association of american medical colleges

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES ANNUAL MEETING

SUNDAY, NOVEMBER 13, 1988
CAS/COD/COTH JOINT PLENARY SESSION
ON MISCONDUCT IN SCIENCE
1:00 - 3:30 P.M.
SALON D

MONDAY, NOVEMBER 14, 1988
CAS BUSINESS MEETING
1:30 - 5:00 P.M.
SALON III

AAMC ASSEMBLY
5:00 - 6:00 P.M.
LA/MIAMI ROOMS

CAS RECEPTION
6:00 - 7:00 P.M.
SALON G

CHICAGO MARRIOTT HOTEL
CHICAGO, ILLINOIS

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

FUTURE MEETING DATES

CAS SPRING MEETING	March 15-17, 1989 Orlando, Florida
AAMC ANNUAL MEETING	October 28 - November 2, 1989 Washington, D. C.
CAS SPRING MEETING	March 14-16, 1990 San Antonio, Texas
AAMC ANNUAL MEETING	October 20-25, 1990 San Francisco, California

COUNCIL OF ACADEMIC SOCIETIES
ANNUAL BUSINESS MEETING

Monday, November 14, 1988
1:30 - 5:00 p.m.
Salon III
Chicago Marriott
Chicago, Illinois

AGENDA

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

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

III. Vice President's Report -- Thomas E. Malone, Ph.D.

IV. Action and Discussion Items

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
SPRING MEETING

April 13-15, 1988
San Diego Princess
San Diego, California

Plenary Session - Issues in Medical Education

The keynote speaker, Edward J. Stemmler, MD, Vice President and Dean, University of Pennsylvania School of Medicine, raised his concerns that medical education has deviated from the scholarly traditions first emphasized by John Morgan in the 18th century. While no crisis exists, he warned of a gradual erosion of scholarship and values and trends toward vocationalism in medical education. He focused on both basic science and clinical education. He noted that the disciplines of modern science fail to engage medical students and, that in contrast to graduate students, they do not move freely between classroom and modern laboratory research but receive basic science passively. He urged a serious examination of the best method to educate medical students in basic sciences.

In the clinical sciences he noted that each new generation of physicians faces more challenges than past generations. A rapidly expanding knowledge base, sophisticated high technology and shortened contact with large numbers of patients are examples of these trends. Clinical training places an inordinate burden on students which displaces the learning process. Strategies need to be developed to deal effectively with medical students in a rapidly changing medical environment. Dr. Stemmler challenged faculty to address these two areas and to reexamine the direction of medical education in a spirit of openness.

The Thursday Plenary session explored the links between basic research and medical education, the role of the MCAT in medical school admissions, proposed MCAT revisions, and the relationship of the AAMC Group on Medical Education to the CAS.

Douglas Kelly, Ph.D., CAS Chair, addressed the institutional balance between basic research and medical education. He noted his concerns that faculty are not making medical education their highest priority and that this was partly based on responding to an institutional value system which emphasizes research productivity and generation of external research funding. He urged a return to the centrality of educating physicians in science and proposed a number of possible changes in the structure of basic science departments, medical school entrance requirements and curriculum which might alter current trends.

Richard L. O'Brien, MD, Chair of the AAMC MCAT Review Committee and Dean at Creighton, spoke on proposed changes in the MCAT exam and what these may bode for prebaccalaureate education. The Committee wishes to enhance the skills analysis portion and incorporate an essay, while shortening the overall exam and

integrating the science subtests. Dr. O'Brien reassured the audience that the validity and reliability of the test would be the same and that the 15 point grade scale would be retained. The Committee is currently surveying faculty and students on the salience of potential science examination topics for medical school and physician practice performance. He concluded that evaluation of the MCAT must be conducted with an eye to broader issues such as 1) the declining applicant pool, 2) minorities in medicine, 3) cultural diversity, and 4) premedical preparation and basic medical sciences.

The plenary concluded with an examination of the appropriate forum within the AAMC for faculty to explore and debate key issues in medical education. Ernst Jaffe', MD, CAS Chair-Elect and Julian I. Kitay, MD, Chair of the AAMC Group on Medical Education (GME) examined the pros and cons of the GME as the forum. Kitay noted that the traditional membership of GME is Associate Deans for Medical Education and explained that it was formed to promote medical education from an institutional point of view. He noted that active members included those seeking change, many of whom emphasized a psychosocial model of medical education. Prior experience with permitting membership by CAS representatives but finding difficulty in integrating them into activities was reviewed by Dr. Jaffe'. During the Council discussion CAS members expressed a clear desire to participate in GME and also expressed the view that GME needs faculty involvement to be effective.

Following the Plenary Session, discussion groups pursued the following topics:

1) faculty development in the teaching role;

2) the link between basic research and medical education;

3) the impact of faculty entrepreneurism on medical education;

4) the GME as the national forum for involvement of faculty in improving medical education.

Recommendations from the discussion groups were referred to the Administrative Board for further consideration or implementation. The basic recommendations of the groups were:

1. <u>Faculty development</u>: There is a need for clearer institutional focus on faculty development, particularly for the teaching role, at each school. Institutions need to develop role models, programs to increase teaching skills, and a reward system linked to performance in teaching. Clarifications of job- and role-expectations throughout the faculty lifespan and identification and stabilization of revenues to support teaching needs are needed.

2. <u>Basic science and medical education</u>: Medical school education must emphasize science as well as humanism. Science education must teach

critical thinking, analytic and problem-solving skills and must be integrated throughout the 4 years of school. Science education will need to bring students to the cutting edge to engage both faculty and students in a true understanding of science. AAMC should promote the attractiveness of medicine and biomedical research careers for the best and brightest students. More MD-PhDs should be trained. AAMC should emphasize programs to improve and document teaching effectiveness.

3. Entrepreneurism and medical education: Entrepreneurism occurs in both basic and clinical sciences and is expected to increase in the future. Taking risks and generating revenue for the institution range from patenting basic science discoveries to aggressive marketing of new clinical services. Such activities are not inherently contradictory to academic missions but it is important to have institutional oversight and control of their scope. Revenues generated through such activities should be used to enhance the academic and educational missions of the school. Control should be vested at the departmental and institutional levels. These revenues may become increasingly vital resources for support of teaching and educational missions in the future.

4. Faculty forum for improving medical education: Such a forum is needed and GME should be the locus. The CAS Administrative Board should meet with the GME Steering Committee to implement this interaction. Specific attention should be directed to communication via newsletters and a reorganized Journal of Medical Education to actually reach teaching faculty. A joint CAS-GME program should be considered at the Annual Meeting. A comprehensive data base of experiments in innovative medical education should be compiled and widely disseminated. GME should address concerns about the status of medical teaching as a profession and professional development as educators for medical faculty. Support for selected faculty attendance at GME should be provided by their institutions.

Business Meeting

I. PRESIDENT'S REPORT
Robert G. Petersdorf, M.D.

Dr. Petersdorf announced that Thomas E. Malone, Ph.D., former Deputy Director of NIH, will become AAMC's Vice President for Biomedical Research on September 1. This Division will continue to staff the Council of Academic Societies. Dr. Petersdorf then introduced an Association proposal to raise dues for all AAMC membership categories including CAS Societies. Dues have fallen to 30% of income and the dues base was last adjusted in 1978. Substantial increases in the base for medical school and teaching hospital dues are proposed with modest increases for academic societies ranging from $270 to $1000 for different dues categories (see tables 1 and 2 attached). Subsequent year dues will rise by projected estimates of the yearly increase in the Higher Education Price Index, rather than CPI. The increased resources will enable the Association to continue to fulfill its mandate to represent the academic medical center community on issues of importance to academic missions and provide programs and services of importance to our schools and faculties. The proposed dues increase was well received by CAS representatives.

II. CAS CHAIRMAN'S REPORT
Douglas E. Kelly, Ph.D.

Dr. Kelly briefly reported on the Council of Deans Spring Meeting. The Deans covered several issues also of interest to the CAS, including:

- affirmative action, especially relating to the declining applicant pool and recruitment of women and minority faculty;
- more stable support of graduate medical education;
- international medical education;
- continuing medical education; and
- strengthening the relationship between the Veterans Administration and the medical education community.

Dr. Kelly announced new initiatives planned by the CAS Administrative Board. A half-day orientation session for new CAS Representatives will be added to the Spring Meeting each year to discuss expectations, responsibilities and opportunities for CAS Representatives. Societies will be urged to appoint their Representatives for terms of at least three years, and the Administrative Board will divide the CAS into "liaison groups", with each Board member responsible for initiating regular contact with approximately 7 CAS societies following the September Board meeting. Each Board member will report to those Societies on issues and plans for the upcoming term and solicit the input of his Affinity

Group on those topics as well as issues or problems the Representatives may wish to have brought to the CAS and/or AAMC.

III.A.-B. ACTION ITEMS

The minutes of the Annual Meeting were approved as submitted, and the three new Societies applying for CAS Membership were unanimously approved. Those Societies are the American Association of Chairmen of Plastic Surgery, Association of Anesthesiology Program Directors, and Association of Pediatric Program Directors. They will become full CAS members upon the approvals of the Executive Council in June and Assembly in November.

IV. DISCUSSION ITEMS

A. CAS Nominating Committee

The 1988-89 Nominating Committee members are Ernst R. Jaffe', MD, American Society of Hematology, Chair; William R. Drucker, MD, American Association for the Surgery of Trauma; Douglas E. Kelly, PhD, American Association of Anatomists; Thomas C. King, MD, American Association for Thoracic Surgery; Beverley Rowley, PhD, Association for the Behavioral Sciences and Medical Education; Stanley Schultz, MD, Association of Chairmen of Departments of Physiology; and Eleanor Z. Wallace, MD, Association of Program Directors in Internal Medicine. The Committee will meet by Conference Call on May 10. A basic scientist Chair-Elect and three new Board members will be nominated.

B. AAMC Recommendations on Housestaff Supervision and Hours

Dr. Jaffe' led the discussion of this document, which articulates guidelines, not rules for housestaff. On behalf of the surgical societies, Dr. Edwin Deitch expressed strong disagreement with the limitations on working hours in the recommendations as inappropriate for a surgical residency. A thoughtful discussion ensued, with consensus from the CAS that if the problem is a rested resident, the focus should be on how to ensure that residents get rested, rather than on enumerating working hours. Although Representatives understood that the AAMC statement was a final position after almost nine months of discussion by Councils, Boards and the Executive Council, there was a general expression of concern about specifying any exact working hours in the document. Several CAS Representatives who are based in New York State commented on that state's draft regulations, which drew heavily on earlier AAMC drafts. Dr. Bentley remarked that AAMC will testify again before the Bell Commission before the New York regulations are finalized.

C. LEGISLATIVE UPDATE
Richard Knapp, Ph.D.

Dr. Knapp presented the FY 1989 recommendations of the Ad Hoc Group for Medical Research Funding, which annually recommends appropriations levels for NIH and ADAMHA. Fifty-five organizations have already become co-signatories to these

recommendations, and all CAS Societies were encouraged to add their names to this list. A coalition to deal in a similar manner with the budget of the Veterans Administration has been formed, and the Friends of VA Medical Care and Health Research proposal was available for signatories at this meeting as well.

Misconduct in science has been the topic of hearings by Chairman Dingell and Congressman Weiss in recent weeks. Serious concerns have been raised:

- o The perception is being established in the minds of many Congressmen that the medical research community has no enthusiasm to uncover fraud, which leads to the belief that the community is primarily interested in covering its tracks.

- o Rep. John Conyers (D-MI) wants criminal penalties imposed for research fraud as part of his proposed legislation dealing with white collar crime.

- o Rep. Ron Wyden (D-OR) wants third party involvement in institutional procedures to deal with misconduct much earlier in the process and insuring the protection of whistleblowers.

An AAMC memo summarizing the hearings will be sent to all councils.

With reauthorization of the National Institutes of Health, several issues are likely to appear in the Senate legislation. A hearing institute, rehabilitation research and authorization for $150 million in facilities construction are expected. The Senate is also expected to prohibit the waiver for fetal research, but take no action on the use of animals in research. It is not yet known what will be in the House of Representatives version. The AAMC submitted testimony in support of the fetal research waiver and facilities authorization and suggesting that further research foci at NIH be organized as centers within present institutes or coordinating committees.

The Administration is attempting to dismantle the Health Manpower Act. Two bills on discrimination in licensure for foreign medical graduates are pending, and no action on making the Veterans Administration a Cabinet Department has occurred. AAMC's efforts on the VA have been primarily in trying to preserve a depoliticized appointment process for the Chief Medical Director.

D. Transition from Medical School to Residency
August G. Swanson, M.D.

Dr. Swanson reviewed the establishment of the November 1 release date for deans' letters. Problems last year included that all the letters arrived on one day and everyone had to adjust to a new, tighter interview and selection schedule. The question now being raised is whether the November 1 date should be modified to allow evaluatory information to be distributed from October 1 to November 1. More time for the selection process has been realized because in 1989 the NRMP rank order will be done on March 1 and the Match will occur on March 22. CAS

Representatives discussed problems with the tight logistics in the first year of the new process. The opinion was expressed that nothing should be changed until the system had had another year to adapt. A straw vote revealed that slightly more societies (24) preferred an October 1 to November 1 release date to a strict November 1 date (17). The continued efforts to shorten NRMP match time were regarded as helpful.

Dr. Swanson also announced that Alpha Omega Alpha will present two distinguished teacher awards of $2500 each to one basic and one clinical science instructor at the AAMC Annual Meeting. Nomination packets will be mailed next week and each U.S. and Canadian medical school may nominate one person for each award. The AOA and AAMC will select the winners jointly. The deadline for nominations is August 26.

E. AAMC Task Force on Physician Supply
Joseph Keyes, J.D.

Mr. Keyes presented the interim report of the Task Force, pointing out the opportunities for comment throughout the process, and that several CAS representatives are members of the Task Force. He pointed out that the interim report included the various approaches of medical schools to admissions and requirements as well as volumes of factual and manpower modeling information. The Task Force is very concerned about the quality of applicants as the applicant pool declines. Other issues which the Task Force is considering are whether the number of physicians leads to "over-doctoring" and whether the number of physicians in particular specialties is too great for each to retain an appropriate skill level. The marketing of medical careers to attract desirable candidates to medicine is receiving increasing consideration.

The Task Force Subcommittees are debating a series of recommendations. The Rabkin Committee is proposing that licensure be dependent upon the completion of an accredited residency program and that the academic component of graduate medical education be emphasized. Recommendations of the Moy Committee include that U.S. academic medicine recognize a moral and diplomatic obligation to contribute to international medical education. The AAMC is already moving to a role in international education through the International Medical Scholars Programs. The Korn Committee is concerned about the capability of medical schools to attract and train biomedical scientists and the attractiveness of research careers.

F. Committee on AIDS and the Academic Medical Center
Vivian W. Pinn-Wiggins, M.D.

This Committee was charged to address AIDS issues specific to the academic medical center. Subcommittees on Institutional Policies and Medical Education have been formed. The AIDS Committee expects to continue for approximately two years, and will periodically report on its deliberations. The statement on professional responsibilities included in the CAS agenda is the Committee's

first policy statement. No specific sanctions for refusing to treat HIV-positive or AIDS patients were included in this policy statement although discussion revealed that several schools have such sanctions.

G. Misconduct in Science
Paul J. Freedman, M.D.

This is an area of concern to faculty and institutions alike. Recent events have resulted in a major Congressional focus on the ability of scientists and institutions to conduct misconduct investigations and seriously address concerns about fraud in federally funded research. A CAS Plenary Session at the Annual Meeting on this topic would be timely and provide a chance for faculty leaders to examine the issues.

H. Faculty Effort on New PHS Grant Application Form.
Elizabeth M. Short, M.D.

The new PHS form 398 provides unclear instructions for faculty effort reporting. All faculty with full medical school appointments applying through the medical school as grantee institution should list 1.0 as their appointment in column 1, regardless of the mix of institutions and salary sources which make up the academic appointment. The effort on the project reported in column 2 becomes effort as a percent of total faculty professional activities. Department chairs should assist PIs in filling out the new form.

Projected Dues Revenues
Fiscal Year 1988-1989

	Dues	Revenues
Medical Schools	$18,900	$2,388,000
Teaching Hospitals	2,745	1,235,000
Academic Societies		
Less than 300	930	
300-999	1,890	
1000-4999	3,735	
5000 & Over	5,600	196,000
Other		84,000
	Total	3,903,000

Association of American Medical Colleges

Dues Structure

	Fiscal Year					
	88-89	89-90	90-91	91-92	92-93	93-94
Medical Schools (127)	18,900	32,500	34,125	35,831	37,623	39,504
Teaching Hospitals (450)	2,745					
General (375)		10,000	10,500	11,025	11,576	12,155
Federal (75)		4,800	5,040	5,292	5,557	5,834
Corresponding (27)	930	2,400	2,520	2,646	2,778	2,917
Academic Societies						
LT 300 Members (32)	930	1,300	1,365	1,433	1,505	1,580
300-399 Members (25)	1,890	2,600	2,730	2,867	3,010	3,160
1000-4999 Members (20)	3,735	5,200	5,460	5,733	6,020	6,321
5000 and Over (8)	5,600	6,300	6,615	6,946	7,293	7,658
Total Revenues (millions)	3,903	8,624	9,054	9,505	9,978	10,475

association of american medical colleges

COUNCIL OF ACADEMIC SOCIETIES
1988 SPRING MEETING
April 13-15, 1988
San Diego, California

FINAL ATTENDANCE LIST

Society	Representatives
Academy of Clinical Laboratory Physicians and Scientists	
Ambulatory Pediatric Association	
American Academy of Allergy and Immunology	
American Academy of Neurology	Rosalie A. Burns
American Academy of Ophthalmology	J. Bronwyn Bateman Joel Sacks
American Academy of Orthopaedic Surgeons	James H. Herndon Wilton H. Bunch
American Academy of Physical Medicine and Rehabilitation	
American Association for the Study of Liver Diseases	
American Association for the Surgery of Trauma	
American Association for Thoracic Surgery	Thomas C. King
American Association of Anatomists	Douglas E. Kelly Roger Markwald
American Association of Chairmen of Departments of Psychiatry	
American Association of Directors of Psychiatric Residency Training	George Ginsberg Stefan Stein
American Association of Neurological Surgeons	
American Association of Pathologists	Yutaka Kikkawa
American Association of Plastic Surgeons	Hal G. Bingham

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Society	Representatives
American College of Neuropsychopharmacology	
American College of Obstetricians and Gynecologists	William Easterling
American College of Physicians	Frank Davidoff
American College of Psychiatrists	Peter F. Regan
American Federation for Clinical Research	William N. Hait
American Gastroenterological Association	John T. Farrar
American Geriatrics Society	
American Neurological Association	
American Orthopaedic Association	
American Pediatric Society	Myron Genel
American Physiological Society	George Hedge Jack L. Kostyo
American Psychiatric Association	Daniel X. Freedman Herbert Pardes
American Society for Cell Biology	Barbara J. McLaughlin George Pappas
American Society for Clinical Investigation	
American Society for Clinical Nutrition	Charles H. Halsted Roland Weinsier
American Society for Clinical Pharmacology and Therapeutics	David W. Nierenberg Richard Weinshilboum
American Society for Pharmacology and Experimental Therapeutics	
American Society for Biochemistry and Molecular Biology	William J. Whelan
American Society of Hematology	Ernst R. Jaffe'

Society	Representatives
American Society of Human Genetics	Maimon M. Cohen Elizabeth M. Short
American Surgical Association	Lawrence H. Cohn
Association for Academic Psychiatry	Louis Rittelmeyer
Association for Academic Surgery	Linda M. Graham
Association for Medical School Pharmacology	
Association for the Behavioral Sciences and Medical Education	DeWitt Baldwin Beverley D. Rowley
Association for Surgical Education	Norman Snow
Association of Academic Departments of Otolaryngology	Warren Y. Adkins Robert I. Kohut
Association of Academic Physiatrists	Phyllis E. Page
Association of American Physicians	
Association of Anatomy Chairmen	Gordon I. Kaye Robert O. Kelley
Association of Anesthesiology Program Directors	David J. Torpey, Jr.
Association of Chairmen of Departments of Physiology	Stanley Schultz
Association of Departments of Family Medicine	Thornton Bryan Harry E. Mayhew
Association of Directors of Medical Student Education in Psychiatry	Irwin N. Hassenfeld John Racy
Association of Medical School Departments of Biochemistry	Thomas E. Smith
Association of Medical School Microbiology Chairmen	Kenneth I. Berns
Association of Medical School Pediatric Department Chairmen	
Association of Orthopaedic Chairmen	Gerald S. Laros
Association of Pathology Chairmen	Vivian W. Pinn-Wiggins

Society	Representatives
Association of Professors of Dermatology	
Association of Professors of Gynecology and Obstetrics	
Association of Professors of Medicine	Harold Fallon
Association of Program Directors in Internal Medicine	Eleanor Z. Wallace
Association of Teachers of Preventive Medicine	
Association of University Anesthetists	Milton Alper C. Philip Larson
Association of University Professors of Neurology	Rosalie A. Burns
Association of University Professors of Ophthalmology	
Association of University Radiologists	Paul J. Friedman
Central Society for Clinical Research	
Child Neurology Society	Gwendolyn R. Hogan
Endocrine Society	
Plastic Surgery Educational Foundation	
Plastic Surgery Research Council	Nancy McKee
Society for Health and Human Values	Rita Charon
Society for Neuroscience	David H. Cohen Joe Dan Coulter
Society for Pediatric Research	
Society for Surgery of the Alimentary Tract	
Society of Academic Anesthesia Chairmen	S. Craighead Alexander
Society of Chairmen of Academic Radiology Departments	
Society of Critical Care Medicine	S. G. Hershey

Society	Representatives
Society of Gynecologic Investigation	
Society of Surgical Chairmen	
Society of Teachers of Emergency Medicine	Glenn C. Hamilton Richard M. Nowak
Society of Teachers of Family Medicine	Alfred O. Berg
Society of University Otolaryngologists	Lanny Garth Close Lee Harker
Society of University Surgeons	Edwin Deitch
Society of University Urologists	David G. McLeod
Surgical Infection Society	Arthur E. Baue
Thoracic Surgery Directors Association	
University Association for Emergency Medicine	Michael Callaham Steven Dronen

AAMC Staff

James Bentley, Vice President, Division of Clinical Services
Edwin L. Crocker, Vice President, Office of Administrative Services
Jane Donovan, Administrative Assistant, Division of Biomedical Research
Louis J. Kettel, Associate Vice President, Division of Academic Affairs
Joseph A. Keyes, Jr., Vice President for Institutional Planning and Development and General Counsel
Richard M. Knapp, Senior Vice President for Governmental Relations
Dorothy J. Lehrman, Staff Associate, Division of Biomedical Research
Joan Hartman Moore, Director, Section for Public Relations
Robert G. Petersdorf, President
John F. Sherman, Executive Vice President
Allan C. Shipp, Staff Associate, Division of Biomedical Research
Elizabeth M. Short, Deputy Director for Biomedical Research
August G. Swanson, Vice President, Division of Academic Affairs
Kathleen Turner, Assistant Vice President

Guests

William T. Butler, Dean, Baylor College of Medicine; Chair, Council of Deans
John W. Colloton, Director and Assistant to the President for Statewide Health Services, University of Iowa Hospitals and Clinics; AAMC Chairman
Julian I. Kitay, Associate Dean for Academic Affairs, University of Texas-Galveston; Chair, Group on Medical Education
Richard O'Brien, Dean, Creighton University School of Medicine; Chair, MCAT Review Committee
Edward J. Stemmler, Executive Vice President and Dean, University of Pennsylvania School of Medicine

ELECTION OF MEMBERS TO THE 1989 ADMINISTRATIVE BOARD

The 1988 CAS Nominating Committee met by Conference Call May 10, July 28 and July 29, 1988 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from those meetings are as follows:

CHAIRMAN-ELECT:

Joe Dan Coulter, Ph.D.
Society for Neuroscience
University of Iowa College of Medicine
Iowa City, Iowa

THREE-YEAR TERMS:

Kenneth I. Berns, M.D., Ph.D.
Association of Medical School Microbiology Chairmen
Cornell University Medical College
New York, New York

Thornton Bryan, M.D.
Association of Departments of Family Medicine
University of Alabama School of Medicine
Family Practice Center
Huntsville, Alabama

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

Information about the nominees appears on the following pages.

The Nominating Committee also nominated S. Craighead Alexander, M.D. as a candidate for a three-year term as At-Large Representative from the Council of Academic Societies to the Executive Council. This nomination will be considered by the AAMC Assembly later today. Dr. Alexander serves on the CAS Administrative Board and represents the Society of Academic Anesthesia Chairmen. He is Chairman of Anesthesiology at the University of Wisconsin Medical Center, Madison, Wisconsin.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: COULTER, Joe Dan, Ph.D.
Present Location (School) The University of IOwa
CAS Society: Society for Neuroscience
Undergraduate School: University of Oklahoma

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

Univ. of Oklahoma Medical Center, Ph.D., 1971, Biological Psychology

Univ. of Texas Medical Branch, Postdoctoral, 1971-73, Neuroanatomy

Univ. of Pisa, Italy, Postdoctoral, 1973-74, Neurophysiology

Univ. of Edinburg, Scotland, Postdoctoral, 1974-75, Neurophysiology

Academic Appointments (with dates)

Assistant Professor, 1975-78,Physiology & Biophysics & Psychiatry & Behavioral Science, Univ. of Texas Medical Branch,Galveston, TX

Associate Professor, 1978-84, Physiology & Biophysics & Psychiatry & Behavioral Science, Univ. of Texas Medical Branch, Galveston, TX

Professor, 1984-85, Physiology & Biophysics & Psychiatry & Behavioral Science, Univ. of Texas Medical Branch, Galveston, TX

Professor & Head, 1985-present, Anatomy, The University of Iowa College of Medicine, Iowa City, IA

Societies/Affiliations:

Society for Neuroscience (Treasurer 1985-86; Governmental & Public Affairs Comm. 1981- , Secretary 1986- ; Council 1985-)

Council of Academic Societies, Assoc. of American Medical Colleges (Member, Administrative Board 1985-)

Association of Neuroscience Departments and Programs (Secretary-Treasurer 1982-86)

American Association of Anatomists
Association of Anatomy Chairmen

American Physiological Society
American Soceity for Cell Biology

Honors/Awards:

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: KENNETH I. BERNS
Present Location (School) Cornell University Medical college
CAS Society: Association of Medical School Microbiology Chairmen
Undergraduate School: Harvard 56-59 Johns Hopkins A.B. 1960

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

11/64 - Ph.D., Biology (Biochemistry), Johns Hopkins University

Thesis: Isolation and Purification of High Molecular Weight DNA from Haemophilus influenzae (awarded distinction)

6/66 - M.D., Johns Hopkins University

1966-1967 - Intern, Pediatrics, Harrieth Lane Service, Johns Hopkins Hospital

Academic Appointments (with dates)

1984-Present -R.A. Rees Pritchett Professor and Chairman, Department of Microbiology & Professor of Pediatrics, Cornell University Medical College, NY, NY

1976-1984 Professor and Chairman, Department of Immunology and Medical Microbiology and Professor, Department of Pediatrics, College of Medicine, University of Florida, Gainesville, Florida

1982-1983 -Fogarty Senior International Fellow with Dr. Ernest Winocour, Virology Department, The Weizmann Institute of Science, Rehovot, Israel

1973-1976 -Director of the Year I Program, Johns Hopkins Univ. School of Medicine

1974-1976 -Associate Professor of Microbiology, Johns Hopkins Univ. School of Medicine

1970-1976 -Assistant Professor of Pediatrics, Johns Hopkins Univ. School of Medicine

1970-1974 -Assistant Professor of Microbiology, Johns Hopkins Univ. School of Medicine

Societies/Affiliations:

American Academy of Microbiology (Fellow)/American Association for the Advancement of Science/American Society for Microbiology: Board of Public and Scientific Affairs Chairman, Committee on Medical Microbiology & Immunology; Chairman-elect, Division of DNA Viruses - 1983; Chairman, Division of DNA Viruses - 1984; President-elect, Florida Branch -1984/American Society for Virology: President-elect - 1987; Program Chairman 1986-1987; Vice Program Chairman - 1985/American Society of Biological Chemists/ Association of American Medical Colleges: Council of Academic Societies - 1984-Present; Biomedical Research Prize Committee - 1987; Task Force on AIDS and the Academic Health Center/Association of Medical School Microbiology Chairmen: President-1985; President-elect-1984; Counselor-1980-1983; Chairman, Committee on Public Policy -1979-Present Harvey Society/ NY Acad. of Sci./Society for Genl. Micro.(U.K.)/Society for Pediatric Resh.

Honors/Awards:

-American Cancer Society FAculty Research Award, 1975-1980
-Fellow in Pediatrics, Johns Hopkins University, 1966-1967
-Fellowship in American Academy of Microbiology
-Fogarty Senior International Fellowship, 1982-83
-Guggenheim Fellowship (Honorary), 1982-83
-Howard Hughes Medical Investigator, 1970-75
-National Merit Scholar (Sears), 1956-60
-NIH Predoctoral Fellowship (declined)
NSF Undergraduate Rsearch Fellowship, June, 1959 -Sept. 59
Phi Beta Kappa/Phi Kappa Phi
Shell Oil Fellowship, 1963-64/Sigma Xi/Who's Who in America, 1982

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Thornton Bryan, M.D.
Present Location (School) University of Alabama in Huntsville
CAS Society: Association of Departments of Family Medicine
Undergraduate School: University of Kentucky
Degree: B.S. Date: 1949
Medical School: University of Louisville Year Graduated: 1954

Location and Nature of Major Graduate Training:

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

Int. - Philadelphia General Hospital - 1954-55

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

Family Practice - Kentucky - 1955-1971

Board Certification:
American Board
Family Practice (Specialty/Date) 1970-76-83 (Specialty/Date)

Academic Appointments (With Dates):

University of Iowa - Associate Professor - 1971-74
University of Tennessee - Professor - 1974-87
University of Alabama in Huntsville - Professor - 1987-Present

Societies/Affiliations:

Kentucky Medical Association - Board of Trustees
Kentucky Chapter - AAFP - President
AMA - KY - Iowa - TN - State Medical Society
AAFP - AAMC - CAS - ADFM - STFM

Honors/Awards:

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Glenn C. Hamilton, M.D.
Present Location (School) Wright State University School of Medicine
CAS Society: Society of Teachers of Emergency Medicine
Undergraduate School: University of Michigan
Degree: BS - Zoology Date: 1965-1969
Medical School: University of Michigan Year Graduated: 1969-1973

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):
Internship - Los Angelos-Harbor General Hospital, Rotating, 1973-1974
Internship - University of Michigan Med Ctr, 1975-1976
Emergency Medicine Residency - Denver General Hospital, 1977-1979

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

Board Certification:

Internal Medicine/1979 (Specialty/Date)
Emergency Medicine/1982 (Specialty/Date)

Academic Appointments (With Dates):

Assistant Professor, University of Cincinnati Medical Ctr 1979-1981 (Emer Med)
Associate Professor, Wright State Univ. Sch of Med 1982-1986 (Emer Med)
Associate Professor, Wright State Univ. Sch of Med 1982-present (Int Med)
Professor, Wright State Univ. Sch of Med 1986-present (Emer Med)

Societies/Affiliations:

ACEP, ACP, AOA, STEM, UAEM, SCCM, AMA, Emer Med Found, AAMC, SMDC, CAS, CMSS, Amer Fed Clin Res, Soc Mag Res Imaging

Honors/Awards:

Silver Tongue Orator Award STEM, 1982; Imagio Obscura Award UAEM, 1983; Teaching Excellence Award EMRA, 1985; Academic Excellence Award STEM, 1986, Presidential Award for Outstanding Achievement Wright State University 1986
First Honorary Fellow Australasian College of Emergency Medicine, 1983

INTERIM REPORT
SUBCOMMITTEE ON DISCONTINUITY IN MEDICAL EDUCATION

Committee Members:

Frank G. Moody, M.D., Chair
Myron Genel, M.D.
Ernst R. Jaffe', M.D.
Douglas Kelly, Ph.D.

This Subcommittee of the CAS Administrative Board was given the task of critically reviewing "The Reform of Medical Education" by Robert Ebert and Eli Ginzberg and the responses to it published in Health Affairs, Volume 7 (2) Supplement. There was consensus that the combining of the last two years of medical school with the first two years of graduate education into a six year curriculum would accrue cohesion to the process of medical education for primary care specialists, and improve the quality of clinical training obtained in medical school and during the early years of residency for all medical specialties. The complexities of initiating such a program were recognized, but it was felt that these should not dissuade the CAS from proposing to the AAMC that it support a comprehensive study of innovative ways in which a six year curriculum might be established.

The Subcommittee was not in favor of endorsing a downsizing of medical school class size or faculty at this time. In addition, the "core teaching faculty" concept did not appear consistent with the traditions that have been the benchmark of medical education in the United States during the past five decades. There was general recognition, however, that the present system has emerged as a survival strategy for both the research and clinical faculty as the financial support systems for medical schools have eroded.

The Subcommittee favors a model in which all faculty in a medical school place a high priority on medical education at both the undergraduate and graduate levels. The Subcommittee recommends that the AAMC provide data on model programs which combine early acceptance and integrated college-medical school education. There appears to be sufficient diversity in applicants and matriculants without further need for emphasis in this area. The issues which include the education of minorities, foreign medical graduates, and future research faculty would appear to be outside of the major thrust of the Ebert-Ginzberg proposal, i.e., the resolution of the discontinuity that exists in the education of physicians as they proceed through medical school and their residency. The six year medical curriculum would appear to be an appropriate starting point for addressing this important issue.

Preface

The Task Force on Women, Minorities, and the Handicapped in Science and Technology:

- Established by the U.S. Congress in Public Law 99-383, Section 8, to report to the President, the head of each participating Federal agency, and the Congress;
- Members are from 15 Federal agencies and leaders in the private sector and education;
- Purpose is to develop a long-range plan for broadening participation in science and engineering;
- Public hearings held in Albuquerque, Atlanta, Baltimore, Boston, Chicago, Kansas City, and Los Angeles between Fall 1987 and Spring 1988;
- An interim report with recommendations is now being issued to emphasize that action rather than more study is needed;
- Task Force report due again in December 1989 on progress being made toward implementation of the recommended plan;
- The Task Force terminates on January 31, 1990.

Cochairs of the Task Force are:

- Dr. W. Ann Reynolds
  Chancellor of the California State University System
- Mr. Jaime Oaxaca
  Corporate Vice President of Northrop Corporation

Executive Summary

Our advanced industrial Nation—the America we have taken for granted for more than a generation—is changing.

Our society is changing: More people are old, fewer are young, more come from minority groups.

Our industry is changing: We are not the world economic leader we were for so long, but a competitor with other industrial nations.

Our education system is changing: Although our colleges and universities are the envy of the world, they are becoming more and more dependent on foreign students and faculty. Our precollege education system has reached a crisis state in which U.S. students are no longer competitive with those in other industrialized countries.

Our present scientific and engineering workforce—the foundation for U.S. technological, economic, and military leadership—is eroding due to retirements and declining student interest.

As a result, the Task Force now reports to the President, the Congress, and the American people that one of our most urgent tasks is to strengthen our science and engineering workforce. The educational pipeline— from prekindergarten through the Ph.D.—is failing to produce the workers needed to meet future demand. Indeed, unless parents, schools, colleges, professional societies, industry, State legislatures, Federal agencies, the President, and Congress act in concert, our national science and engineering workforce will continue to erode and the prospects for maintaining an advanced industrial society will diminish.

In the year 2000, 85 percent of new entrants to the Nation's workforce will be members of minority groups and women. Meanwhile the number of people with disabilities who can go out into the workplace will rise. These three groups have historically been underrepresented in science and engineering. The Nation can meet future potential shortfalls of scientists and engineers only by reaching out and bringing members of these underrepresented groups into science and engineering. America's standing and competitiveness depend on it.

Goals for the Nation

Goal #1

Changing America: The Nation should adopt the goal that all children born today, from all backgrounds, have a quality education, including mathematics and science education and the opportunity to participate in the science and engineering workforce to their fullest potential.

Goal #2

PreK-12 Education: The Nation should reform the preK-12 education pipeline so that our children's mathematics and science competence is better than that of students in countries with which we compete.

Goal #3

Higher Education: The Nation should increase the number and diversity of American students graduating in science and engineering. By the year 2000, we should produce enough professionals in these fields, including more from underrepresented groups, to meet the demand for faculty and for industry and Federal personnel.

Goal #4

Federal Research and Development: Federal research and development funds influence the Nation's entire science and engineering effort. They generate new knowledge, and employ and train scientists and engineers. These funds should be leveraged to help develop a more diverse, world-class generation of scientific and engineering workers by the year 2000.

Goal #5

Federal Employment: The Federal Government should continue to be a pacesetter in developing a work environment that is accessible, equitable, and favorable in attracting and advancing groups underrepresented in science and engineering.

Goal #6

Influence of Culture: Our Nation's future hinges on having an ample supply of people who achieve in mathematics and science, are science-literate, and perform technical jobs with world-class competence. The entertainment industry and the mass media— powerful influences in shaping society's values—must participate in reshaping popular attitudes toward science and engineering.

Declining Autopsy Rates

The first published study of discrepancies between premortem and postmortem diagnoses was made by Cabot[1] in 1912 who emphasized the value of the autopsy in detecting diagnostic errors. This has been confirmed by many subsequent studies (e.g., Goldman[2], 1984; Battle et al[3], 1987; and Landefeld et al[4], 1988). Although overwhelming scientific evidence and clinical experience have proven the value of autopsies in medical education, research, and in monitoring the quality of care for hospitalized patients, autopsy rates have steadily declined since World War II. Autopsy rates in U.S. hospitals have declined from about 50 percent in the 1940s to 41 percent in 1964, 35 percent in 1972, 22 percent in 1975, and to an estimated 10 to 15% overall and 30% in teaching hospitals in 1985.

Goldman et al (1983)[5] reviewed the value of the autopsy in three medical eras and found no real differences in discrepancies during these periods. During 1959-60, 1969-70, and 1979-80, 8 percent to 12 percent of autopsies showed major missed diagnoses for which treatment would have expected to result in cure or prolonged survival. Goldman and his colleagues suggested that modern technology had not improved the overall accuracy of clinical diagnostics. A quantitative assessment of factors influencing discrepancies between premortem and postmortem diagnoses was made by Battle et al (1987)[3] involving 32 university and community hospitals of various sizes and it was concluded that the rate of discrepancies was influenced by the type and size of hospital, the age and sex of the patient, and the disease responsible for the patient's death. The autopsy rate appeared to have equivocal or no influence in community hospitals.

The decline in autopsy rates has been attributed in part to a feeling among clinicians that modern diagnostics do in fact permit them to know everything about their cases; the lack of exposure of medical students to autopsies, leaving them uneducated about the value of the autopsy; and a lack of interest on the part of pathologists. Perhaps of equal importance to the decline are the elimination of autopsy requirements by the Joint Commission on the Accreditation of Hospitals, the absence of insurance and Medicare reimbursement and fear of litigation. On the latter point, studies have suggested that autopsies may lower the number of malpractice awards and reduce the risk of financial loss from malpractice suits.

In 1985 the Association of Pathology Chairmen (APC) declared the autopsy decline as an area of major concern and appointed an Autopsy Task Force to collect data, address issues, and make recommendations on ways to improve the quality of autopsy service and to enhance the autopsy rate. This report is in preparation. Academic chairmen of not only pathology departments but also surgical and internal medicine departments have agreed that a rate in excess of 60 percent is desirable to maintain educational standards. The APC has petitioned the Council of Academic Societies (CAS) to affirm the value of the autopsy and to assist in efforts to increase the autopsy rate. The CAS Administrative Board has recommended that the AAMC Executive Council explore ways the autopsy rate might be increased at teaching hospitals and in medical education.

References

1. Cabot, R.C.: Diagnostic pitfalls identified during a study of 3000 autopsies. JAMA 1912; 59:2295-2298.

2. Goldman L.: Diagnostic advances vs the value of the autopsy: 1912-1980. Arch Pathol Lab Med 1984; 108: 501-505.

3. Battle R.M., Pathak D., Humble C.G., et al. Factors influencing discrepancies between premortem and postmortem diagnoses. JAMA 1987; 258:339-44.

4. Landefeld C.S., Chren M., Myers A., Geller R., Robbins S., Goldman L.: Diagnostic Yield of the Autopsy in a University Hospital and a Community Hospital. N Engl J Med 1988; 318:1249-1254.

5. Goldman L., Sayson R., Robbins S., Cohn L.H., Bettman M., Weisberg M. The value of the autopsy in three medical eras. N Engl J Med 1983; 308:1000-1005.

Experiences of Medical Students in Obtaining Residencies:

Comparison of 1987 with 1988 Graduates

The transition from medical school to residency largely involves the senior year of medical school and the experiences of medical students in obtaining a residency. Beginning in 1986, sixteen questions were added to the AAMC's medical student Graduation Questionnaire to obtain information about the residency application process and its effect on students' senior year. The analysis of the experiences of 1986 graduates were provided to those who attended the Association's annual meeting in November of 1986. It served to focus the discussion at a special session entitled Graduate Medical Education and the Transition from Medical School to Residency.

In the discussions about how to make the transition from medical school to residency less disruptive, the following actions were particularly stressed:

- Move the deadline for submission of rank order lists to the National Resident Matching Program later in the year. The NRMP later announced that the date for 1988 graduates would be shifted from early January to February 19.

- Establish a date for the release of deans' letters to programs. The Council of Deans established November 1, 1987 as the date for the release of deans' letters for the 1988 class to programs.

- Move program application deadlines to later in the year.

- Restrain programs from asking candidates to do "audition" electives to be considered for selection to a program.

- Inform program directors of the limitations of using National Board of Medical Examiners examination scores in making selection decisions. The National Board sent a bulletin detailing the limitations of National Board scores to all program directors.

The dialogue about the transition began too late in the selection process to have an effect on the experiences of the 1987 class. This was confirmed when the data from the class of 1987 survey were compared with the 1986 results. There was essentially no difference in the experiences reported. This year the survey of the class of 1988 shows definite changes, generally in the direction of improving the selection process and smoothing the transition. Because the policies and actions of programs in each specialty differ, the experiences of candidates for one specialty can be quite different from those of another. The legends under each table highlight the changes in experiences of the 1988 class as compared to 1987.

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	
(Change from 1987 in Parentheses)												
Anesthesiology	7.2	(+2.3)	7.6	(-1.1)	51.1	(-10.1)	33.3	(-8.2)	0.0	(-.2)	499	(-11)
Dermatology	6.3	(-2.6)	10.1	(-1.7)	52.5	(-2.3)	28.5	(+4.8)	0.0	(0.0)	158	(+23)
Emergency Medicine	20.2	(+2.2)	10.1	(-.8)	44.6	(-1.9)	23.3	(+.8)	.7	(-.4)	287	(+3)
Family Practice	31.0	(+1.2)	10.9	(+.1)	36.1	(-4.6)	20.9	(+3.1)	.5	(0.0)	1007	(-418)
Internal Medicine	11.5	(-.2)	9.0	(0.0)	52.1	(-2.8)	25.8	(+3.3)	1.0	(-.2)	1021	(+78)
Neurology	12.1	(-1.2)	14.3	(+2.3)	42.9	(-10.4)	29.1	(+7.8)	.5	(+.5)	182	(+32)
Neurosurgery	20.8	(+3.8)	18.9	(+.7)	43.4	(-8.9)	14.2	(+2.8)	0.0	(0.0)	106	(+18)
Obstetrics/Gyn	10.5	(-1.0)	4.3	(-4.3)	65.7	(+3.1)	18.5	(+3.4)	.2	(-.4)	531	(+7)
Ophthalmology	16.7	(+6.6)	21.5	(-1.6)	50.0	(-5.7)	10.1	(0.0)	0.0	(-.3)	288	(-28)
Orthopedic Surgery	26.1	(+1.1)	14.7	(-3.5)	47.1	(+1.7)	11.0	(+.7)	0.0	(-.7)	456	(0)
Otolaryngology	4.9	(+.6)	12.6	(-3.6)	66.1	(-2.0)	14.8	(+4.5)	.5	(0.0)	183	(-2)
Pathology	15.0	(+4.0)	10.2	(-.3)	45.6	(-14.1)	28.6	(+10.4)	0.0	(0.0)	147	(-34)
Pediatrics	28.1	(+8.1)	4.6	(-1.3)	49.9	(-8.1)	15.7	(+.4)	.6	(0.0)	477	(-47)
Psychiatry	16.3	(-4.2)	6.0	(-1.7)	54.3	(+1.8)	21.6	(+3.7)	.8	(+.2)	514	(+7)
Radiology	6.3	(+.7)	9.1	(-1.5)	54.7	(-7.8)	28.7	(+8.6)	0.0	(-.9)	574	(+36)
Surgery	21.6	(-1.4)	9.5	(+.9)	53.8	(-3.3)	13.9	(+3.2)	.3	(+.1)	582	(-83)
Urology	0.0	(-3.4)	5.0	(+1.0)	73.0	(+1.2)	20.6	(-.1)	.7	(+.7)	141	(-33)
All Respondents	14.3	(-.6)	8.1	(-1.2)	46.6	(-6.7)	20.6	(+1.9)	1.9	(-1.2)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The junior year remains the principle year for choosing a specialty, but for the class of 1988, there was a definite increase in the percentage making their decision in the fourth year, and an accompanying decrease in the proportion making their specialty choices in year three. The shift toward a larger proportion in the fourth year could be related to the extension of the deadline for submission of rank order lists to the National Resident Matching Program from early-January to mid-February and the movement of application deadlines from summer/early fall to fall/early winter.

TABLE 2
Percentage of Respondents Reporting When One or More Programs Required Completed Application (Including DL&T)*

Specialty	Prior to July	During July	Aug	Sep	Oct	Nov	Dec	No. of Respondents
(Change from 1987 in Parentheses)								
Anesthesiology	.2 (-1.9)	.4 (-4.5)	1.2 (-14.2)	2.0 (-23.8)	6.2 (-30.6)	32.7 (-2.5)	48.3 (+15.4)	499 (-11)
Dermatology	1.3 (+.6)	1.3 (+.6)	0.0 (-1.4)	4.4 (-4.4)	8.9 (-2.2)	15.8 (-19.0)	54.4 (-3.3)	158 (+23)
Emergency Medicine	1.4 (+.4)	.7 (-.7)	2.4 (-6.4)	2.4 (24.3)	6.6 (-31.7)	34.8 (-4.2)	40.1 (+.4)	287 (+3)
Family Practice	.3 (-.2)	.9 (-1.0)	2.7 (-2.2)	2.7 (-10.8)	4.6 (-17.3)	20.6 (-17.3)	60.1 (+6.6)	1007 (-418)
Internal Medicine	1.0 (+.4)	.7 (-.3)	2.0 (-1.0)	1.3 (-6.1)	3.4 (16.6)	16.3 (-28.2)	65.5 (+9.1)	1021 (+78)
Neurology	.5 (+.5)	.5 (-3.5)	2.7 (-3.3)	1.6 (-20.4)	11.5 (-11.1)	30.2 (-10.4)	41.2 (+20.6)	182 (+32)
Neurosurgery	0.0 (-1.1)	.9 (-2.5)	3.8 (-33.7)	17.9 (-46.8)	24.5 (-11.8)	34.9 (+25.9)	5.7 (+3.5)	106 (+18)
Obstetrics/Gynecology	.4 (+.3)	.6 (-.7)	1.1 (-5.1)	3.6 (-23.4)	7.3 (-35.2)	36.0 (-20.4)	40.3 (+4.3)	531 (+7)
Ophthalmology	.7 (-4.9)	.3 (-18.3)	3.1 (-45.6)	8.3 (-31.5)	20.1 (+13.5)	36.1 (+18.7)	22.6 (-9.3)	288 (-28)
Orthopedics	.4 (-2.2)	.9 (-5.4)	2.4 (-47.8)	4.8 (-78.5)	9.4 (-63.4)	42.8 (+7.3)	30.5 (+16.1)	456 (0)

(Continued)

There has been a definite shift of application deadlines toward November/December. Most programs have accommodated to the November 1st dean's letter release date and the change in the NRMP rank order list submission deadline.

TABLE 2 (Continued)
Percentage of Respondents Reporting When One or More Programs Required Completed Application (Including DL&T)*

Specialty	Prior to July	During July	Aug	Sep	Oct	Nov	Dec	No. of Respondents
(Change from 1987 in Parentheses)								
Otolaryngology	1.1 (-5.3)	1.1 (-22.6)	5.5 (-72.8)	16.9 (-56.0)	31.1 (-2.9)	29.5 (+19.3)	6.0 (+.1)	183 (2)
Pathology	.7 (+.2)	.7 (+.7)	1.4 (-4.6)	1.4 (-19.0)	6.1 (-25.3)	28.6 (-13.3)	55.1 (+7.1)	147 (-34)
Pediatrics	.2 (-.7)	.4 (-.9)	3.1 (-.9)	1.9 (-6.6)	3.4 (-9.9)	22.4 (-15.0)	59.5 (+2.3)	477 (-47)
Psychiatry	1.0 (+.5)	.8 (-1.7)	1.2 (-16.1)	4.5 (-23.9)	8.9 (-21.0)	28.4 (+1.0)	41.8 (+8.5)	514 (+7)
Radiology	.2 (-1.1)	1.2 (-3.6)	1.4 (-16.2)	6.6 (-38.3)	9.9 (-36.3)	40.1 (+4.6)	30.3 (+2.7)	574 (+36)
Surgery	.3 (-1.0)	.9 (-.6)	2.6 (-8.0)	3.3 (-26.7)	6.4 (-33.1)	29.2 (-19.6)	48.1 (+1.5)	582 (-83)
Urology	0.0 (-.5)	.7 (-5.0)	6.4 (-25.2)	15.6 (-45.3)	27.0 (-9.2)	36.9 (+17.4)	7.1 (+3.7)	141 (-33)
All Respondents	.5 (-.7)	.7 (-2.6)	2.2 (10.5)	3.6 (-20.7)	7.5 (-21.8)	26.7 (-12.3)	48.6 (+5.4)	10082 (-906)

*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: 1988 AAMC Graduation Questionnaire

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	
(Change from 1987 in Parentheses)						
Anesthesiology	52.1	(-34.0)	30.1	(+3.4)	499	(-11)
Dermatology	41.1	(-29.3)	38.0	(+8.4)	158	(+23)
Emergency Medicine	51.6	(-34.3)	31.0	(+6.0)	287	(+3)
Family Practice	45.6	(-27.2)	27.5	(+2.5)	1007	(-418)
Internal Medicine	43.2	(-31.8)	32.8	(+5.3)	1021	(+78)
Neurology	47.8	(-24.2)	29.7	(+9.0)	182	(+32)
Neurosurgery	48.1	(-40.5)	36.8	(+10.7)	106	(+18)
Obstetrics/Gynecology	42.9	(-41.8)	34.5	(-5.2)	531	(+7)
Ophthalmology	57.3	(-20.5)	20.1	(-.5)	288	(-28)
Orthopedic Surgery	55.0	(-33.8)	29.2	(+.3)	456	(0)
Otolaryngology	54.1	(-34.5)	35.5	(+5.8)	183	(-2)
Pathology	42.9	(-21.2)	21.8	(+1.9)	147	(-34)
Pediatrics	37.9	(-27.4)	29.6	(+8.2)	477	(-47)
Psychiatry	37.5	(-27.8)	18.3	(-3.1)	514	(-10)
Radiology	46.5	(-37.3)	34.3	(+3.6)	574	(+36)
Surgery	45.4	(-37.0)	35.9	(-.3)	582	(-83)
Urology	53.9	(-30.6)	27.7	(+4.7)	141	(-33)
All Respondents	45.1	(-31.0)	30.3	(+3.5)	10082	(-906)

*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: 1988 AAMC Graduation Questionnaire

There was a remarkable drop in the frequency of 1988 graduates reporting that one or more programs required NBME Part I scores. This was accompanied by a slight increase in the proportion of respondents reporting that Part II scores were required.

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	
(Change from 1987 in Parentheses)				
Anesthesiology	31.7	(-3.2)	499	(-11)
Dermatology	32.3	(+9.4)	158	(+23)
Emergency Medicine	61.3	(-7.0)	287	(+3)
Family Practice	34.7	(-3.8)	1007	(-418)
Internal Medicine	30.0	(-3.1)	1021	(+78)
Neurology	28.0	(+11.7)	182	(+32)
Neurosurgery	76.4	(-7.7)	106	(+18)
Obstetrics/Gynecology	51.2	(-8.9)	531	(+7)
Ophthalmology	27.4	(+2.1)	288	(-28)
Orthopedic Surgery	84.9	(-2.6)	456	(0)
Otolaryngology	62.8	(-8.6)	183	(-2)
Pathology	15.0	(-3.8)	147	(-34)
Pediatrics	32.1	(-3.0)	477	(-47)
Psychiatry	24.3	(-10.6)	514	(+7)
Radiology	30.5	(-3.8)	574	(+36)
Surgery	47.9	(-3.5	582	(-83)
Urology	67.4	(+2.5)	141	(-33)
All Respondents	38.5	(-4.2)	10082	(-906)

*The percentage of nonresponses and the percentage of students reporting that no programs made this suggestion are excluded.
SOURCE: 1988 AAMC Graduation Questionnaire

Overall, there was a decrease in programs recommending that students take "audition" electives at their institutions. However, in excess of 60 percent of students applying to programs in emergency medicine, neurosurgery, orthopedics, otolaryngology and urology were asked to consider taking 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	
(Change from 1987 in Parentheses)						
Anesthesiology	24.0	(-1.5)	8.6	(-2.6)	499	(-11)
Dermatology	33.5	(+.1)	15.2	(+4.1)	158	(+23)
Emergency Medicine	15.0	(-4.0)	22.0	(+.2)	287	(+3)
Family Practice	16.2	(-.4)	10.6	(+1.6)	1007	(-418)
Internal Medicine	55.9	(-14.8)	23.0	(+.1)	1021	(+78)
Neurology	29.7	(+1.0)	8.8	(-.5)	182	(+32)
Neurosurgery	8.5	(-6.3)	30.2	(-.5)	106	(-18)
Obstetrics/Gynecology	20.9	(-5.6)	21.1	(-.7)	531	(+7)
Ophthalmology	27.8	(-5.0)	17.7	(-1.4)	288	(-28)
Orthopedic Surgery	19.7	(-3.5)	38.8	(+1.8)	456	(0)
Otolaryngology	18.0	(+1.8)	16.4	(-10.6)	183	(-2)
Pathology	42.2	(+7.4)	8.8	(+1.6)	147	(-34)
Pediatrics	55.3	(-8.4)	23.9	(-2.2)	477	(-47)
Psychiatry	26.3	(-1.1)	16.3	(+.5)	514	(+7)
Radiology	26.7	(-1.7)	11.8	(-1.1)	574	(+36)
Surgery	31.6	(-4.2)	21.0	(-3.1)	582	(-83)
Urology	14.2	(-6.5)	17.7	(-.7)	141	(-33)
All Respondents	33.5	(-5.7)	19.0	(-.2)	10082	(-906)

*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.
SOURCES: 1988 AAMC Graduation Questionnaire

The proportion of respondents who took two or more electives in the specialty planned for graduate medical education at their own institution dropped from 39.2 percent to 33.5 percent. Overall, there was essentially no change in the proportion taking two or more electives at other institutions. Neurosurgery and orthopedic candidates reported the highest frequency of two or more electives at other institutions.

TABLE 6
Percentage of Respondents Reporting That One or More Programs Asked Them to Make a Commitment Before the Match*

Specialty	Percent		No. of Respondents	
(Change from 1987 in Parentheses)				
Anesthesiology	20.2	(+1.8)	499	(-11)
Dermatology	6.3	(-2.6)	158	(+23)
Emergency Medicine	6.3	(+2.5)	287	(+3)
Family Practice	7.6	(+1.0)	1007	(-418)
Internal Medicine	8.8	(+1.0)	1021	(+78)
Neurology	11.5	(+.1)	182	(+32)
Neurosurgery	11.3	(+3.4)	106	(+18)
Obstetrics/Gynecology	14.1	(-.8)	531	(+6)
Ophthalmology	10.1	(-.4)	288	(-28)
Orthopedic Surgery	16.4	(-12.3)	456	(0)
Otolaryngology	8.7	(-.6)	183	(-2)
Pathology	32.0	(-11.1)	147	(-34)
Pediatrics	9.9	(+3.2)	477	(-47)
Psychiatry	14.4	(-38.8)	514	(+7)
Radiology	18.8	(-17.7)	574	(+36)
Surgery	7.9	(+.7)	582	(-83)
Urology	9.2	(-5.2)	141	(-33)
All Respondents	11.5	(-2.8)	10082	(-906)

*The percentage of nonresponses and the percentage of students reporting that no programs asked for a commitment before the match are excluded.
SOURCE: 1988 AAMC Graduation Questionnaire

There was a slight overall decrease in the frequency of respondents reporting they were asked to make a commitment before the match. The most dramatic change was a drop for psychiatry candidates, from 53.2 percent to 14.4 percent.

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	
(Change from 1987 in Parentheses)												
Anesthesiology	22.8	(+2.6)	25.1	(-2.4)	23.2	(-.5)	27.7	(-2.1)	18	(0)	499	(-11)
Dermatology	36.1	(+2.7)	32.3	(+1.9)	16.5	(+2.4)	10.8	(-3.3)	12	(-2)	158	(+23)
Emergency Medicine	15.0	(-1.9)	23.0	(-.6)	29.3	(+3.6)	30.0	(-.7)	19	(0)	287	(+3)
Family Practice	30.5	(+2.6)	30.0	(-1.4)	18.2	(-1.0)	17.4	(+1.0)	14	(-1)	1007	(-418)
Internal Medicine	27.3	(+2.0)	28.0	(+.9)	21.5	(+1.3)	20.4	(-.9)	15	(-2)	1021	(+78)
Neurology	20.3	(+.3)	23.6	(-5.1)	24.2	(+4.2)	28.6	(-.1)	18	(0)	182	(+32)
Neurosurgery	6.6	(-4.8)	19.8	(+.5)	19.8	(-7.5)	46.2	(+12.1)	23	(+1)	106	(+18)
Obstetrics/Gynecology	19.2	(+.7)	26.0	(+1.8)	23.9	(+.4)	28.2	(+.7)	19	(0)	531	(+7)
Ophthalmology	22.9	(+3.9)	24.0	(-.4)	25.3	(-1.6)	24.3	(-3.5)	17	(-1)	288	(-28)
Orthopedic Surgery	19.5	(+3.1)	21.3	(+2.7)	27.4	(-3.3)	27.4	(-1.8)	18	(-2)	456	(0)
Otolaryngology	17.5	(+1.8)	23.5	(+2.4)	29.5	(+2.5)	26.8	(-4.5)	18	(-2)	183	(-2)
Pathology	34.0	(+2.5)	29.9	(-2.7)	19.0	(+4.6)	12.9	(-3.7)	13	(0)	147	(-34)
Pediatrics	27.7	(+2.5)	26.4	(-3.2)	23.5	(+1.2)	19.5	(+1.2)	15	(-1)	477	(-47)
Psychiatry	32.9	(+1.8	28.2	(-.6)	18.5	(+.6)	16.5	(-.3)	14	(0)	514	(+7)
Radiology	13.6	(-4.3)	21.6	(-1.8)	28.2	(+5.0)	33.6	(+1.0)	20	(+1)	574	(+36)
Surgery	12.7	(+1.4)	19.6	(+.4)	29.4	(+1.9)	35.1	(-3.4)	21	(-1)	582	(-83)
Urology	7.8	(-3.1)	21.3	(+5.8)	22.7	(+3.7)	44.0	(+.3)	23	(0)	141	(-33)
All Respondents	23.4	(+1.3)	25.9	(-.2)	22.9	(+.1)	24.1	(-.5)	17	(-1)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The average number of days spent applying and interviewing for a residency dropped by one day. Candidates for neurosurgery and urology reported the highest number, with an average of 23 days for each. Pathology candidates again had the lowest average at 13 days.

TABLE 8
Number of Dollars Spent Applying and Interviewing for a Residency Position*

Specialty	Respondents Who Spent $0-499		$500-999		$1,000-1,499		$1,500 or more		Average Dollars Spent		Number Responded	
(Change from 1987 in Parentheses)												
Anesthesiology	27.3	(+3.6)	18.4	(-4.5)	15.2	(-2.3)	35.7	(+2.4)	1174	(+26)	499	(-11)
Dermatology	40.5	(-2.5)	20.3	(+3.3)	13.3	(-4.5)	17.1	(+3.0)	796	(+41)	158	(+23)
Emergency Medicine	16.4	(-2.3)	17.8	(-1.6)	17.1	(+.2)	44.6	(+2.3)	1459	(+147)	287	(+3)
Family Practice	47.4	(-3.5)	21.1	(-.9)	12.2	(-1.0)	14.0	(+3.4)	651	(+17)	1007	(-418)
Internal Medicine	33.9	(-2.9)	21.7	(-1.6)	16.6	(-.9)	23.4	(+3.3)	898	(-5)	1021	(+78)
Neurology	22.0	(-4.6)	16.5	(-9.5)	20.9	(+7.6)	37.9	(+6.5)	1340	(+196)	182	(+32)
Neurosurgery	6.6	(+3.2)	6.6	(-4.8)	15.1	(+2.6)	64.2	(-2.9)	2306	(+351)	106	(+18)
Obstetrics/Gynecology	23.0	(+4.1)	23.0	(+.5)	17.7	(+1.1)	32.0	(+2.2)	1186	(-3)	531	(+7)
Ophthalmology	19.1	(+4.3)	14.6	(-6.6)	13.2	(-2.6)	49.0	(+2.5)	1536	(-11)	288	(-28)
Orthopedic Surgery	16.9	(+3.7)	14.3	(-5.4)	20.0	(+.9)	44.7	(-.9)	1537	(+59)	456	(0)
Otolaryngology	13.1	(+2.9)	15.3	(-1.5)	13.1	(-4.2)	55.2	(+3.3)	1798	(+149)	183	(-2)
Pathology	30.6	(-5.3)	23.1	(-.7)	12.2	(0.0)	27.9	(+5.3)	1038	(+114)	147	(-34)
Pediatrics	35.6	(-.5)	21.2	(-4.0)	17.0	(+2.5)	22.2	(+1.8)	869	(-3)	477	(-47)
Psychiatry	30.7	(-2.5)	24.3	(0.0)	14.8	(-2.0)	24.1	(+3.2)	979	(+12)	514	(+7)
Radiology	18.8	(-5.7)	18.8	(+.4)	16.7	(+.2)	41.5	(+3.3)	1406	(+172)	574	(+36)
Surgery	14.6	(-2.2)	18.7	(+.2)	17.9	(-2.4)	45.5	(+3.1)	1515	(+47)	582	(-83)
Urology	7.1	(-2.0)	14.9	(-4.6)	13.5	(-7.8)	61.0	(+12.8)	1796	(+160)	141	(-33)
All Respondents	28.4	(-2.3)	20.3	(-1.8)	16.1	(-.5)	30.4	(+3.2)	1114	(+50)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The average amount spent by all respondents increased by 4.7 percent. There was an 18 percent increase in expenditures by candidates for neurosurgery programs.

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	
(Change from 1987 in Parentheses)						
Anesthesiology	77.2	(+.6)	21.2	(-1.1)	499	(-11)
Dermatology	70.9	(+.5)	25.9	(-3.7)	158	(+23)
Emergency Medicine	83.6	(+.5)	15.0	(+1.2)	287	(+3)
Family Practice	58.8	(-1.9)	37.8	(+.6)	1007	(-418)
Internal Medicine	66.5	(+1.6)	30.8	(-2.7)	1021	(+78)
Neurology	69.2	(+9.8)	28.6	(-10.7)	182	(+32)
Neurosurgery	76.4	(-4.3)	16.0	(-1.1)	106	(+18)
Obstetrics/Gynecology	72.9	(-1.7)	25.0	(-.8)	531	(+7)
Ophthalmology	85.4	(+1.2)	12.2	(-2.3)	288	(-28)
Orthopedic Surgery	88.6	(+.4)	9.6	(-.5)	456	(0)
Otolaryngology	80.3	(-5.1)	17.5	(+6.1)	183	(-2)
Pathology	65.3	(+4.0)	32.0	(-3.9)	147	(-34)
Pediatrics	65.0	(-.9)	33.3	(+.1)	477	(-47)
Psychiatry	62.5	(+2.3)	34.8	(-2.1)	514	(+7)
Radiology	76.3	(-1.0)	21.3	(+.1)	574	(+36)
Surgery	74.1	(-3.6)	24.2	(+3.1)	582	(-838)
Urology	79.4	(-5.7)	17.7	(+4.0)	141	(-33)
All Respondents	69.8	(-.3)	27.5	(-.3)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

There was essentially no change in the extent to which the pursuit of a residency influenced the choice of respondents' electives and the organization of their clinical education.

COUNCIL OF ACADEMIC SOCIETIES
SPRING MEETING

March 15-17, 1989
Sonesta Village Hotel
Orlando, Florida

American Medical Faculty in the 21st Century:
Challenges and Responsibilities

Is the triple-threat academician obsolete?

How do we recruit future faculty?

How should academic units in medical schools be organized?

A luncheon and orientation for new CAS Representatives will be held Wednesday, March 15 at 12:30 p.m. All CAS Reps, both new and old, are encouraged to attend this initial presentation.

The Sonesta Village Hotel is a 96 acre lakefront resort 15 minutes from Orlando International Airport and 10 minutes from Epcot Center and Disney World. Temperatures in Orlando in March average 80 during the day and 65 at night.

Tentative Schedule

Wednesday, March 15, 1989

12:30 - 4:30 p.m.	Luncheon and Orientation for new CAS Representatives
6:00 - 7:00 p.m.	Keynote Speaker
7:00 - 8:00 p.m.	Reception
8:00 - 10:00 p.m.	Dinner

Thursday, March 16, 1989

8:30 a.m. - 1:00 p.m.	Plenary Sessions Continental Breakfast served
6:00 - 7:00	Wrap-up of plenary sessions
7:00 - 8:00	Reception
8:00 - 10:00	Dinner

Friday, March 17, 1989

8:30 a.m. - 1:00 p.m.	CAS Business Meeting Continental Breakfast served