Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Mr. Baime and Ms. Liggett:

Thank you for your letter of July 16, in which you requested our approval of recommendations you have made concerning the internship deferment provisions in the Federal regulations governing the Guaranteed Student Loan (GSL) and the Supplemental Loans for Students (SLS) programs (34 CFR 682.210(g)). You have also requested confirmation of the understandings reached during our meeting of July 9, 1987. Mr. George Harris, of my staff, and I would like to thank Ms. Carolyn Henrich, Ms. Wendy Pechacek, and both of you, for providing us with your insights about the problems involving this deferment.

We agree that by virtue of the fact that an individual has a medical degree, e.g., M.D., or has attained the education necessary to enter a medical internship program, indicates that the internship program requires the individual to have at least the equivalent of a bachelor's degree. Therefore, State licensing agencies may use this letter as their authorization to certify that medical internship programs require at least a baccalaureate degree.

While we do not plan to compile the list discussed in item two of your letter, we would be happy to distribute such a list to the guarantee agencies for their use if it was compiled by your organization.

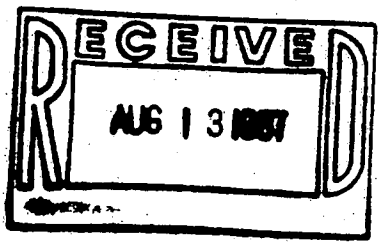
Your understanding is correct that a borrower who is enrolled in a residency program at an eligible institution, may, if he or she is considered by the school to be a full-time student, receive a deferment based on "in-school" status.

I hope that this response has provided you with information that will be useful to your constituents. Once again, thank you for the information which you have shared with us concerning medical and dental internships. Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Larry Oxendine

Larry Oxendine
Acting Chief
Guaranteed Student Loan Branch
Division of Policy and
Program Development



JCAH'S PROPOSED SURVEY GUIDELINES FOR ACADEMIC HEALTH CENTERS

At its April, 1987 meeting, the Executive Council reviewed a report by the Joint Commission on Accreditation of Hospitals on the "Assessment of Teaching and Research Contributions to Systematic Quality Assurance in Academic Health Centers." The report, prompted by academic medical centers hospitals' (AMCH) generally poor record for meeting JCAH quality assurance standards and complaints by hospitals that the JCAH does not recognize their unique characteristics and quality enhancing features, identified problems with the survey process for AMCH's and possible solutions. The JCAH recently developed its plan to improve the survey process for AMCH's. The plan consists of (1) the addition of a physician with AMCH experience to the survey team and (2) new survey guidelines designed to assess the extent to which teaching and research activities contribute to compliance with Joint Commission standards. The proposed guidelines, which are attached, will be field tested at three or four academic health center sites this fall. At the conclusion of the field test, the results and surveyors' recommendations will be referred back to the JCAH for final review and adoption.

Joint Commission on Accreditation of Hospitals

MEMORANDUM

DATE: July 16, 1987

TO: Standards and Survey Procedures Committee

FROM: Donald W. Avant

SUBJECT: Survey Guidelines for Academic Health Centers

At the March 1987 S-SP Committee meeting, staff presented a report on academic health centers' performance regarding Joint Commission monitoring and evaluation standards. The report detailed the generally poor record of academic health centers in meeting these standards as well as the contributing causes, and concluded that the unique characteristics of academic health centers with respect to their teaching and research activities is not fully considered in our current survey process. In order to address this situation, staff requested Committee approval to develop a set of survey guidelines especially adapted to the academic health center environment. Pursuant to the Committee's approval, the attached survey guidelines are provided for Committee consideration. The guidelines are designed to assess the degree of substantive contribution of teaching and research activities conducted by an academic health center towards compliance with Joint Commission monitoring and evaluation standards.

Staff now requests S-SP Committee approval to field test the survey guidelines at three to four academic health center sites. The results of the field test would be presented to the next S-SP Committee meeting in November 1987.

These survey guidelines were presented to the Hospital Accreditation Program's Professional and Technical Advisory Committee which endorsed the field test of the guidelines.

Recommendation

*** The S-SP Committee is requested to approve a field test of the draft survey guidelines in 3-4 academic health centers, with the understanding that the field test results and appropriate recommendations will be presented at the November 1987 S-SP Committee meeting.

attach.

CONTENTS

INTRODUCTION

In 1986, the Joint Commission on Accreditation of Hospitals conducted a study for the purpose of assessing the contribution of teaching and research in academic health centers (AHC) to systematic quality assurance. The objectives of the study were

1. To determine the extent to which clinical teaching and clinical research now comprise or could constitute planned and systematic, ongoing quality assurance, as defined by JCAH standards.

2. To assess the effectiveness of clinical teaching and clinical research in monitoring and improving the quality and appropriateness of patient care as set forth in the generic model for monitoring and evaluation.

The study was based on structured site visits and accreditation surveys of 13 University Hospitals and five major AHC-affiliated hospitals. Among the conclusions of the study were the following:

1. AHC hospitals have unique characteristics which set them apart from non-AHC hospitals. These are their wide range of expertise at subspecialty and sub-subspecialty levels of care; the openness and pervasiveness of concurrent review of care; and extensive clinical research.

2. Based on current physician surveyor guidelines, AHC hospitals have low levels of compliance with all clinical medical staff standards for quality assurance, particularly the monitoring and evaluation of quality and appropriateness (M&E of Q&A).

3. Certain AHC teaching and patient care review functions potentially lend themselves to efficient adaptation to the M&E model. These include morbidity and mortality conferences; correlation conferences; and various clinical prospective control mechanisms.

4. Subspecialist level consultations, expert second opinions, and consensus techniques could be accepted as the equivalent of criteria in applying the M&E model to AHC hospitals.

5. Guidelines are needed for judging the adequacy of scope of review of tertiary-level care in the multiple subspecialty units, in relation to the M&E model.

6. The survey process should include evaluation of the scope of clinical research that involves diagnosis or treatment in relation to the M&E model. Guidelines are also needed for this.

7. There are no compelling arguments for adopting new JCAH standards specifically for AHC hospitals. The concerns can best be addressed through modifications in the survey process.

8. AHCs firmly support voluntary accreditation and are willing to actively cooperate with JCAH in devising means of taking their unique characteristics into appropriate account in the survey process.

These conclusions are the basis of the proposed modifications of and additions to the surveyor guidelines for the Hospital Accreditation Program (HAP) physician surveys of AHC. They apply only to University Hospitals and affiliated principal teaching hospitals of such centers. The latter include only those which are equivalent to University Hospitals in (1) direction and staffing by full-time faculty members, (2) participation by the full-time faculty in patient care, (3) teaching and training of medical students, residents, fellows and trainees, and (4) major programs of clinical research. The modifications acknowledge the unique resources and capabilities of these AHC hospitals to meet the basic intent of the JCAH standards for quality assurance if not the exact procedural requirements defined in the standards. The specific resources and capabilities which are believed to meet this requirement are limited to the following:

1. The high degree of specialization and subspecialization in the clinical departments, i.e., the highest levels of clinical expertise in the evaluation and management of patients presenting with rare conditions or with unusual or unusually severe manifestations or problems in management of common disorders ("tertiary-level care").

2. The conduct of clinical research and clinical trials, the results of which are the basis for continual improvement in standards of diagnosis and treatment.

3. Concurrent and prospective control mechanisms for assuring the quality and appropriateness of patient care, i.e., subspecialist-level consultations; mandatory independent expert reviews of patient management; use of expert consensus in arriving at difficult diagnoses or in formulating complex treatment plans.

The AHC study identified several widely prevalent teaching and patient care review activities which are implicitly conducted as forms of quality assurance. Additional text is provided below to assist surveyors in their consultative function of advising AHC as to alternate means of modifying these activities into compliant forms of M&E.

The proposed additions do not exempt AHC from compliance with any JCAH standards. The specific areas addressed by the proposed modifications and additions to the survey process are:

A. M&E of Q&A in the major clinical departments and clinical support serviced.

1. Compliance of specified types of clinical research with the intent of M&E.

2. Application of subspecialty expertise in place of explicit criteria.

3. Multiple independent consultations in place of explicit criteria.

4. Expert consensus in interpretations of diagnostic imaging and pathologic tissue.

5. Concurrent and prospective procedures.

B. Sampling of high frequency procedures

1. Surgical case review.

2. Blood usage review.

Many of the AHC's combined teaching and patient care review functions implicitly and informally evaluate patient care. Examples are morning report; work rounds, teaching rounds, grand rounds; clinical conferences; clinical-pathological conferences; case presentations; and seminars. Usually, little formal record is kept of the proceedings and conclusions of these activities, except for what may be written in progress notes or in consultant reports. The current HAP Scoring Guidelines, with the addition of a few details, are sufficient for judging compliance of these functions with the M&E requirement.

The greatest difficulty is assessing the scope of M&E in relation to the highly specialized clinical diagnostic and treatment services required by the tertiary-level patient population which is dispersed among a large number of subspecialty departments and services. These units often conduct clinical research and clinical trials. New guidelines are presented for assessing the extent to which such subspecialist care and clinical research meet the intent of M&E, i.e., a systematic process which leads to demonstrable improvement in all important aspects of patient care.

To make this assessment possible, it will be necessary for AHC surveyors to collect and analyze considerably more data and information than is now the case. This cannot be effectively undertaken during HAP surveys, as presently conducted, because of limitations of time and limited familiarity of many surveyors with these highly specialized clinical activities. Compiling the required information will require the assistance of a new member on the survey team. This consultant physician surveyor should be selected on the basis of suitable clinical background in AHC and familiarity with clinical research and subspecialty care of tertiary-level patient populations.

GUIDELINES FOR CONSULTANT PHYSICIAN SURVEYOR

In surveys of AHC, the consultant physician surveyor performs the following functions:

A. Identify major categories of tertiary level patients.

1. This is applicable to the subspecialties of the major clinical departments, most commonly medicine, surgery, pediatrics, obstetrics-gynecology, and psychiatry.

2. Examine each department's patient profile which displays the frequency distributions of diagnoses and/or conditions and of operations and/or procedures. From this, in consultation with the respective Chairman or Chief, identify the proportion of patients in each specialty and subspecialty area that could be classified as "tertiary", e.g., rare clinical conditions or unusual or difficult presentations or complications of common conditions; diagnostic puzzles; experimental operations and procedures; patients requiring experimental radiation or chemotherapy or other drug treatment, or any form of management that is only available in AHC.

3. For each major specialty and subspecialty, enter on Data Summary I the number of patients per year in each and the percent of the total that meet criteria for "tertiary-level". Enter the same information for secondary-level patients.

B. Identify clinical research that corresponds to M&E.

1. The types of clinical research which meet the intent of M&E are:
   a. Reports of cumulative experience in diagnosis and treatment of patients

   b. Research that improves diagnosis and/or treatment in secondary-level patients, i.e., conditions for which standards are generally known and applied in the average hospital

   c. Research that results in the development of standards of care for tertiary level patients

   d. Cooperative clinical trials or protocol-driven studies which involve the monitoring of patient response to treatment, including short-term and long-term outcomes

   e. Clinical studies of differential diagnosis or diagnostic sensitivity, specificity, or predictive findings

   f. Refinement of indications for and results of experimental surgical procedures

   g. Clinical investigations of the management of patients with various end-stage conditions with poor prognoses

   h. Outcome studies which include evidence of clinical benefit to patients participating in the studies

   i. Clinical trials of innovative approaches to hospital-based clinical management of patients

To be classified as the equivalent of M&E, the clinical research must both (1) involve evaluation or care or follow-up of patients and (2) contain evidence that participating patients were clinically benefitted he research. Examples of research which do not qualify as meeting the intent of M&E are all forms of bench research, clinical epidemiology, nosology, critical reviews of tne literature, studies of utilization, health services research does not directly benefit patients, e.g., analysis of discharge data, adjusting mortality rates for risk factors.

2. From each subspecialty area within the department, obtain a list of publications for the preceding three years and of clinical research in progress. The annual report of the department may be a useful source. Identify those studies whose title suggests they meet the criteria listed above. Obtain reprints of a reasonably representative sample of these and determine whether the studies meet one or more of tne listed criteria.

3. Based on your findings, estimate the percent of the clinical research conducted by each major subspecialty in the preceding three years that meets the intent of M&E. Enter the estimated percent on Data Summary I under column 4, "% compliant clinical research."

C. Estimate the proportion of the tertiary patient population included in the relevant clinical research.

1. For each major subspecialty, estimate the percent of tertiary-level and secondary-level patients that have been included in the clinical research that meets the survey criteria. Base these estimates on the number and types of subjects included in the sample of studies you examined in the reprint provided, augmented as indicated by discussion with various clinical investigators.

2. enter these estimates in columns 1A and 1B of Data Summary II for each department and subspecialty

D. Estimate the proportion of the tertiary- and secondary-level patient population that is managed by subspecialists or under the direction of subspecialists.

1. Obtain a listing of all regularly scheduled subspecialty conferences, rounds, clinics, seminars, and any other clinical teaching or patient care review functions. Routine teaching rounds that do not involve the attendings or residents responsible for the patients' care are not included.

2. Review reports or entries in a sample of current patient records that describe the results of such sessions. Interview the subspecialists, residents or fellows regarding the types of patients included in these functions and the approximate proportions of tertiaryand secondary-level patients. Examine samples of consultant reports on patients and determine whether the consultative advice was followed.

3. Based on the information from these sources, estimate the proportion of tertiary- and secondary-level patients in each major subspecialty that are either directly managed by subspecialists or receive formal, explicit consultation which significantly affects the management of the cases.

4. Enter the estimated percents in columns 2A and 2B of Data Summary II.

E. Complete Data Summary I and II.

1. Under "Comments" on Data Summary I:

a. State the number of reprints you examined for each major department and the sample size it represents, based on the total of published studies whose titles suggested they met the survey criteria for being considered as a form of M&E.

b. Briefly describe the degree of variability or consistency you observed within and across subspecialities in their conduct of patient-oriented clinical research that met the survey criteria.

c. Indicate the degree of confidence to be placed on the estimates for the various subspecialties.

d. Place the reprints you examined in the JCAH envelope that you were provided.

e. Add any other information that you believe should be considered in interpreting the data.

2. Under "Comments" on Data Summary II:

a. Briefly indicate the degree of confidence to be placed on the estimated percents of patients included in M&E that conforms to the intent of M&E.

b. State the same for the estimates of percents of patients receiving subspecialist care.

c. Add any other comments which you believe are relevant to the interpretation of the data.

SURVEY GUIDELINES FOR JCAH SURVEYOR

The following modifications to survey guidelines apply only to University Hospitals and any affiliated principal teaching hospitals that have equivalent teaching, clinical research, facilities and equipment for patient care or access to equivalent facilities and equipment. The modifications are necessary for two principal reasons. First, AHC have co-equal responsibilities for teaching and research in addition to patient care. The contributions of the teaching functions and clinical research to monitoring and improving patient care must be systematically assessed. Secondly, most University Hospitals and other principal teaching hospitals have a high degree of subspecialization within

major departments. In addition, support services such as Anesthesiology and Radiology usually have departmental status. Consequently, there is insufficient time for the physician surveyor to adequately assess the quality assurance functions in all major clinical departments and services. For these reasons, two modifications have been made in the survey process for AHC hospitals:

1. A consultant surveyor with a current AHC background in clinical teaching, research and patient care will evaluate the qualitative and quantitative contribution of clinical research and subspecialty level expertise to the monitoring and evaluation of the quality and appropriateness of patient care. The consultant will obtain data on the proportion of the patient population in each specialty and subspecialty which represents tertiary-level complexity or severity of illness or condition and thus requires the unique expertise of an AHC hospital. The consultant will provide an estimate of the proportion of such patients as well as secondary-level patients that are receiving benefit from clinical research or from subspecialty expertise in their management that is comparable to conventional monitoring and evaluation of patient care.

2. The JCAH surveyor will survey the compliance of all clinical departments with the M&E standards as they pertain to more routine or secondary-level patients in the usual fashion. Certain functions are to be recognized as significantly but not substantially meeting the intent of some Required Characteristics (RC) of the generic M&E standard. Specifically, the following will be recognized in lieu of explicit criteria:

   a. Subspecialist determinations in evaluating the appropriateness of procedures or patient management

   b. Expert consensus in interpreting images or tissue

   c. Mandatory independent consultations for elective operations and invasive procedures

   d. Disease- or condition-specific protocols

In addition, AHC will be permitted to sample high frequency operations, procedures and transfusion therapy without having first to conduct 100% reviews.

Given the ongoing reviews of care in the course of the many conferences, consultations, special studies and the like, it is understandable that faculty of AHC believe they are complying fully with the intent of JCAH standards. Similarly, the objection to "documentation for documentation's sake" is unarguable. However, the evaluation of AHCs identified a number of steps that could be taken to convert a number of these now implicit, unrecorded processes of review into valid forms of M&E. These will be described below as aids to JCAH surveyors when consulting with AHC on alternate acceptable means of complying in non-burdensome ways with the M&E requirements.

A. Acceptable Alternatives to Explicit Criteria in the Generic M&E Model (pp. 29 - 30 of HAP Scoring Guidelines).

Certain forms of concurrent or prospective review or control of care based on subspecialist clinical knowledge and judgement will be accepted as significantly complying with the requirement that M&E of Q&A include the application of criteria which reflect "current knowledge and clinical experience".

1. MS 6.1.1.3.3 and MS 6.1.1.3.3.1. These are the Required Characteristics on which to score compliance with the use of criteria in M&E in any specialty or subspecialty that is classified as a department in the medical staff bylaws or rules and regulations. Judgement by single-disease subspecialists (e.g., diabetologists or diabetic retinopathologists), or single procedure surgeons (e.g., removing pituitary tumors) or physicians with only tertiary care responsibilities (e.g., neonatal intensivist) will be scored as "2" in the absence of written criteria. If a support service is not a department or major service, compliance is scored as indicated below.

2. AN 5.2.1.2.1. In subspecialized departments, designated anesthesiologists may provide care only for patients undergoing cardiac surgery or neurosurgical procedures or for patients with severe trauma. In such situations, AN 5.2.1.2.1 is scored as "2" without written criteria.

3. DR 4.2.1.2.1. In departments with abdominal or CNS or pediatric radiologists, the consensual judgements of such highly specialized individuals can be scored as "2" in the absence of written criteria.

4. ER 9.2.1.2.1. Many AHC have developed clinical algorithms or protocols to guide staff management of patients presenting with commonly seen emergency situations. Such algorithms are acceptable as significantly fulfilling the function of criteria if derived from the literature and if the use of such algorithms is uniformly enforced.

5. PA 7.2.1.2.1 M&E of the accuracy of interpretations of tissue by pathologists who are known through their research as experts in single diseases or disease groups can be rated a "2" without use of written criteria.

6. RA 4.2.1.2.1. In M&E of care of oncology patients, radiation oncologists who subspecialize in any one type of cancer (breast/gastrointestinal/urologic/etc.) or lymphomatous disease can substitute their judgements for criteria and have this scored as "2".

7. RP 6.2.1.2.1. Prospective review of all requested therapy by a subspecialist in pulmonary disease qualifies as significantly meeting this Required Characteristic.

Note that the foregoing applies only to the Required Characteristics that specify the use of criteria in the M&E process. All other Required Characteristics are scored on the basis of objective data pertaining to

a. Assigned responsibility for the M&E function

b. The planned and systematic nature of the process

c. Inclusion of both quality and appropriateness of care and treatment

d. The objective evaluation of the clinical performance of all individuals providing patient care in the department

e. Inclusion of all major clinical activities

f. Ongoing data collection, not intermittent studies

g. Periodic analysis and peer review of the data

h. Determinations regarding opportunities to improve care or identification of problem areas

i. Actions taken as appropriate and indicated

j. Evaluation of the effectiveness of the actions

k. Recording and monthly reporting of findings, conclusions, actions and follow-up

Each of these Required Characteristics is scored independently of RC MS 6.1.1.3.3 and MS 6.1.1.3.3.1. When subjective judgements regarding any important aspect of patient evaluation or management are made by subspecialists, it is possible to record in simple tabulations the number of cases (numerator data) in which they changed for the better the management or course of individual patients. The total number of cases seen (denominator data) is usually routinely recorded. When the judgements pertain to requests by attending physicians or residents for a particular service, e.g. a bone scan or respiratory therapy or a transfusion, simple cumulative data can be easily compiled which indicate whether any one clinical service or group of physicians has been assisted to order more rationally by virtue of the concurrent reviews.
Most important in the M&E is the inclusion of objective data on the clinical performance of all staff members, including the subspecialists whose judgements are accepted as significantly comparable to written criteria. Subjective judgements of the subspecialists regarding their own clinical performance or that of their colleagues do not constitute compliance with MS 6.1.1 or QA 2.5.1 and 2.5.2 (see below, p. 18).

8. RC MS 6.1.2.3.1 may also be scored as "2" if a subspecialist in a particular procedure uses subjective clinical judgement in assessing the appropriateness of a procedure. Similarly, <u>bona fide</u> mandatory independent consultation by two faculty members on proposed elective surgery can be scored as "2" also.

B. Sampling of High-Frequency Procedures

The principal teaching hospitals of AHC often do large numbers of routine operations and invasive procedures, commonly exceeding 1000 per month. Also owing to their unusual case mix, AHC hospitals give large numbers of transfusions of blood components and derivatives. In these situations, AHC are permitted to base surgical case review and blood usage review on representative sampling (RC MS 6.1.2.2.1 and RC MS 6.1.5.2.1.1, respectively), without having first to conduct 100% review which demonstrates consistent compliance with criteria. The guidelines for sampling surgical and transfusion cases are given on p. 41 and p. 57, respectively, of the HAP Scoring Guidelines

C. Scoring AHC Compliance with Other Standards

The pervasive issue in judging compliance of AHC hospitals is the lack of data corresponding to the Required Characteristic. This is attributable in part to the "fishbowl" thesis though the assertion is made that every staff member knows what and how well every other staff member in the particular specialty or subspecialty is doing. The lack of recorded evidence of reviews is often explained by the assertion that since AHC generally set standards of care through their clinical research, it would be redundant and wasteful of precious time and resources to simply "document" the already obvious. Nonetheless, JCAH standards require objective evidence of compliance. Consultative advice on acceptable, non-burdensome methods of compiling such data may help AHC faculty to "institute activities and mechanisms that will bring the organization into compliance with the standards." Two JCAH standards which are rarely met in AHC hospitals are those for departmental monthly meetings and use of the results of quality assurance activities in the reappointment and reappraisal process and renewal or revision of clinical privileges.

1. Monthly Meetings (MS RC 3.7)

Departments in AHC hospitals hold many weekly and monthly meetings for the purposes of clinical teaching and review of patient care. However, it is unusual for these departments to convene all members of their active staff monthly. Often, what is labelled as the monthly meeting is a regularly scheduled review session such as the M&M conference (see below). Rarely in AHC do such meetings devote a significant portion of the agenda to active consideration of the results of monitoring and evaluation of quality and appropriateness, results of other medical staff monitors, and results of other important QA functions that relate to the department's clinical activities, e.g., infection control. Specialties listed as support services in the AMH, such as Anesthesiology and Radiology, are usually full-fleged departments in AHC. For this reason, they too are required to hold monthly meetings. HAP Scoring Guidelines for monthly meetings (pp. 25 - 27) apply fully to all major departments, minor departments, and major subspecialties within departments. 2. QA Data in Reappraisal and Renewal of Privileges (QA RC 2.5.1, 2.5.2)

The alleged widespread implicit peer review which characterizes patient care in AHC causes department chairman to look upon JCAH requirements for using "relevant findings from the quality assurance activities" in reappraisal of their staff as unnecessary, if not repugnant. However, compliance requires both (1) objective data on the clinical performance of all departmental members who have clinical privileges (i.e., data from the M&E of Q&A, other staff monitors, and any departmental evaluations) and (2) objective evidence that these data have been reviewed as an integral part of the process of reappraisal and review and renewal of clinical privileges.

3. Morbidity and Mortality Conference

Surgical departments in AHC generally conduct morbidity and mortality (M&M) conferences as the mainstay of their own QA activities. The usual format is the presentation and discussion of problem cases, with little if any recording of conclusions, recommendations or actions. These conferences are often described by the Chairmen and Chiefs as meeting all the requirements for M&E. However, in most AHC, a number of key components required in M&E are missing from the M&M sessions:

a. Accurate and consistent reporting of all complications, not merely those selected by residents for presentation

b. Inclusion of non-surgical invasive procedures and endoscopy

c. Providing clinical criteria for the identification of complications

d. Conducting valid peer review of all major complications

e. Maintaining cumulative data on the results of peer review

f. Periodically reviewing and reporting on these data

g. Identifying trends or patterns of clinical performance

h. Taking action, following up, and reporting results of action taken

Simple methods are available for performing all of the above without additional staff or computer support. The M&M review would then comply fully with the M&E model for those important aspects of care.

4. Correlation Conferences

Another widely used teaching and review function is the correlation conference, generally centering on the accuracy of special studies in recognizing pathology or physiologic abnormalities which have been identified as present or absent by more direct means. In most AHC, these conferences also tend to consist of the presentation and discussion of cases selected because of their unusual nature. However, reviewing a few atypical cases provides no evidence that staff

performance in regard to other more prevalent cases conforms to acceptable standards of practice. For this reason, most such conferences do not comply with the M&E model.

In radiological correlational conferences, the most frequently missing elements are:

1. Representation of all imaging modalities

2. Comparison of radiologic diagnoses with other major sources of definitive diagnoses, e.g., operative findings, pathology reports, results of endoscopy, results of cardiac catherization and the like

3. Systematic compilation of true and false positive rates, true and false negative rates, and indeterminate rates

4. Periodic analysis of aggregate and staff-specific data

5. Regular reporting of conclusions, actions taken and their effectiveness

These elements, if present, would make correlation conferences substantially compliant with the M&E standard.

5. Prospective Control Mechanisms

The degree of expertise among AHC faculty in all clinical areas promotes the use of prospective control mechanisms, e.g., in radiology, respiratory therapy, and prescribing drugs. As was stated above, such controls applied by subspecialists can be accepted as significantly complying with the requirement for explicit criteria, i.e., given a score of "2". Converting the implicit judgements into explicit criteria is a simple matter, especially when these controls are applied to ordinary levels of secondary care, as in drug prescribing, transfusion therapy, and respiratory therapy. Use of such criteria would facilitate the implementation of the other components of the M&E model. Even without such criteria, however, AHC faculty can be helped to recognize the minimal amount of effort required to record data which would demonstrate the positive effects of such controls on the diagnosis, management and outcomes of patients or on the appropriateness of ordering support services by the hospital staff.

SCORING GUIDELINES

Scoring compliance of AHC hospitals with M&E of Q&A (MS 6.1.1 and corresponding required characteristic for the clinical support services) takes into account the special data collected by the consultant physician surveyor, specifically the scope and content of clinical research and subspecialty-level care that meet the intent of M&E. The data recorded on Data Summary I and II should be discussed with the consultant surveyor before completing the special forms provided for determining the scores for M&E. Copies of all supplementary forms and guidelines for completing them are found in the section below.

Two forms are provided for determining the compliance scores for M&E:

1. Departmental Summary Score Sheet

   One of these forms is to be completed for each major clinical department and its main subspecialties. The summary sheet contains information from the regular survey and the data obtained by the consultant surveyor. The guidelines accompanying the form describe the steps to be taken in arriving at a score for MS 6.1.1.

2. Composite Score Sheet

   The scores for all departments, obtained from the Departmental Summary Score Sheet, are entered here. A median score is then identified. This becomes the score to be assigned to RC MS 6.1.1.1 through RC MS 6.1.1.4.2.

SUPPLEMENTAL FORMS AND GUIDELINES

Consultant Surveyor Data Summary I

Case Mix of Subspecialties in Clinical Departments and Major Services and Percent of Clinical Research That Qualifies as M&E of Q&A

Dept/Major Service	Column 1 No. Cases/ Year	Column 2 % Tertiary Cases	Column 3 % Secondary Cases	Column 4 % Compliant Clin. Res.
MEDICINE				
General Med.				
Cardiology				
Endocrinology				
Gastroenterol.				
Hematology				
Infect.Dis.				
Metabolic Dis.				
Pulmonary Dis.				
Rheumatology				
Total/Means				

Comments:

Guidelines for Completing Data Summary I

1. Enter in column 1 the total number of patients per year, rounded to the nearest hundred, for the entire department and for each of the subspecialties. Enter "NA" if any listed service is not present in this department. Write in any additional subspecialties that have substantial numbers of patients and the number of patients seen per year in the hospital by that service.

2. Enter in column 2 the percent of patients that are classified as tertiary-level.

3. Enter in column 3 the percent of patients classified as secondary-level, i.e., 100 - % in column 2.

4. Enter in column 4 the percent of clinical research that meets the criteria for being classified as M&E of Q&A (pp.7 - 8).

Consultant Surveyor Data Summary II

Percent of Tertiary- and Secondary-Level Patients Included in Compliant Clinical Research or Managed by or Under the Direction of Subspecialists

	Column 1		Column 2	
	Percent Pts. in Compliant Clinical Research		Percent Pts. Under Subspecialist Care	
Dept/Major Service	A Tertiary Pts.	B Secondary Pts.	A Tertiary	B Secondary
General Med.				
Cardiology				
Endocrinology				
Gastroenterol.				
Hematology				
Infectious Dis.				
Metabol. Dis.				
Pulmonary Dis.				
Rheumatology				
_____				
_____				
Totals				

Comments:

Guidelines for Completing Data Summary II

1. For the entire department as well as each subspecialty, list in column 1A the percent of tertiary-level and in column 1B the percent of secondary-level patients that were included in clinical research that met the criteria on pp. 8 - 9. The percent for tertiary patients is the product of columns 2 and 4 on Data Summary I. The percent for secondary patients is the product of columns 3 and 4 on Data Summary I.

2. Enter in column 2A the estimated percent of tertiary-level and in column 2B the percent of secondary-level cases that received care from or under the direction of subspecialists, as per guidelines pp. 9 - 10.

JCAH Surveyor Departmental Summary Score Sheet

Scoring of Monitoring and Evaluation of Quality
and Appropriateness in Major Clinical Departments and Services

A. Dept./Service: MEDICINE

1. % secondary level patients ..... _____

2. % such patients covered by M&E scored as "1" or "2" _____

3. product of line 1 X line 2 ..... _____

4. % secondary-level pts. in compliant clinical research _____

5. product of line 1 X line 4 ..... _____

6. sum of lines 3 and 5 ..... _____

7. % tertiary level patients ..... _____

8. % such patients included in relevant clinical research _____

9. product of line 7 X line 8 ..... _____

10. % tertiary patients not included in relevant clinical research _____

11. % such patients receiving subspecialist care..... _____

12. product of line 10 X line 11 ..... _____

13. sum of lines 6, 9, 12 ..... _____

14. Score on RC MS 6.1.1 ..... _____

Comments:

Guidelines for Completing Departmental Summary Score Sheet

1. Complete this form after discussing with the consultant surveyor any special considerations pertaining to the data entered on Data Summary I and II.

2. Enter on line 1 the estimated percent of "secondary level" patients in this department from the consultant surveyor's Data Summary I.

3. Enter on line 2 your best estimate of the proportion of all secondary level patients that for the preceding 12 months were included in M&E of Q&A that was significantly or substantially in compliance with all components of the generic model (see pp. 29 - 30 of HAP Scoring Guidelines).

4. Multiply the percents on lines 1 and 2 and enter the product on line 3.

5. Enter on line 4 the percent of secondary-level patients included in compliant clinical research. This number is found in column 1B of Data Summary II.

6. Multiply the percents on lines 1 and 4 and record the product on line 5.

7. Add the percents on lines 3 and 5; enter the sum on line 6.

8. Enter on line 7 the percent of tertiary-level patients in this department, as recorded on Data Summary I.

9. Enter on line 8 the percent of tertiary-level patients that participated in compliant clinical research, as recorded in column 1A of Data Summary II.

10. Multiply the percents on lines 7 and 8 enter the product on line 9.

11. Enter on line 10 the percent of tertiary-level patients not included in compliant clinical research.

12. Enter on line 11 the percent of such patients receiving care from or under the direction of subspecialists (column 2A of Data Summary II).

13. Multiply the percents on lines 10 and 11 and enter the product on line 12.

14. Enter the sum of lines 6, 9 and 12 on line 13.

15. Locate the percent entered on line 13 in the following table and enter the corresponding score on line 14.

Percent on line 10	Score
Above 90%	1
76% - 89%	2
51% - 75%	3
26% - 50%	4
25% or less	5

JCAH Surveyor Composite Score Sheet

Departmental Scores of M&E Based on Current Guidelines and New Guidelines for Assessing Clinical Research and Subspecialist Care as M&E

Dept/Major Service	Column 1 Total Patients/Year	Column 2 Score on RC MS 6.1.1
Anesthesia	_____	_____
Medicine	_____	_____
Ob-Gyne.	_____	_____
Orthopedics	_____	_____
Pediatrics	_____	_____
Psychiatry	_____	_____
Rehab. Med.	_____	_____
Surgery	_____	_____

Comments:

Guidelines for Completing Composite Score Sheet

1. Enter in column 1 the total number of patients per year for each department or major clinical service, using the Data Summary I for each department.

2. List in column 2 the scores for each department or major service that were entered on line 14 of the Departmental Summary Score Sheets.

3. Identify the median score on the above list, taking into account the relative sizes of the departments.

4. Enter this score on the SRF for MS 6.1.1 through 6.1.1.4.2.

5. On the SRF, state the basis for selecting the median score. Indicate if it was the actual arithmetic median or if any adjustments were made because of differences in numbers of patients among departments, degree of uncertainty over accuracy of some data or any other considerations.

VI. C. CHANGES IN THE EXAMINATION SEQUENCE FOR LICENSURE

The National Board of Medical Examiners has informally explored with the Federation of State Medical Boards the establishment of an examination sequence for licensure which would replace the present dual examination program. As initially proposed, the sequence would consist of NBME Part I, NBME Part II, and for NBME Part III, the substitution of the FLEX examination. Eligibility for the NBME portions of the sequence would no longer be restricted to LCME-accredited medical school students.

This proposal was discussed by the CAS and COD Administrative Boards at their September meetings. L. Thompson Bowles, M.D., Dean of Medicine at George Washington University and President of the National Board led this discussion.

1988 CAS SPRING MEETING

April 13-15, 1988

San Diego Princess Hotel
Mission Bay
San Diego, California

Wednesday, April 13, 1988

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

Thursday, April 14, 1988

7:45 - 8:30 a.m.	Breakfast
8:30 a.m. - 12:30 p.m.	Plenary Session
12:30 - 2:00 p.m.	Lunch

Shortly after 2:00, an as-yet unnamed field trip will be available.

7:00 - 9:00 p.m.	Dinner Speaker: Robert G. Petersdorf, M.D. President, AAMC

Friday, April 15, 1988

7:45 - 8:30 a.m.	Breakfast
8:30 a.m. - Noon	Business Meeting