AGENDA
COUNCIL OF DEANS ADMINISTRATIVE BOARD
Thursday, March 15, 1973
AAMC Conference Room
9:00 A. M. - 3:00 P. M.

I. Call to Order

II. Approval of Minutes, Meeting of December 14, 1972 ---------- Tab A

III. Chairman's Remarks - Dr. Sherman M. Mellinkoff

IV. Follow-Up on COD Spring Meeting, 1973; Preliminary Planning for COD Spring Meeting, 1974 ---------- Tab B

V. Annual Meeting Program ---------- Tab C

VI. Admissions, Problems, Follow-Up

- Visitations Meeting, Dr. Clifford Grulee ---------- Tab D

- Matching Plan Meeting, Dr. Clifford Grulee ---------- Tab E

VII. Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibilities for Graduate Medical Education, Dr. August G. Swanson ---------- Tab F

VIII. Report from the Ad Hoc Committee on Continuing Education, Dr. August G. Swanson ---------- Tab G

IX. Federal Relations

A. Impact of the President's Budget, Mr. Joseph Murtaugh

B. RMP-CHP - AAMC Position Regarding Legislative Extension Dr. Andrew Hunt ---------- Tab H

C. HR1: Professional Fees Reimbursement, PSRO's, Dr. Robert Van Citters

X. The OSR: Where it is, Where it's Going - Mr. Kevin Soden

XI. Management Advancement Program Progress Report, Dr. Marjorie Wilson

XII. Management Programs Coordinating Committee Meeting, Dr. Robert Stone

INFORMATION ITEMS

I. CAS Conference on the Impact of Large Center Categorical Grants on the Academic Health Center - March 29, 1973 ---------- Tab I

II. CAS Workshop on Individualized Medical Education - March 29-31, 1973 ---------- Tab J

III. WHO Study on International Migration of Health Manpower ---------- Tab K

IV. International Consortium for the Advancement of Female Health ------- Tab L

V. Correspondence Regarding the Medical College Admissions Assessment Program ---------- Tab M

Association of American Medical Colleges

Minutes

Administrative Board
of the
Council of Deans

December 14, 1972
9 A.M. - 4 P.M.
Conference Room
AAMC Headquarters

PRESENT: (Board Members)

Clifford G. Grulee, M.D.
Andrew Hunt, M.D.
William Maloney, M.D.
William Mayer, M.D.
Robert S. Stone, M.D.
Robert L. Van Citters, M.D.

(Staff)

John A. D. Cooper, M.D.
Charles Fentress
Paul Jolly, Ph.D.
Joseph A. Keyes
Joseph S. Murtaugh
James R. Schofield, M.D.
Marjorie P. Wilson, M.D.

ABSENT:

J. Robert Buchanan, M.D.
Ralph Cazort, M.D.
Sherman M. Mellinkoff, M.D.
Emanuel M. Papper, M.D.

I. CALL TO ORDER

Dr. Maloney, substituting for Dr. Mellinkoff, called the meeting to order shortly after 9:00 a.m.

II. MINUTES OF THE PREVIOUS MEETING

Minutes of the November 3, 1972 Council of Deans Administrative Board were approved as circulated in the agenda book.

III. REPORT OF THE EXECUTIVE COMMITTEE RETREAT

The Administrative Board reviewed the staff summary of the Executive Committee Retreat. There was some discussion regarding the events stimulating the selection of the priorities chosen by the Executive Committee. The primary care initiative, for example, which was mentioned as among the foremost of the new priorities established for the Association, arose as a result of the deliberations of the Association's Task Force on Health Services. The Board expressed some concern that Association activities in this area might tend to exacerbate relationships with the AMA. Preliminary discussions with the AMA, however, indicate that they support the concept of academic health center involvement in the development of models for primary care and the training of physicians in such settings. Board members expressed the view that the Association needs to be sensitive to the potential for the duplication of effort between the AMA and the AAMC and the need to coordinate similar activities, for instance, the study on family practice being done by the AMA and the curriculum study being done by the AAMC.

Two items were identified by the Board as deserving of particular prominence and attention. The first was continuing education. It was the belief of the Board that evolving concepts of the continuum of medical education and the advent of the PSRO's mandated by the Social Security Amendments will stimulate a greater awareness of and a more precise definition of the need for continuing education for practicing physicians. The Board was of the view that academic medical centers can and should play a major role in meeting this need. The second item was the RMP-CHP. Noting that the authorizing legislation for these programs is due to expire, the Board held the view that the Association should have a well-considered and articulated position with respect to their extension. The Board took this view because the involvement of some medical centers in this program is quite significant.

ACTION: By motion, seconded and passed, the Administrative Board adopted the following resolution:

"The Administrative Board has reviewed the report of the AAMC Officers Retreat and the priorities recommended by it. The Board concurs with these

recommendations and suggests greater acknowledgement in the AAMC priorities of commitments of schools in continuing education as the result of the evolving concepts of the medical educational continuum in the implications of H.R. 1 to continuing education."

There was a brief discussion of the problems of financing continuing education programs at the academic medical center. It was concluded that reliance on either state or federal money to support these programs would be unrealistic; in the estimate of the Board, the practicing physician has a responsibility for bearing part of the cost of his continuing education. One means by which this is currently being accomplished is the program worked out in the State of Washington. There, the state medical society has raised the dues of individual physicians twenty-five dollars which is specifically ear-marked for support of the continuing education program at the University of Washington.

IV. THE SPRING MEETING OF THE COUNCIL OF DEANS

The staff reviewed the progress to date in implementing the Board's design of the Spring Meeting Program. Dr. Petersdorf and Dr. Haggerty had agreed to present papers as requested. The speaker for the first session had not yet been finally selected.

This first session was to provide the background and setting for future discussions. It would trace the recent history of funding patterns in medical centers and demonstrate the increasing dependence of medical education on patient-generated income. There would be an effort to uncover the ramifications of pursuing potential funding alternatives in the future. One central question would be whether medical schools should seek to increase or decrease their dependence upon hospital care and professional services income. Several economists were suggested for undertaking this task. A second suggestion, based on the perception that funding sources were to a large degree dependent upon political realities, was that someone in touch with the political world might be more precient about the future sources of funds than an economist.

The Board was highly desirous of making the Spring Meeting a valuable learning experience for the deans. It was hoped that this meeting would provide an opportunity for following up on the Management Advancement Program experiences that many of the deans would have had by providing an opportunity to consider in some depth a particular management problem which they all would be facing. One suggestion for the first session was that it demonstrate the application of one management technique of considerable interest: modeling. It was suggested that perhaps a consultant should be retained to study the area in some depth and suggest a modeling approach applied to either a real or a hypothetical medical center. On the other hand, because the AAMC is a repository for all of the data which such a consultant would need, and because the Association had certain staff capabilities to manipulate this data under the guidelines set by the Administrative Board, it became apparent that a staff study of existing dependence on patient-generated income would be an appropriate starting point for the morning program.

One outside influence to which the schools will be required to accommodate is the changing patterns for professional services reimbursement mandated by H.R.1. Thus it was felt that this factor should receive considerable attention.

With these broad outlines of the morning's program thus established, the Board left the remainder of the program planning to the staff and an informal subcommittee of the Board consisting of Dr. Stone and Dr. Van Citters.

V. QUALITY OF CARE SUBCOMMITTEE REPORT - NEXT STEPS

The Board reviewed the recommendations of the Health Services Task Force on the Quality of Care. It had no further recommendation to make regarding the implementation of the program suggested by the subcommittee. The discussion resulted simply in the exhortation that the Association "get on with it."

VI. THE ADMISSIONS COMMITTEE REPORT FOLLOW-UP

The Board noted with approval the staff efforts to implement the recommendations of the ad hoc committee on admissions

problems adopted by the Council of Deans. The seminar "The Dynamics of a Student Matching Program" scheduled to be held on December 11, 1972 had not taken place because an automobile accident prevented the principals from making their connecting flights.

With respect to the feasibility study on a student matching plan, the Board expressed some concern that the write-up prepared for the Executive Committee Retreat might have contained a self-fulfilling prophecy that the program was not feasible. The staff response was that the statement causing the concern was an attempt to be sensitive to the issue raised at the Council of Deans meeting that the prior wording constituted a self-fulfilling prophecy that the plan was not only feasible but would be implemented. There was no attempt to bias the wording on one side of the issue or another.

VII. COD INPUT TO AAMC PRIORITIES

The Board considered that this matter had been adequately discussed under its consideration of the results of the Executive Committee Retreat.

VIII. CONSIDERATION OF OSR BUSINESS MEETING

The Board considered and rejected a suggestion that the Chairman of the Organization of Student Representatives be invited to attend the Administrative Board meetings as a matter of course. It adopted the suggestion that the Chairman be invited to attend the next meeting of the Administrative Board to present a progress report on the development of the OSR and its view of its own role and function.

The Board adopted the suggested changes in the OSR rules and regulations developed at the Business Meeting of the OSR, November 2 and 3, 1972.

ACTION: On motion, seconded and carried, the Board approved the following amendments to the OSR Rules and Regulations proposed by the OSR:

"a) Section 4 (Officers and Administrative Board), Article A, Paragraph 3, should be changed to read:

'The Secretary, who duties it shall be (a) to keep the minutes of each regular meeting, (b) to maintain an accurate record of all actions and recommendations of the Organization, and (c) to insure the dissemination of the minutes of each regular meeting and a record of all actions and recommendations of the Organization, of the organizations contigent to the AAMC Assembly, and of the Organization's representatives on the committees of the AAMC, within one month of each meeting.'

b) Section 3 (Membership). Add:

'C. Each school shall choose the term of office of its representatives in its own manner.'"

IX. LUNCHEON WITH THE ADMINISTRATIVE BOARDS OF THE CAS AND COTH AND MEETING WITH SSA OFFICIALS

At 12 noon the Board adjourned for luncheon with members of the CAS and COTH Administrative Board.

Following lunch the group was joined by Thomas M. Tierney, Director, Bureau of Health Insurance and Robert Hoyer, Assistant Director of the Bureau, Social Security Administration. The two hour meeting which followed was devoted to an exploration of Section 227 of P.L. 92-603 "Payments of Supervisory Physicians in Teaching Hospitals."

Section 227 provides that reimbursement "for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis.

There are two exceptions to this provision:

1) Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients."

2) The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients

(and the majority of whom paid) on a fee or package charge bais for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made."

A number of questions were raised and responded to, e.g.:

--Concerning implementation of the second exception as stated above, what documentation or other changes in the organizaion of professional services, if any, will be required?

-- Concerning the "private patient" relationship, do the anticipated changes have a similar implementation in the hospital based specialties . . . specifically radiology, pathology, cardiology?

-- What factors will determine whether "consultations" are on a fee or cost basis? If consultations are on a cost basis, how will cost be calculated?

-- If it is determined that reimbursement for services of teaching physicians should be included under Part A on an actual cost or equivalent cost basis, how will cost be calculated? (Time and effort?)

The SSA Officials were quite candid in admitting that for a number of issues the final interpretation of the legislation and the drafting of regulations had not been completed. At Mr. Tierney's suggestion, the Association agreed to appoint an ad hoc committee to work with the SSA staff in developing regulations which would take account of the vital interests of the teaching hospitals to the maximum feasible extent.

The committee subsequently appointed consists of:

Robert A. Derzon (Chairman)
Director of Hospitals & Clinics
University of California
San Francisco

John M. Dennis, M.D.
Professor of Radiology
University of Maryland

L. Edgar Lee, Jr., M.D.
Assistant Dean for Administration
Case Western Reserve University

Arnold S. Relman, M.D.
Chairman, Department of Medicine
University of Pennsylvania

G. Thomas Shires, M.D.
Chairman, Department of Surgery
University of Texas
Southwestern Medical School

Robert Van Citters, M.D.
Dean
University of Washington
School of Medicine

Charles B. Womer
Director
Yale-New Haven Hospital
New Haven

X. Adjournment

The meeting was adjourned shortly after 3:00 p.m.

PROGRAM IN MEDICAL SCIENCES

Florida State University • Florida A & M University • University of Florida College of Medicine

Office of The Director

March 9, 1973

Dr. Marjorie Wilson, Director
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Marjorie:

Enclosed is the second and (thanks to you and Jim) improved version of the proposal to study cooperative programs in medical education. I hope it is near enough to what we discussed to be able to take it directly to the appropriate meetings next week.

Please transmit the extra copies to Jim and to Tom Bowles and Gus Swanson - as I promised I would send one to each of them.

Thanks very much for your help. If the staff likes it, I will be glad to work on the project in any capacity.

Sincerely yours,

Paul R. Elliott

Enclosure

Student Health Center • Florida State University • Tallahassee • Florida • 32306 • A.C. 904-599-4690

THE UNDERGRADUATE UNIVERSITY AND THE MEDICAL SCHOOL:

INTEGRATED AND INTERACTING PATHWAYS IN MEDICAL EDUCATION

I. INTRODUCTION:

Medical education in the twentieth century has always maintained a dynamic and evolving character, adjusted both externally and internally to meet the changing needs of society, and to meet the perceived objectives of the medical profession. In the last two decades, the rate of change and adjustment has increased to the point of becoming a preoccupation (and even an occupation) of many medical educators. In the domain of professional education, and very possibly, in all of higher education, no field of study has undergone a comparable series of metamorphoses.

In very recent years, the last six or eight, increasing pressures for the education of more physicians, for adjustment of the composition of entering classes to reflect more accurately the composition of our society, for the development of outreach programs centered on health care delivery, and for an increase in the time and content flexibility of the medical curriculum have created a unique and positive environment for change. That environment for change is now reaching out to those years which in the past were traditionally separate entities of "premedical" and "postgraduate" education. In fact in 1972, the primary foci of experimentation within the medical curriculum appears to have shifted to those premedical and postgraduate periods.

As the economic base for all of higher education continues to diminish, it is increasingly likely that the undergraduate years and the residency years will become even further involved in the dynamics of medical education. In this proposal we will be considering specifically some of the changes occurring in the relationship between baccalaureate and medical education.

The Undergraduate University and Medical Education:

Much has been written regarding the role of the academic medical center in a University setting, but until recently, with the occasional and positive exceptions of a Northwestern or a Johns Hopkins, the relationship of these two units of higher education was more often one of mutual tolerance than of involvement; and that tolerance was generally one of polite professional courtesy between the "pure" liberal arts humanist and the "applied" human engineer. Even the plethora of funds for research and graduate education in the sciences from 1955 to 1970 did little to adjust the artificial barriers separating the two sides of the campus.

However, the pressures on medical education alluded to in the introduction coupled with the economic pressures on all of higher education are generating a renewed interest in cooperative programs between the medical school and the undergraduate university. In these days of demand for "accountability" in higher education, the multiple use of existing facilities and faculties, time-shortened curricular pathways and increased numbers of graduating physicians, as incorporated in most cooperative programs, represent positive values to those private and public agencies concerned with the support of medical education.

This is not to say that the development of cooperative programs in medical education has no merit beyond the economic carrot and stick. In fact, in a variety of aspects - ranging from student needs, to educational philosophy, to the needs of society - they are somewhat overdue. It is to say that this positive rationale coupled with the forces of social and economic necessity have created an environment where the proliferation of such programs is not only likely, but is potentially explosive. It is the further contention of this brief introduction that the development, accreditation, and control of such new programs will be much more difficult to monitor than was the post-Flexnerian development from 1910 to 1965 of the discrete and rather isolated unit called a medical school. Medical schools are, for good reasons, essentially similar if not identical. Undergraduate colleges, for as many good reasons are highly dissimilar.

It is not surprising therefore, that these newly developed cooperative programs represent widely different models. Four basic models are obvious:

1. Completely integrated six year programs, e.g. Michigan's Interflex.

2. Dispersive component curriculum, e.g. The State of Indiana plan.

3. Two + Four programs with the primary curriculum alteration at the undergraduate campus, e.g. Hahnemann-Wilkes; Albany-RPI.

4. Four + Two programs with basic science curriculum transferred to undergraduate component, e.g. Florida State-Florida A & M - Florida.

Since the author of this document is the administrator of such a cooperative program, it is difficult to avoid a tone of advocacy for their development. My view is one of positive optimism for this "new" direction in medical education. Yet at this particular time, what is needed is neither advocacy, nor uninformed criticism, but critical evaluation. Further, there is the need for definitive information about existing programs in order to furnish optimal conditions for the development of new cooperative ventures in medical education

when they are warranted, and to develop a working foundation of knowledge for the Liaison Committee on Medical Education, and for the Department of Institutional Development of the Association of American Medical Colleges.

II. PROPOSAL:

It is proposed that the development of an objective analysis of cooperative baccalaureate- medical education programs be coordinated by the A.A.M.C. with support to be generated from a request to a private foundation (See Budget page). In brief, this proposal recommends (1) the careful generation of six analytical papers, (2) to be prepublished as a monograph for the 1973 Annual Meeting of the AAMC, (3) with five of those papers to be presented at a half-day session of the Council of Deans or Council of Academic Societies at the 1973 meeting. (4) If necessary and advisable, this could be followed by a working conference on cooperative programs in the Spring of 1974, requiring an additional request for outside funding.

ANALYTICAL PAPERS:

The analytical papers as proposed are:

A. Historical overview and general description of the evolution of Non-M.D. degree medical education programs, including all cooperative, integrated, or interacting programs between Medical Schools and undergraduate institutions.

B. A critical analysis of the financing of cooperative programs.

C. A critical analysis of all student affairs aspects of such cooperative programs.

D. A critical analysis of the curriculum of cooperative programs.

E. A critical analysis of the administration and faculty staffing of cooperative programs.

F. An appendix in which are presented formally-structured descriptions of all existing cooperative programs.

This appendix would require the development of a questionnaire (thus furnishing the common reportorial format) to be completed by the senior administrator of each existing cooperative program.

Some of the areas to be covered in the questionnaire might include:

1. Funding

- Sources of Budget (Federal, State, Private)
- Approximate Direct Costs by Categories
- Medical School Input
- University or College Input

2. Students

- Selection (when, by whom, criteria)
- Financial Aid
- Student Affairs Staff
- Counseling
- Determination of Promotion of Students (when, by whom)

3. Curriculum

- Required and Prerequisite Courses
- Total Hour Requirements
- Grading System
- Clinical Correlations
- Point of Entrance into Medical Curriculum (if not fully integrated)

4a. Administration

- Structure
- Relationship to Medical School
- Relationship to University Administrative Units
- Relationship to Other Health Professions Programs
- Relationship to Undergraduate College Departments

4b. Faculty

- Number
- Departmental or College Affiliation
- Source of Faculty for Clinical Correlations
- Salary Range by Rank
- Projected Faculty Size

4c. Physical Facilities

- New Facilities Planned or Constructed
- Renovated Facilities (cost and purpose)

5. Objectives of Program - an opportunity for each administrator to describe the special philosophy and objectives of their Program.

Editing and Publication:

The authors of the analytical papers would be selected as follows:

Papers A-E (critical analyses) - to be written by selected medical faculty or administrators with special and broad knowledge of the five areas presented.

Appendix - to be compiled by a staff member of the AAMC.

One of the selected authors and the AAMC staff member compiling the appendix would serve as co-editors of the monograph to be prepublished for the AAMC Annual meeting. Four of the authors of the analytical papers (A-E) would receive a $500 honorarium. The co-editors of the monograph would each receive a $1000 honorarium. (See Budget).

LOGISTICS:

As now envisioned, the preparation of this publication would entail the following sequence of events.

1. Final development of proposal for outside support (by April 1, if possible).

2. Upon receipt of financial support, the selection of the Co-editors.

3. Selection of the remaining four authors of the analytical papers.

4. Meeting of the authors and co-editors in Washington to develop the questionnaire (May, 2-3 days).

5. Mailing of questionnaire with returns expected by June.

6. Meeting of the authors and co-editors to develop rough outlines of the papers (July, 2-3 days).

7. Final drafts of the six papers due by September 1.

8. Prepublication and mailing in early October.

9. Presentation of papers (A-E) at annual meeting if approved as a session topic.

IN SUMMARY:

A. The economic, social, and philosophical environment of medical and baccalaureate education has created the potential for the proliferation of cooperative and interacting programs between medical schools and undergraduate colleges. Many such programs are now being considered, planned or implemented.

B. It is important that developing (and warranted) programs have the best possible information about existing programs available to them.

C. For purposes of monitoring and accrediting new integrated and interacting programs by the LCME and the Department of Institutional Development (AAMC), it is important to have an objective analysis of this cooperative area of medical education.

D. This proposal represents a means of obtaining such objective analysis and of presenting it to the medical education community without an overtone of advocacy or of criticism.

PROJECT BUDGET

PERSONNEL:

1.	AAMC Staff Support	$5,000.00
2.	Authors' Honoraria (4 X $500)	2,000.00
3.	Co-editors (2 X $1000)	2,000.00

EXPENSE:

1.	Travel (2 meetings X 3 days) for Four Authors and Editor	2,000.00
2.	Publication and Mailing Costs	5,000.00
	TOTALS:	$16,000.00

D R A F T

March 15, 1973

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Explanation of Proposed Four-Stage Plan to Help Alleviate the Admissions Crisis for the 1975-76 Entering Class*

Unless appropriate steps are taken by medical school deans and admissions officers, approximately 40,000 applicants are expected to file some 280,000 applications for only about 15,000 places in the 1975-76 entering class. The magnitude of excessive paperwork and expensive processing in store is brought home even more forcefully when one calculates the above almost nineteen applications for each available place.

On the recommendation of the AAMC Council of Deans, an extensive study was conducted during the past year of possible ways to help alleviate the growing admissions crisis. This study included a thorough investigation of the feasibility of an admissions matching plan as one possible solution.

Results of the above feasibility study plus alternative solutions were presented on March 12, 1973 to a large advisory panel representing the COD, CAS, GSA, OSR and the AAHP. Although it was apparent that a matching plan was technically feasible and relatively inexpensive, it was the consensus of the panel and of AAMC staff that an alternative four-stage plan would be more feasible at this point in time and would accomplish most, if not all, of the objectives of a matching plan. If the four-stage plan proves to be acceptable and successful, however, a matching plan might be an eventual logical next step, particularly as regards the "Uniform Acceptance Date" stage of the proposed plan.

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*Prepared by Dr. Davis G. Johnson, Director of AAMC Division of Student Affairs.

The proposed four-stage plan is summarized on the attached chart and is largely self-explanatory. Special attention, however, is called to the following points:

1) Stage 1 (Information Dissemination) could conceivably reduce the potential pool from 40,000 to perhaps 35,000 and might well lower the average number of applications per applicant from the current 7 to perhaps 6. This above would result in an overall reduction of 70,000 applications. The publicizing of more specific information about the characteristics of accepted students has long been urged by applicants and by premedical advisors and many schools have started doing this, particularly those participating in AMCAS.

2) Stage 2 (Early Decision Plan) could eliminate approximately 45,000 applications if the proposed target of 50% of the 15,000 places were filled via this plan. It should be noted that under this proposal, applicants would have 2½ months to apply, advisors would have until October 15 to submit their evaluations and the medical schools would have until November 15 to complete their screening of EDP applicants. Incidentally, non-EDP applications would also be submitted anytime after July 1, but they would be clearly marked so the schools could process them at their leisure. A description of EDP is attached.

3) Stage 3 (Uniform Acceptance Date) would allow any EDP applicant rejected on November 15 a month to file additional applications. It would also allow the advisors until January 15 to submit their evaluations on these and on all non-EDP candidates. Even more importantly, the uniform date would enable the medical school to consider its remaining pool as a whole and would permit the applicant to receive and consider all of his offers simultaneously. He would also have a full month (rather

than the current two weeks) to compare schools on financial and other grounds and to reach a firm decision, thus greatly reducing the current problem of widespread "musical chairs."

4) Stage 4 (Rolling Admissions) would enable schools to complete balancing their classes. Since only a proposed 10% of the class would be filled after February 15, admissions staffs should have a much less demanding Spring work schedule than is now the case. This in turn, should help prepare them for the slightly heavier Summer and early Fall work schedule that could result from filling up to 50% of the class via the Early Decision Plan.

5) Rejection notices would continue to be mailed as promptly as possible after all of the rejectee's pertinent admissions credentials have been received and evaluated by the medical school. This will allow the rejected applicant to start making alternative plans as early as possible.

Proposed next steps are as follows:

1) Approval in principle of the proposed four-stage plan at the Spring, 1973 regional meetings of the GSA (and of the AAHP and OSR)?

2) Official approval of the four-stage plan (slightly modified if necessary) at the Fall, 1973 national meetings of the GSA, OSR and COD.

3) Implementation of the national plan starting in November, 1973 to help alleviate the admissions crisis for the 1975-76 entering class.

4) Implementation of plan on a local or regional level starting in the Spring of 1973, if desired, to help simplify the application process for the 1974-75 entering class.

DGJ/sg 3/15/73

Attachments: 1) Draft of Proposed Four-Stage Plan

2) Description of Early Decision Program

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Draft of Proposed National Four-Stage Plan to Help Alleviate the Admissions Crisis for the 1975-76 Entering Class#

Stage	Key Features of Plan	Proposed % of Places to be Filled	Advantages of Each Stage (assuming potential 40,000 applicants for 15,000 places)	Proposed Dates			
1 - Information dissemination to applicants and advisors	Publicize widely (a) national facts such as only 1 in 50 out-of-state applicants are admitted to state schools and (b) local statistics about characteristics of last entering class at each medical school	—	1) Should help discourage some poorly qualified individuals (5,000?) from applying "to any medical school at all." 2) Should help discourage others from applying to specific schools (1 each?) where their chances of admission are essentially zero. 3) The above would eliminate 70,000 applications.	Admissions Book Deadline - 11/73 AMCAS Participation Deadline - 12/73 AMCAS Booklet Deadline - 2/74 The Advisor, Datagrams and news releases - starting immediately Medical School Catalogs and Admissions Publications - 1973 on			
2 - Early Decision Plan (EDP)*	Applicant applies to only 1 school by specified date (e.g. 9/15) which he agrees to attend if accepted by given date (e.g. 11/15)	up to 50%	1) Would eliminate approximately 45,000 applications (7,500 x 6) or an average of about 400 per school. 2) Should enable schools to enroll more of their first-choice applicants.	Application Dates	Premedical Evals. Due	Applicants Notified	Applicants Reply by
				7/1 - 9/15	10/15	11/15	12/1
3 - Uniform Acceptance Date	No offers other than EDP would be made until specified date (e.g. 2/15)	40% or more	1) Would allow schools to consider balance of applicant pool as a whole, with more equity for applicants and a better chance to obtain a balanced class. 2) Would eliminate "musical chairs" for all but a maximum of 10% of acceptees. 3) Month to reply to simultaneous offers allows applicant time to consider financial and other aspects of decision.	7/1 - 12/15	1/15	2/15	3/15
4 - Rolling Admissions	Offers may be made any time following specified date (e.g. 2/16)	10%	1) Would allow schools to balance out class as regards women, minority group members, out-of-state residents, etc.	7/1 - 12/15	1/15	2/16 to Start of Classes	2 Weeks After Receipt of Offer

*Possibly rename as "Single Application Stage."
#Could also be instituted at the local or regional levels for 1974-75 entering class if desired but would require special publications.

N.B. Rejection notices should be mailed as soon as possible after the rejectee's admissions credentials have been received and evaluated by the medical school.

DGJ/sg 3/15/73

Description of Early Decision Program as it will appear in the AMCAS Information Booklet for the 1974-75 Entering Class

For the 1974-75 entering class, 19 AMCAS participating medical schools and three non-participating schools will take part in the Early Decision Program. This officially publicized program provides the following advantages to the applicant:

1. Permits the applicant to file a single early application prior to September 1, 1973.

2. Guarantees a prompt decision from the school, usually by October 1, 1973.

3. Allows the applicant who is not accepted by a given school as an Early Decision candidate to be reconsidered and possibly accepted by that school as a regular candidate early in the admissions season.

To participate in an Early Decision Program, the applicant must apply to only one U.S. medical school. If the applicant applies as an Early Decision candidate to any U.S. medical school whether or not it is participating in AMCAS, he cannot apply to any other U.S. medical school until after the Early Decision has been made on his application. The applicant must attend that school if it offers him a place during the Early Decision segment of the admissions year.

If the applicant is not accepted by the medical school which he applied as an Early Decision candidate, he may arrange to apply to additional schools as desired.

* * * * * *

Schools That Have Announced Official Early Decision Program for 1974-75 Entering Class

1. Brown*
2. California - San Diego
3. University of Chicago
4. Chicago Medical
5. George Washington
6. Hawaii
7. Illinois
8. Loyola
9. Meharry*
10. Nevada
11. Northwestern
12. Ohio at Toledo
13. Medical College of Pa.
14. Rush
15. Southern Illinois
16. Texas - Galveston*
17. Utah
18. Medical College of Va.
19. Vanderbilt
20. Washington - Seattle
21. Washington Univ. - St. Louis
22. Wisconsin

* Schools not participating in AMCAS

DGJ/slw 3/16/73

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Proposed Role of OSR and GSA Representatives in Monitoring Procedures of the National Intern and Resident Matching Program (NIRMP)*

(1) The OSR's role in assisting in the maintenance of the NIRMP should be mainly one of channeling student reports of non-compliance to a committee established to review such problems by the dean of each medical school.

(2) Depending on local administrative structure, the dean might, for example, appoint the Associate Deans for Student and Clinical Affairs and the OSR representative as a complaint review committee. It is assumed that the Associate Dean for Student Affairs is a GSA representative.

(3) In late Spring when the NIRMP is explained to the rising seniors, the importance of working through and within the established procedures should be stressed. Students would be asked to report to the OSR representative evidence of attempts on the part of any internship or first-year graduate program to seek contract agreements outside of the established arrangement for matching. The OSR representative should attend this meeting and should indicate how he can be reached by students wanting to report such evidence to him or her.

(4) Depending on procedures established by the NIRMP complaint review committee on each campus, the OSR representative could promise anonymity to a complaining student, but he would be responsible for securing all pertinent data in a form pre-established by the complaint review committee. As necessary, the OSR representative would request a meeting of the committee to determine whether the data submitted merit follow-up and, if so, who should be responsible for further investigation and communication. Should it be confirmed that irregularities exist and that the hospital program in question did not intend to abide by its NIRMP agreement, the committee would advise the dean, who would send a letter detailing the situation to the NIRMP Board of Directors with a copy to the AAMC's Executive Committee. It would then be up to the NIRMP Board to take prompt action with respect to investigation of the charges and to provide for subsequent communication with all medical schools as appropriate.

(5) OSR representatives should be involved in the monitoring procedure only as collectors of information about suspected non-compliance and as participants in detailed review of these data by the complaint review committee. Although OSR representatives should not deal directly with programs perpetuating alleged infractions, they can play an exceedingly important role not only by serving on the complaint review committee but also by persuading their fellow students to help maintain the NIRMP at the highest possible level by refusing to accede to any attempt to bypass or undercut the approved procedures.

*Developed by staff of the AAMC Department of Academic Affairs on the basis of suggestions from the OSR Administrative Board.

Attachments: 1) Suggested Report Form
2) Manuscript on "The NIRMP and its Current Problems"

DGJ/sg 3/14/73

W#8334

D R A F T

Suggested Form for Reports of Non-Compliance with Regulations of the National Intern and Resident Program (NIRMP)*

1. Description of non-compliance (Describe in detail when the incident(s) took place, what individuals, programs and institutions were involved and exactly what transpired.)

2. Report completed on _____ (date) by _____ name (optional), Class of 197___ (yr. of graduation)

at _____ (name of school).

3. Report reviewed on _____ (date) by _____ (name of OSR representative).

4. Report presented by OSR representative to Complaint Review Committee on _____ (date).

5. Action by Complaint Review Committee (Check all that apply)

☐ Investigation conducted with following outcome: _____

_____

☐ Advised Dean on _____(date) that irregularities exist and that hospital program in question does not intend to abide by its NIRMP agreement.

☐ Other (specify) _____

_____

_____

Signatures of members of Complaint Review Committee: 1) _____

2) _____ 3) _____

6. Explanatory letter sent to NIRMP Board of Directors with copy to AAMC Executive Committee by _____ (signature and title of Dean) on _____ (date).

* * * * * *

*Form to be completed concerning any significant attempts by an internship or first-year graduate program to seek contract agreements from students outside of the established regulations for NIRMP matching.

DGJ/sg 3/12/73

W#8334 - R

Manuscript Submitted to the Journal of Medical Education

THE NIRMP AND ITS CURRENT PROBLEMS

by
Joseph Ceithaml*-and Davis G. Johnson**

The National Internship Matching Program (now the National Internship and Residency Matching Program [NIRMP])has been successfully matching graduating medical students to internships in the hospitals of their choice for 22 years. In the last year or two, some problems have arisen which need attention lest they weaken the efficacy of NIRMP. This communication summarizes these problems in the context of a recent AAMC survey of experiences with the NIRMP by the 1972 graduates of U.S. medical schools.

To appreciate the problems, one must first understand the matching plan. In the Matching Program there are three principal elements. First there is the graduating medical student seeking a post graduate clinical appointment (usually an internship) in a hospital of his highest possible choice. Next there is the clinical program director at the hospital seeking to fill his quota of places with the best possible applicants. And finally there is the NIRMP itself which simply implements the procedure by which the students may obtain the best appointments they can and the hospitals, in turn, may secure the best of their applicants.

Historically, the Matching Program was conceived some 22 years ago under the auspices of the Association of American Medical Colleges (AAMC) by a small group of Medical School Student Affairs representatives who sought to bring some order and reason into the chaotic "catch as catch can" non-system of internship assignments of that time. Interestingly enough, before the Matching Program was finally adopted it was significantly modified in accordance to suggestions made by a group of senior medical students. These students, representing a relatively large

*Dean of Students, University of Chicago, Pritzker School of Medicine
**Director, AAMC Division of Student Affairs

(over, please)

number of medical schools, met in New York City during the winter holidays of 1950, reviewed the original matching plan proposal, and then made recommendations. These recommendations were incorporated into the final draft of the Matching Program which was subsequently approved by the medical students, the medical schools and the hospitals (1).

The NIRMP has a Board of Directors with representatives from the following organizations concerned with graduate medical education: the AAMC, the American Medical Association, the American Hospital Association, the Catholic Hospital Association, the American Protestant Hospital Association, and the American Board of Medical Specialties. In addition, representing the student participants, there are 3 students on the Board, including one from the Student American Medical Association.

The NIRMP also has an Executive Committee and a small full time staff. Relatively simple guidelines were established by the Board of Directors with the consultation of all interested parties, whereby the students, after applying to various hospitals send a confidential ranking of these hospitals to the NIRMP, and the hospitals, in turn, send the rank order of their applicants to NIRMP. The NIRMP then matches the students' choices with the hospitals' to effect the highest possible matching, and both the students and the hospitals agree to abide by the matching results.

The Matching Program has served both the students and the hospitals exceedingly well for over 20 years, and each year, some 96 to 98% of the graduating students and 98 to 99% of the hospital units approved for training, participate in the Internship Matching. However, in recent years changes have occurred which are understandably creating some problems. Free-standing internships are being phased out of existence and at the same time more and more clinical disciplines are no longer requiring an internship as a prerequisite for a first-year residency appointment.

To complicate matters, during the current transitional years, the program directors were not bound by the NIRMP guidelines since they were considering only interns for the residency appointments. Now, however, these same program directors are obligated to respect the NIRMP guidelines if they wish to consider medical students for their residency appointments. Under these circumstances, the following situations obtain: a) For the medical student seeking only an internship, there are no significant problems. b) For the medical student considering either an internship or a first-year residency appointment, there may be a problem if the program director of the residency program insists that the student make his decision without waiting for the Matching Program results to be announced. c) For the residency program director seeking to fill some of his first-year residency places with graduating students, again there are problems. His objective is to fill his quota of residents. Those he selects from the intern pool of applicants may be selected outside of the NIRMP guidelines just as in the past. But those he selects from the medical student pool of applicants must be selected in accordance with NIRMP guidelines, and that is where the rub is.

The NIRMP still remains simply as the machinery to implement the procedure in the manner that the medical schools and their students and the hospitals see fit. It has now been suggested that the NIRMP should also assume responsibility for maintaing the sanctity of the guidelines and for enforcing the "all or none" principle. This principle states that if a medical center or hospital offers any of its first-year post graduate clinical appointments (internships or first-year residencies) to graduating medical students it may not offer any such appointments to any graduating medical students outside the NIRMP prior to the announcement of the NIRMP results. A corollary to this principle states

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that if any program director in a hospital intends to offer positions to medical students not in accordance with the NIRMP guidelines, such a decision would disqualify all other programs in that hospital from participating in the NIRMP.

In the Spring of 1972, the NIRMP Board of Directors, cognizant of a small but significant number of violations of NIRMP guidelines, primarily in the case of first-year residency appointments, requested the Group on Student Affairs (GSA) of the AAMC to conduct a survey to ascertain, among other things, to what extent violations of the NIRMP guidelines had occurred in the 1972 Matching Program. Appropriate questionnaires were sent to the 94 medical schools which had four year graduating classes in June of 1972. It is highly significant and reflects the great importance attached to the Matching Program, that all 94 schools responded.

A summary of selected items in the questionnaire to which there were objective responses appears in Figure 1. Items 1 and 2 show that of the 9,014 reported first-year graduate appointments, 9% were residencies. Item 3 indicates that, coincidentally, 9% of the 1972 seniors secured their appointments outside the NIRMP. Of these 783 students, however, only those 26% in Items 3d and 3e were violating the spirit, if not the letter, of the NIRMP guidelines. Thus, of the 9,014 reported students, only an estimated 201 or 2% were involved in NIRMP violations in 1972.

Item 4 reveals that only the "sham" use of NIRMP appeared to have a significantly adverse effect on the Matching Program. Item 5, however, indicates that 21% of the residency appointments were obtained outside the NIRMP by medical students. Furthermore, it is expected that by 1975, a majority of first-year appointments will be residencies. Therefore, unless the violations of the NIRMP guidelines as they pertain to first-year residencies are curbed now, the Matching Program could become

relatively ineffective, and the result would be a throwback to the disorganized, chaotic, and highly unsatisfactory non-system of the pre-NIRMP era.

Item 6 identifies the clinical disciplines which were reported by the medical schools to have put pressure on medical students to make a private advance agreement rather than adhering to the NIRMP guidelines. Most frequently reported were Psychiatry by 41 schools; Ob/Gyn by 13 schools; Ophthalmology by 7 schools; and Surgery by 6 schools. It is unfortunate that in order to assure themselves of the residency appointments they seek, a relatively small number of program directors has succeeded in doing a great disservice, both to their disciplines and to the students whom they encourage to violate their NIRMP contractual agreements.

Item 7 shows that 67 (or 77%) of the 87 schools responding to the item reported that all or a majority of their students would support the NIRMP in a showdown. This was further confirmed by the recent action of the Organization of Student Representatives of the AAMC, which like the Group on Student Affairs representatives, wants the NIRMP to take all steps necessary to enforce the NIRMP guidelines.

In summary, violations of the NIRMP guidelines were virtually unknown when all of the first-year graduate appointments were internships. Now when 9% of these appointments are residencies, a small but a significant number of violations have been reported. As an increasing proportion of the first-year appointments become residencies, however, the current problems may become very serious unless the violations of the NIRMP guidelines are promptly eliminated. The NIRMP has served the hospitals

(over, please)

and the medical students superbly for twenty-two years, and can continue to do so, provided it continues to receive the full cooperation of all parties involved. The NIRMP needs and deserves that cooperation.

Reference

1. Mullin, F. J. and Stalnaker, J. M. The Matching Plan for Internship Appointment. J. Med. Educ., 26:341-46, 1951.

FIGURE 1

Summary of Results of Section A of Questionnaire to Student Affairs Officers Concerning the National Intern and Resident Matching Program (NIRMP)*

	No.	%
1) How many of your 1971-72 seniors went on to internship training?	8,192	91
2) How many of your 1971-72 seniors went on to residency training?	822	9
TOTAL number of individuals	9,014#	100

3) Of these, how many obtained their appointment to the first year of graduate training outside of the NIRMP by the following means?	Estimated@ No.	%
a) Married to classmate and took option of negotiating directly with program directors.	139	18
b) Started graduate training during January-March, 1972 and thus officially exempted from NIRMP participation.	104	13
c) Didn't sign up for NIRMP for other reasons. (Major reasons were military internships, 97; hospital not in NIRMP, 43; and Canadian internship, 29).	312	40
d) Made a private advance agreement with the director of a U.S. graduate training program so withdrew from NIRMP.	69	9
e) Made a private advance agreement but "went through the motions" of staying in the NIRMP.	132	17
f) In program but not matched by NIRMP.	27	3
Estimated TOTAL of Individuals	783 (9% of 9,014)	100

* Based on replies from all 94 U.S. medical schools with senior students during 1971-72, with results presented in the format of the questionnaire which was distributed by the AAMC Division of Student Affairs during September, 1972.

9,014 represents 94% of the 9,551 graduates reported in the 1971-72 Education Issue of the JAMA. Discrepancy due to incomplete replies on NIRMP questionnaire and to some graduates not immediately entering house staff training.

@ Approximately 50% of the replies to question 3 were "estimated."

(over, please)

4) To what extent do you feel the above methods of "bypassing" the NIRMP have weakened the program at your school?

Means of "Bypassing" the NIRMP	Extent Weakened NIRMP					
	None	Some	Greatly	Very Greatly	No Reply	Total Schools
a) Married to classmate	71	13	0	1	9	94
b) Started training early	55	17	1	0	21	94
c) Not signed up for other reasons	47	20	7	3	17	94
d) Signed up but withdrew	42	23	7	3	19	94
e) "Sham" use of NIRMP	32	17	14	8	23	94
f) Other	(Not applicable)					
TOTAL No.	247	90	29	15	89	470
TOTAL %	53%	19%	6%	3%	19%	100%

	No.	% of 9,014
5) How many of your 1971-72 seniors went directly into residency programs?	822	9
Of these, how many did so outside of the NIRMP?	173 (21% of 822)	2

6) Which disciplines, if any, have put pressure on your students during the past year to make a private advance agreement rather than adhering to the NIRMP guidelines?

(Disciplines reported most frequently were Psychiatry - by 41 schools; OB-GYN - 13; Ophthalmology - 7; and Surgery - 6).

7) In order to help maintain the NIRMP, what proportion of your student body do you estimate would be willing to refrain from applying to and/or from signing an agreement with any training program not abiding by the NIRMP rules?

All - 16; A Majority - 51; A Minority - 15; None - 2; Other - 3; No Reply - 7

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Council of Deans

DATE March 14, 1973

TO: The Council of Deans Administrative Board

FROM: Mr. Joseph A. Keyes

SUBJECT: The Report of the Actions of the Council of Deans Taken at the March 9, 1973 Session

ACTION: On motion, seconded and adopted:

"The Council of Deans recommends that the Executive Council direct the revision and expansion of the paper entitled, 'Medical Education, the Institution, Characteristics and Program - A Background Paper', to include a discussion of the issues presented and the development of a potential long-range strategy for approaching their solution; such a paper to take the form of a 'green paper' for discussion and review by the Executive Council, the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals and ultimate adoption by the AAMC Assembly."

2. On motion, seconded and adopted:

"The Council of Deans recommends that the Executive Council develop, for public release in an appropriate manner, a statement of the Association's support of the present role and contribution of the Veterans Administration in the support of medical education and acknowledging the appreciation of the Association for the effectiveness of the present leadership in enhancing VA medical school relationships."

JAK:evc

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAR 9 1973

INTER-OFFICE MEMO

Retain – 6 mos.	☐
1 yr.	☐
5 yrs.	☐
Permanently	☐
Follow-up Date	☐

DATE March 7, 1973

TO: Joe Keyes

FROM: Dr. James B. Erdmann

SUBJECT: Program Material for the 1973 AAMC Annual Meeting for the Consideration of COD

Thanks for your time on March 5 and your promise to pursue the possibilities with Marjorie and, if appropriate, with the COD Administrative Board. In summary, this is the information I wanted to share and obtain the advice of you and Marjorie on.

Two events, each of major significance are approaching major stages of development between now and the time of the Annual Meeting. The first is our own activity related to the development of an Admissions Assessment Program (MCAAP). The second involves the release of the report of the Goals and Priorities Committee of the NBME to the medical education community. Both of these events were of serious concern to the Group on Medical Education who discussed the potential of each for program material at the Annual Meeting. The first suggestion was that a joint GME/GSA day devoted to the topics was attractive. Further discussion by GME and GSA officers and AAMC staff recognized that the implications of these events were very likely of major interest to the COD and CAS as well. At that point, the possibilities were tested out with Gus, who indicated that CAS had some serious plans for a separate program on Sunday, November 4. He did like the idea personally and recommended that we do explore it further with you and Marjorie for COD consideration. It now has taken the shape of a full day devoted to assessment. Assessment would be treated from the perspective of the contiuum, i.e. at selection, just prior to enrollment, during medical school, etc. Evaluation of academic progress would be presented in terms of external and internal measures (NBME and faculty respectively) and would include both instructional and certifying types (formative and summative respectively). I think you can see how MCAAP progress, the NBME Goals and Priorities Committee Report, National Test Item Bank, etc. are logical topics for discussion.

The ideas regarding program I hope you understand are in an evolving stage. So far both GSA and GME have indicated an interest in being associated with the planning and sponsorship of such a program and would like to determine the interest of the COD relative to its other possibilities. We feel that all day Wednesday would be an opportunity to plan such a program.

COPIES TO:

Since planning is in its early stages, not a great deal of clarification is possible, but if you have any questions, I'll give them a try. Tom Bowles is also equally involved and can respond to any inquiries.

JBE/emw

cc: Dr. Tom Bowles
Dr. Gus Swanson

IV. Follow-up on COD Spring Meeting, 1973; Preliminary Planning for COD Spring Meeting, 1974

We will need to begin almost immediately making arrangements for the 1974 Spring COD Meeting. Questions to be resolved include an evaluation of this year's program and format, the date and location of next year's meeting, and some discussion of topics and format for next year's meeting.

We have put a tentative hold on the Broadmoor Hotel, Colorado Springs for the dates March 6-9 and a hold on the Greenbrier, White Sulfur Springs, West Virginia for the dates March 27-30, 1974. Both have adequate facilities for the meeting.

Rates - Greenbrier: $35/day; includes three meals, gratuities and public space.

Rates - Broadmoor: $21/day; includes only meeting room space.

Transportation: The following pages give an indication of the flight schedule to the two locations.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

DATE March 6, 1973

TO: COD Administrative Board

FROM: Joseph A. Keyes

SUBJECT: The Broadmoor Hotel, Colorado Springs, Colorado

The hotel can accommodate one hundred twenty-five persons. They can provide meeting space for one hundred twenty-five persons and four breakaway rooms.

The availability is as follows:

March 6-9 and March 27-30

March 6-9 would be better all around because the 27-30 they expect to be crowded. Breakaway rooms will probably be difficult for them to provide March 27-30.

The rates for 1974 will be determined this June.

Rates quoted at this time are:

Singles, $21.00

Doubles (Twin Beds), $24.00

These rates are the group discount rates.

The hotel does have banquet facilities.

Travel time to and from the airport is approximately twenty to twenty-five minutes, depending on the traffic; the airport is about twelve to fifteen miles from the Broadmoor Hotel.

evc

Flights to Colorado Springs, Colorado from the East Coast, the West Coast, Chicago, and Dallas are relatively good flights. Most of the flights during mid-day are connecting flights.

Listed are flights from New York City, Boston, Washington, D. C., Los Angeles, and Chicago. All flights from Boston are connecting flights. All flights from Washington National Airport are connecting flights. There is one flight from Dulles Airport that makes two stops and does not connect. New York City has one flight that is not a connecting flight, but that flight makes three stops. Chicago has two flights that do not make connections; one in the morning and one in the late afternoon. Los Angeles has one flight that does not make connections. That flight is an early flight, 9:40AM, Pacific Standard Time.

Washington, D. C.			Eastern Standard Time		
X6	6:00 PM	D	9:17 PM	BN101	
Boston, Massachusetts			Eastern Standard Time		
X7	7:30 AM		12:16 PM	TW193	ONE STOP
	10:49 AM	DEN	11:50 AM	FL691	
X7	7:30 AM		12:23 PM	TW193	ONE STOP
	10:49 AM	DEN	12:00 N	CO133	
X7	7:30 AM		12:47 PM	TW193	ONE STOP
	10:49 AM	DEN	12:25 PM	BN61	
	12:00 N		3:26 PM	TW185	NO STOPS
	2:12 PM	DEN	3:00 Pm	FL693	
	1:35 PM		5:59 PM	UA321	NO STOPS
	2:59 PM	Chi. (O'Hare)	4:45 PM	CO71	
	4:30 PM		7:56 PM	UA163	NO STOPS
	6:50 PM	DEN	7:30 PM	FL697	

X - Except
1 - Monday
2 - Tuesday
3 - Wednesday
4 - Thursday
5 - Friday
6 - Saturday
7 - Sunday

Chicago, Illinois — Central Standard Time

	9:25 AM	O	10:50 AM	CO137
	4:45 PM	O	5:59 PM	CO71

Los Angeles, California — Pacific Standard Time

	9:40 AM	L	12:31 PM	CO70

New York, New York — Eastern Standard Time

X6	4:45 PM	J	9:17 PM	BN101	THREE STOPS

2/15/'73:evc

PIEDMONT AIRLINES
QUICK REFERENCE SCHEDULE FOR
GREENBRIER VALLEY AIRPORT

FROM GREENBRIER VALLEY AIRPORT
TO:

Leave	*Arrive*	*Flight*
ATLANTA		
2:41PM (via Roanoke)	5:06PM	PI 916/37
CHICAGO		
1:22PM (via Cincinnati)	4:37PM	PI 937 DL 732
CINCINNATI		
1:22PM	3:28PM	PI 937
9:04PM	11:31PM	PI 919
LOUISVILLE		
1:22PM (via Cincinnati)	5:59PM	PI 937/PI 964
NEW YORK		
(La Guardia)		
2:41PM (via Roanoke)	5:20PM	PI 916/74
(Newark)		
2:41PM (via Roanoke)	6:47PM	PI 916/38
ROANOKE		
9:01AM	9:22AM	PI 900
2:41PM	3:02PM	PI 916
4:31PM	4:52PM	PI 902
WASHINGTON		
9:01AM (via Roanoke)	10:40AM	PI 900/984
2:41PM (via Roanoke)	4:17PM	PI 916/42
4:31PM	6:31PM	PI 902

PI — Piedmont Airlines
DL — Delta Air Lines

PIEDMONT AIRLINES
QUICK REFERENCE SCHEDULE FOR
GREENBRIER VALLEY AIRPORT

TO GREENBRIER VALLEY AIRPORT
FROM

Leave	*Arrive*	*Flight*
ATLANTA		
10:43AM	1:10PM	PI 34/937
(via Roanoke)		
CHICAGO		
10:30AM	2:29PM	DL 759/
(via Cincinnati)		PI 916
CINCINNATI		
7:15AM	8:49AM	PI 900
12:55PM	2:29PM	PI 916
2:25PM	4:19PM	PI 902
LOUISVILLE		
6:30PM	8:52PM	PI 18/919
(via Roanoke)		
NEW YORK		
(La Guardia)		
10:45AM	1:10PM	PI 1/937
6:15PM	8:52PM	PI 49/919
(both flights via Roanoke)		
(Newark)		
10:45AM	1:10PM	PI 73/937
(via Lynchburg)		
ROANOKE		
12:48PM	1:10PM	PI 937
8:30PM	8:52PM	PI 919
WASHINGTON		
10:00AM	1:10PM	PI 3/937
(via Roanoke)		
7:00PM	8:52PM	PI 983/919
(via Roanoke)		

(Effective: April 30 1972)

All times listed are local Day Light Savings Times. Schedules subject to change without notice.

V. Annual Meeting Program

The following page describes the theme and format of the Association's Annual Meeting. Monday afternoon is set aside for Council business meetings and Wednesday morning for Council program meetings. Indications are that items needing specific COD action may be few and subject to rather expeditous handling. Thus it may be possible to devote a significant proportion of the business meeting to the presentation and discussion of reports of Association activities of major importance to deans, for example, developments in the area of accreditation: the activities of the Coordinating Council on Medical Education, the Liaison Committee on Graduate Medical Education, etc; and the efforts of the Management Programs Coordinating Committee, the Management Advancement Program and the Management Systems Development Program.

Several suggestions have been received regarding possible COD programs. More detailed material on these suggestions will be distributed at the Board meeting but briefly they are: 1) A paper (attached) by K. L. Kutina, M.B.A. and L. E. Lee, Jr., M.D., "A Management Decision Oriented View of Medical School Information System Requirements," presented at the 1973 BOS seminar. 2) A program devoted to an exploration of the costs, administrative arrangements and quality control considerations relating to satelite medical education programs. A proposed program is being developed by Paul Elliott, Ph.D., Director of the Program in Medical Sciences at Florida State. 3) A program jointly sponsored by the COD and the AAMC Group on Medical Education devoted to the exploration of the role internal and external assessment programs in the selection and promotion of students. Conceived as consisting of two sessions, the program would center around the report of the National Board of Medical Examiners Goals and Priorities Committee and the AAMC's Medical College Admissions Assessment Programs.

1973 AAMC ANNUAL MEETING

"Preparation and Role of the Physician: Comparative Approaches"

The Association's 1973 Annual Meeting will be held November 4 - 8 in Washington, D. C. This represents a change in format from the weekend meeting to one which will begin on Sunday and continue through Thursday. This change in format came at the request of the Executive Council, and weekday meetings have been scheduled for all coming years, when available. The Executive Council concurred in the format and theme of the meeting at its December 15, 1972 meeting.

The 1973 meeting will examine the changing role of the physician in the United States and abroad. Two or three international speakers will discuss this phenomenon from the perspective of their countries, and the remaining speakers will relate these experiences to the present and future American physician. The Alan Gregg Lecturer will provide a global summation of the changing role of the physician and how the medical schools might better prepare students to meet the new challenges.

Since the Annual Meeting has grown to well over 3,000 participants, it has become an increasingly attractive forum for political speeches on health. With the meeting location in Washington, it would be difficult and politically unwise to attempt to exclude completely Congressional and Administration spokesmen. Moreover, the presentations of the political leaders seem to be the most favorably discussed part of the meeting.

The Association has asked President Nixon to address our meeting. Should the President prove unwilling, the Secretary of HEW will be asked in his place. In addition, Congressman Wilbur Mills and Senator Russell Long have been asked to speak.

With Sunday serving as the arrival date for most participants, Plenary Sessions will be held on Monday and Tuesday mornings. Business meetings of the Councils will be held on Monday afternoon and the Assembly on Tuesday afternoon. Wednesday morning will be reserved for a program of the Councils, similar to the joint COD-CAS program held last year. Sunday afternoon, Wednesday afternoon, and all day Thursday will be open for committee meetings and meetings of outside groups (including Academic Society meetings).

	S	M	T	W	T
AM	///	Plenary	Plenary	Council Program	Misc.
PM	Misc. / OSR	Council Business	Assembly Minority	Misc.	Misc.

A MANAGEMENT-DECISION ORIENTED VIEW OF MEDICAL SCHOOL INFORMATION SYSTEM REQUIREMENTS

By

K. L. Kutina, M.B.A.
and
L. E. Lee, Jr., M.D.

School of Medicine

Case Western Reserve University

August 23, 1972

INTRODUCTION

At the School of Medicine of Case Western Reserve University the principle has been established that an effective management information system, because of resource limitations, can only be developed modularly[1]; and that each additional module added will be evaluated *based on its contribution to managerial planning and decision-making procedures.* This is meant to be in sharp contrast to a policy of establishing information systems via a cataloging of medical center activities, without regard to each data component's impact on top management's needs.

The managerial planning and decision-making procedures referred to here can be defined as having three basic components as discussed in (1):

1.) Long-range planning (4-10 years into the future);

2.) Programming (1-3 years into the future); and

3.) Budgeting (0-1 year into the future).

The long-range planning and programming activities tend to merge into one continuum at CWRU called *program or operations planning* and rely on a set of computerized simulation models which generate forecast operational data and budgets in a programmatic format, as well as by organizational unit (as listed in Table I), and the usual expense and income categories.

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[1]Nevertheless, there should be a plan for the total *integrated* information system, and each module added should fit a slot in this plan.

Table I

ORGANIZATIONAL UNITS FOR LONG-RANGE
PLANNING AND PROGRAMMING PURPOSES

Basic Sciences
University Hospitals
County Hospitals
Other Affiliates
Support Departments
Total Medical School

Exhibit I is a sample output from the model system for the Basic Sciences Group. This particular printout contains hypothetical data and is included for illustrative purposes only. It should be noted that at CWRU, since all the affiliated hospitals are corporately independent of the University, the only hospital-borne expenses (second data column in Exhibit I) normally included in the School's planning procedure are salaries of personnel who have direct involvement in University programs.

The short-term (zero to one year) budgeting operation, being a detailed name-by-name, item-by-item procedure is not carried out in a program format but rather only by expense and income categories within each organizational unit. At CWRU it is felt that major programmatic decisions are necessarily made over a longer time scale than one year -- thus it is required that planning tools have program cost determining capabilities, but it is not worth the large additional effort that would be necessary to produce a program format in the very short-range, necessarily highly detailed, budgeting procedures. Decisions in the short-range theater such as individual salary increases, optimal utilization of grant funds, purchases of specific pieces of equipment, dollars for travel or supplies, etc. are at the departmental level and are made in the context of guidelines established by the planning

EXHIBIT I

BUDSIM RUN FOR CWRU SCHOOL OF MEDICINE
EXPENSE AND INCOME BY PROGRAM - FISCAL 19XX/XX

BASIC SCIENCES (DOLLARS IN THOUSANDS) RUN DATE 8/16/72

	PAYMENT SOURCES			PROGRAMS					
				INSTRUCTION				RES	PAT SERV
	UNIV	HOSP	TOTAL	MD	GRAD+ P-DOC	HSE OFF	OTHER		
DIRECT EXPENSE									
FACULTY	1300	30	1330	110	205	5	50	955	5
HOUSE OFFICERS	0	0	0	0	0	0	0	0	0
STAFF	920	10	930	50	100	0	15	765	0
FRINGE	270	0	270	20	40	5	10	190	5
STUDENT SUPPORT	350		350	20	290	0	0	40	0
OTHER NON-SAL	1140		1140	30	350	0	5	755	0
TOTAL DIR	3980	40	4020	230	985	10	80	2705	10
INDIRECT EXPENSE									
UNIV CHARGE: PLT	130		130	40	10	0	5	75	0
ADMIN	250		250	50	30	0	5	165	0
LIBRARY	30		30	5	15	0	2	8	0
NET HOSP CHARGE		0	0	0	0	0	0	0	0
TOTAL INDIR	410	0	410	95	55	0	12	248	0
TOTAL EXPENSE	4390	40	4430	325	1040	10	92	2953	10
% EXPENSE	99.1	0.9	100.0	7.3	23.5	0.2	2.1	66.7	0.2
INCOME									
RESTRICTED									
TUITION	210		210	70	50	0	90	0	0
ENDOWMENT	0		0	0	0	0	0	0	0
RESEARCH	2500		2500	0	0	0	0	2500	0
TRAINING	800		800	0	530	0	0	270	0
STATE SUBSIDY	130		130	130	0	0	0	0	0
FED CAPITATION	50		50	50	0	0	0	0	0
MISC GIFTS	90		90	0	90	0	0	0	0
HOSPITAL		40	40	0	0	20	0	0	20
TOT RESTRICT	3780	40	3820	250	670	20	90	2770	20
% RESTRICTED	99.0	1.0	100.0	6.5	17.5	0.5	2.4	72.6	0.5
PROGRAM NET	-610	0	-610	-75	-370	10	-2	-183	10
UNRESTRICTED									
ENDOWMENT	50		50						
MISC GIFTS	0		0						
TOTAL INCOME	3830	40	3870						
INCOME - EXPENSE	-560	0	-560						

OPERATIONAL DATA	
NO OF FT FACULTY	78
NO OF PT FACULTY	2
NO OF VOL FACULTY	4
FTE HSE OFFICERS	0
FTE POST-DOCS	17
FTE GRAD STUD	90
FTE UNDERGRAD	17
FTE MD STUD	374
FTE OTHER STUD	75
NET SQ FT UNIV	116000
NET SQ FT UH	0
NET SQ FT COUNTY	0

PROGRAM EXPENSE SUMMARY

		%
INSTRUCTION	1467	33.1
RESEARCH	2953	66.7
PATIENT SERVICE	10	0.2
TOTAL	4430	100.0

process which incorporates programmatic decisions. The utility of carrying the program format down to the level of detailed short-range budgeting decisions is questionable, and the cost would most likely be prohibitive.

At the core of this paper is the philosophy and functioning of the program planning and budgeting system which is evolving at the CWRU School of Medicine, and how it is serving to pin-point the most critical management information needs of the institution. Perhaps the most valuable by-product of the process of developing and implementing comprehensive operational and financial simulation models for planning purposes is the vivid way in which data shortcomings are highlighted. It stands to reason that if the models are geared to the needs of managerial decision-making and if they realistically simulate the operations and financial structure of the institution, the informational needs of management are identical with those of the models. In addition, the rigor of the analysis required for simulation model development is such that it will probably reveal data needs *critical to the managerial decision process* the importance of which were previously unrecognized. To understand the management information system needs at the CWRU School of Medicine, then, it is necessary to look at its program planning and budgeting system in more detail.

Model's-eye View of the School of Medicine

Exhibit II is a graphical representation of the CWRU School of Medicine as it is simulated by the planning model system. The key factors to take note of here are:

1.) Certain demand elements (graduate students, post-doctoral students, interns, and residents), *in addition to requiring educational services, also serve as resource inputs* -- i.e. they provide instruction, research, and patient service effort at the operational level;

2.) From the point of view of the Medical School, demand for patient service is viewed simply as a requirement for a given number of service man-hours per year which must be supplied from the resources available;

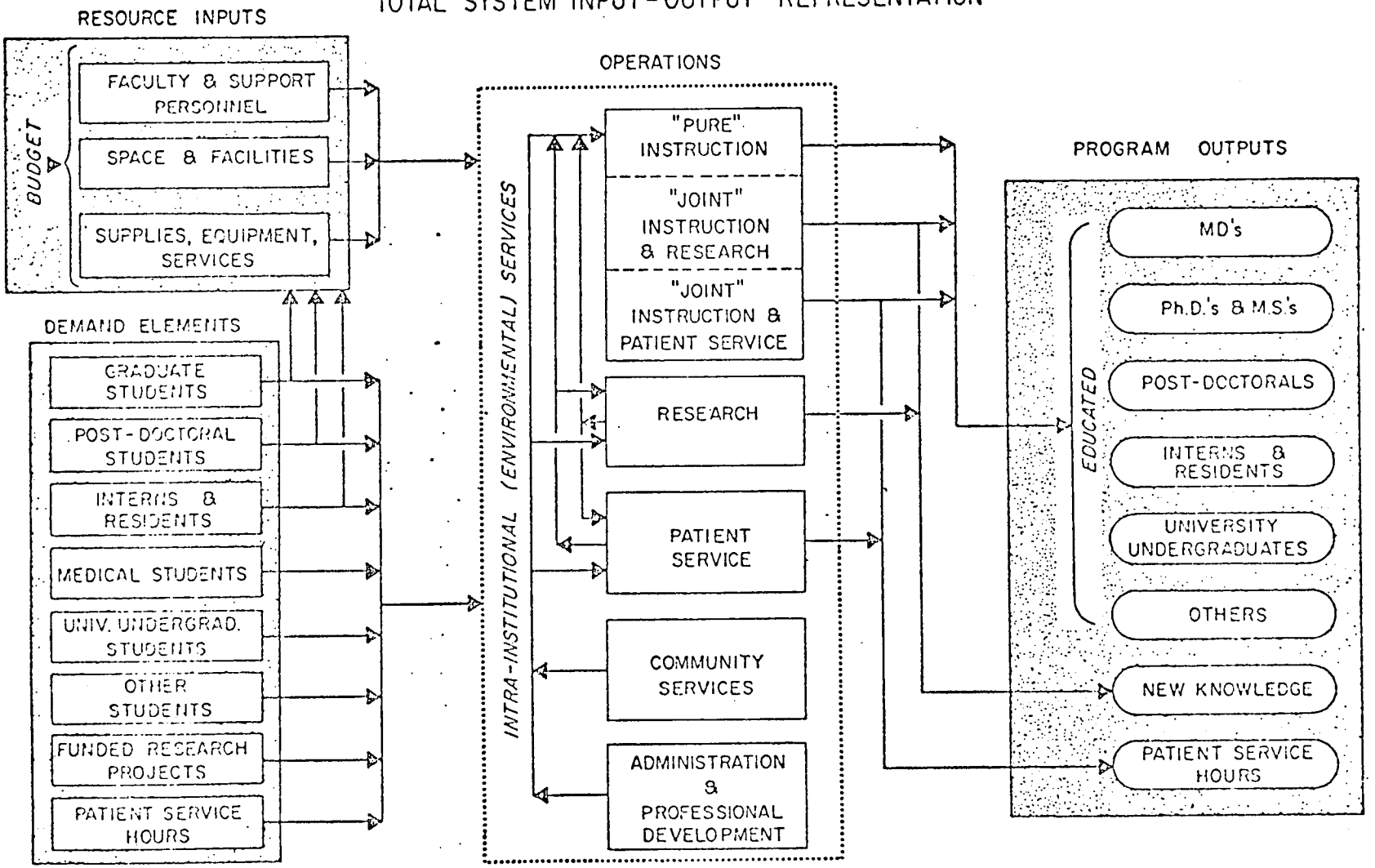
3.) Within the operations of the institution certain activities are viewed as existing only to provide the appropriate institutional environment for its missions of teaching, research and patient care.[1] This is true of administration, faculty professional development, and community services (including services to granting agencies). Similarly, the activity of research not only produces results in satisfaction of an independent demand (via funded projects) and is thereby a legitimate program output in its own

[1]Denoted by the "intra-institutional services" arrows on the left side of the operations sector in Exhibit II.

EXHIBIT II

CASE WESTERN RESERVE UNIVERSITY — SCHOOL OF MEDICINE

TOTAL SYSTEM INPUT-OUTPUT REPRESENTATION



right, but also the existence of a certain minimum level of this activity is necessary to provide an adequate institutional environment to carry on effective programs of teaching and patient service. Thus, this minimum level is allocable or chargeable to the teaching and patient service programs. The same rationale applies to patient service with respect to teaching and research; and

4.) Certain faculty activities within the operations sector clearly produce joint products. At CWRU the primary activities of this type are joint instruction + research (e.g. a graduate student working under a faculty member's direction on his dissertation research project), and joint instruction + patient service (e.g. a faculty member with students accompanying him on his rounds). Other joint activities are possible (i.e. joint patient service + research, or joint patient service + research + instruction), but it is not useful to segregate these at CWRU. The hallmark of joint product activities is that the effort relating to any single product produced by the joint activity is not rigorously physically separable in the real world. Obviously, however, for program costing purposes some arbitrary split must be utilized.

Major Areas of Planning and Decision-Making

The areas of planning and decision-making having a major impact on the operation of the Medical School, and with which the techniques discussed in this paper are concerned, relate to changes in:

1.) Enrollment;

2.) Student mix (proportions of M.D., Ph.D., etc.);

3.) Curricula content and length;

4.) Other program operating levels and modes;

5.) Staffing and compensation policies;

6.) Funding patterns; etc.

The capability of making meaningful decisions and plans involving changes of the type listed above is dependent upon having reasonably accurate estimates of the *incremental resources required and incremental output program costs* as a result of the proposed course of action *in time to implement the change*.

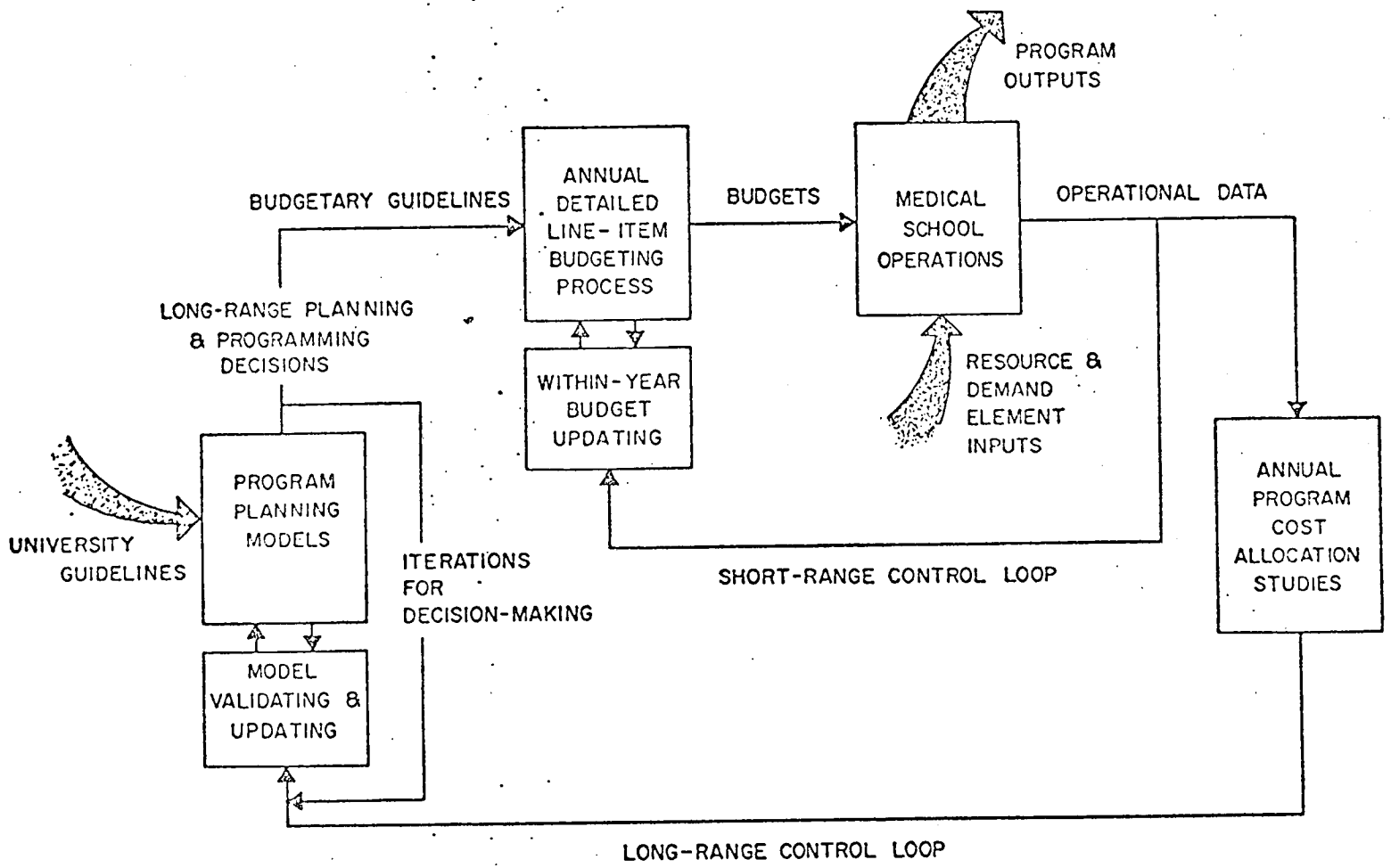
A System to Respond to the Planning and Decision-Making Needs

An important component of any program planning and budgeting system is a rigorous procedure for updating its predictive capability. This is the function of the feedback control loops shown in Exhibit III. The program planning models produce projected expense and income in a program format for successive years into the future. As those years become reality, actual program cost allocation studies are executed. A comparison of final plans generated for a given year with the actual (after-the-fact) program cost study -- taking into account any unplanned final operating changes -- will indicate the predictive accuracy of models. Model parameters can be adjusted on the basis of these analyses. Another approach is to use the models to simulate immediate past years for which program cost studies are completed. Comparison of these model results with actuals is an excellent basis for model parameter "fine tuning".

The short-range control loop in Exhibit III performs a similar function to the long-range control loop. The original budget for a given year is, of course, prepared before the start of the year. As the year progresses,

EXHIBIT III

PROGRAM PLANNING AND BUDGETING SYSTEM WITH FEEDBACK CONTROL



actual year-to-date information becomes available and the budget is adjusted accordingly to better represent the remainder of the year. This process is done quarterly in the School of Medicine at CWRU.

This system obviously depends on an adequate information system. Its needs are discussed in the next section.

Overview

Exhibit IV displays the major data base components required to support the operation of the various subsystems of the program planning and budgeting system. The program cost allocation methodology referred to here is that developed by the AAMC. See reference (3), where specific data requirements are detailed. Once the planning subsystem provides budget guidelines the annual budgeting procedure (including quarterly updates) essentially requires only standard financial data, currently available via the CWRU accounting system (financial accounting is a central University service of the Controller's Office). The information needs of the planning simulation models are listed above the respective models in Exhibit IV.

Curricular Data File

This file must contain information concerning every course currently offered by Medical School departments such as:

1.) The type of instruction involved (pure instruction, joint research + instruction, etc.);

2.) Organizational source of the instructor;

3.) Student group size per section of the course;

4.) Instructor contact hours per section; and

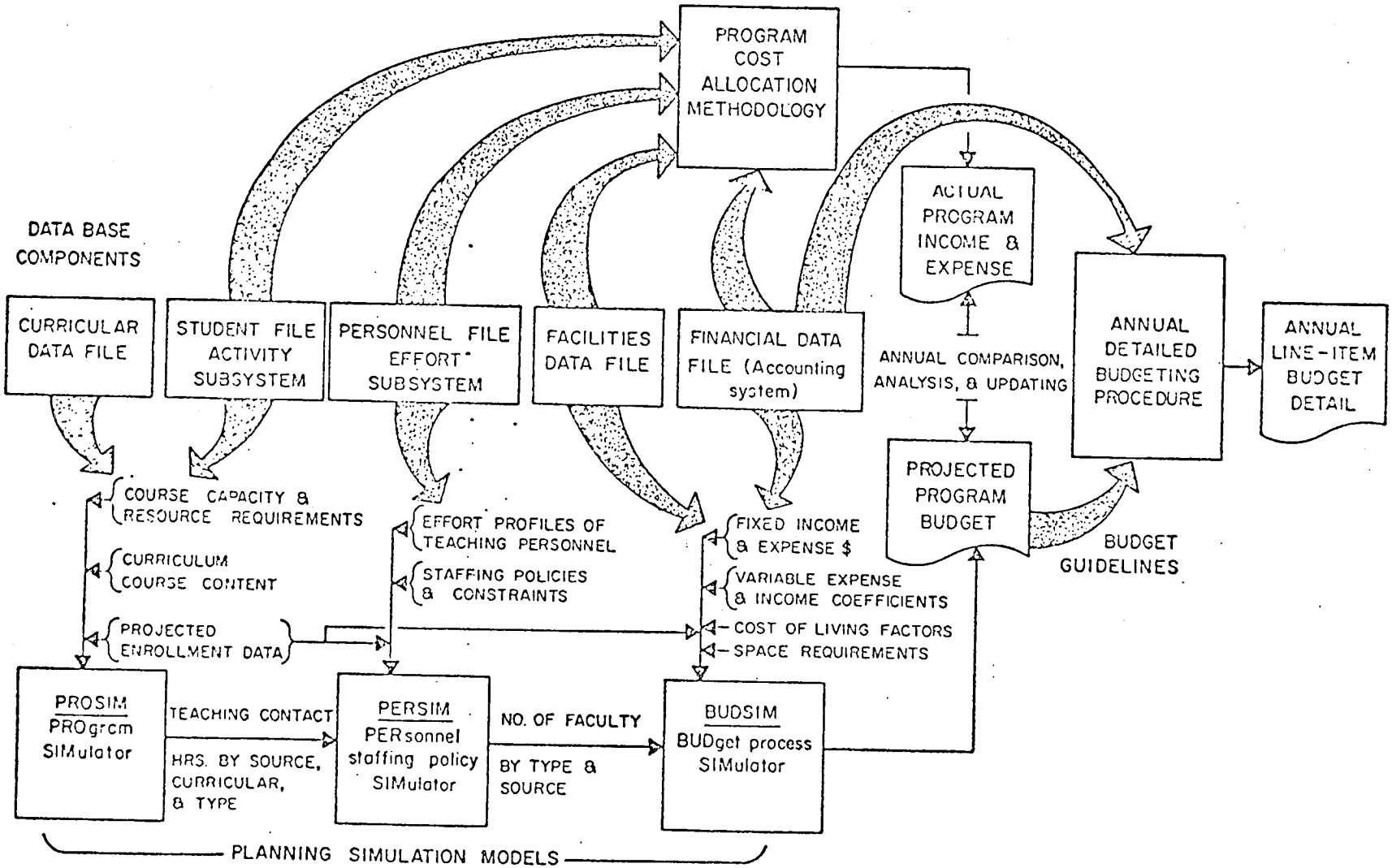
5.) Course content of each curriculum in terms of;

   a.) Required courses, and

   b.) Optional courses with probabilities of their being taken by a typical student.

EXHIBIT IV

DATA BASE REQUIREMENTS TO SUPPORT PROGRAM PLANNING & BUDGETING SYSTEM WITH FEEDBACK CONTROL



Student File - Activity Subsystem

Although it is necessary to retain a great variety of information about a student for a host of different purposes, the specific data needed here is only:

1.) The curriculum in which he resides; and

2.) What courses he has taken each term and the hours of credit received.

Personnel File - Effort Subsystem

This component of the data base must contain for the most recently completed academic year:

1.) Detailed activity data, in hours, on all teaching personnel (faculty, graduate students, and house officers);

2.) Per cent effort distributions for all other employees;

3.) Rank or employee classification; and

4.) The department in which employee is home-based.

The most critical and complex sector of this data is that related to faculty. At CWRU a sampling methodology utilizing stratification has been designed and implemented (4) which combined with personal interviewing is being used to obtain faculty activity data. Appendix A of this paper is a layout of the stratification design showing actual faculty numbers for 1970-71, and Appendix B is a sample copy of the questionnaire filled out for a hypothetical faculty member.

Facilities Data File

This file contains documentation of all space utilized by the School

of Medicine and indicates:

1.) Room number;

2.) Building;

3.) Organizational assignment;

4.) Net useable square feet;

5.) Programmatic utilization; and

6.) Institutional ownership.

Financial Data File

Although, like most, it has shortcomings, the University accounting system at CWRU with some recently added supplements is supplying essentially adequate financial data to support the School's program planning and budgeting system.

Integrated Medical Center Information System (IMCIS)

Essentially all the data requirements discussed in this paper are incorporated in the IMCIS data base (8), which has been discussed at previous AAMC workshops (6). What has been attempted in this paper is to *spotlight those particular data base elements especially crucial to the managerial decision-making process,* and which have high priority in MIS development at CWRU.

APPENDIX A

FACULTY STRATIFICATION DESIGN FOR EFFORT SAMPLE
(FULL-TIME FACULTY ONLY)

	M.D. CURRICULUM TEACHING COMMITTEE CHAIRMEN	SALARIED 100% FROM RESEARCH GRANTS	SALARIED 100% FROM A HOSPITAL AFFILIATE	FACULTY OF MEDICAL TECHNICIAN PROGRAM	ALL OTHER FACULTY (NOT IN COLUMNS 1-4)
BASIC SCIENCE DEPTS.	6* / 3**	10 / 3	-- / --	-- / --	62 / 16
DEPTS. AT HOSPITAL AFFILIATE 1	26 / 7	26 / 7	31 / 8	10 / 3	186 / 47
DEPTS. AT HOSPITAL AFFILIATE 2	8 / 3	5 / 2	52 / 13	1 / 1	45 / 12
DEPTS. AT HOSPITAL AFFILIATE 3	-- / --	-- / --	34 / 9	-- / --	-- / --
DEPTS. AT HOSPITAL AFFILIATE 4	-- / --	-- / --	18 / 5	-- / --	-- / --

*Total faculty classified in this stratum.

**Sample size selected from this stratum.

APPENDIX B

CWRU FACULTY HOURS OF MEDICAL SCHOOL AND AFFILIATED HOSPITAL ACTIVITIES - 7/1/ 71 to 6/30/ 72

(Please do not report any given hour in more than one place)

NAME Hypothetical, I. M. HOME DEPT. Medicine - [illegible] DATE PREPARED 7-24-72

RANK CODE 1130 (Asst. Prof.) STATUS [illegible] - Regular

1. PURE INSTRUCTION: (Med. School or Hosp. Based - Not Involving Patient Service)

Course	Hrs Prep & Admin	Hrs Stud Cont	Total	What % of your students were: Med Stud	Grad Stud	Post Doc	Cont Ed	Hse Off	Other
Phase I Subject Comm, Options	10	12	22	95	5	___	___	___	___
Phase II Subject Comm, Options	20	30	50	95	5	___	___	___	___
Phase III Lectures, Seminars, Options	--	80	80	[illegible]	[illegible]	___	___	___	___
University Under Courses	2	5	7	[illegible]	[illegible]	___	___	___	100
University Grad Courses	18	40	58	[illegible]	[illegible]	___	___	___	50
Continuing Ed	--	2	2	___	___	___	100	___	___
Dissertation or Thesis Supervision	--	100	100	___	___	100	___	___	___
Other (Identify, i.e. Dental, Med Tech)	___	___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___	___	___
___	___	___	___	___	___	___	___	___	___

2. PURE RESEARCH: 1000 hrs. *(Including preparation of research papers, grant proposals, etc.)*

RESEARCH WITH STUDENTS: 300 hrs.

What % of this time is allocatable to:

Med Ed	Grad Ed	Post Doc Ed	Hse Off Ed	Research Output
10	70	10	___	10

Identify (Phase I, II, III)

3. COUNSELING AND TUTORING:

Med. Stud. 15 hrs. House Off. 50 hrs. Grad. Stud. -- hrs. Post Doc. -- hrs.

Other -- hrs. (Identify ___)

4. GRANTING AGENCY ADVISORY SERVICES: 20 hrs. *(NIH, NSF - Project Review Boards, etc.)*

5. COMMUNITY, GOVERNMENTAL, AND PROFESSIONAL SOCIETY SERVICES: 35 hrs.
(Services to AAMC, Health Agency Boards, Prof. journal editorial boards, etc.)

6. PROFESSIONAL DEVELOPMENT: 200 hrs. *(Report here only time which is not directly relatable to specific research, teaching or patient service which should be reported in other categories)*

APPENDIX B (Cont.)

7. ACTIVITIES INVOLVING PATIENT SERVICE:

ACT	CODES (see below) MD CURR COMP	PRIMARY PURPOSE	HOSP	HOURS ADMIN & PREP	STUD CONTACT	TOTAL	% OF HRS ALLOCATABLE TO PAT SERV	MD STUD ED	HOUSE OFF ED	OTHER ED
1	5	1	UH	--	196	196	10	80	10	
2	0	4	UH	--	100	100	95		5	
0	0	4	UH	--	200	200	100			
1	0	4	UH	--	100	100	80	10	10	

8. ADMINISTRATION: *(Such as Faculty Senate, General Faculty, Legal Faculty, Search Committees, Bed Utilization Committees, Patient Chart Committees, etc.)*

ADMINISTRATIVE ACTIVITY	If Assignable to Specific Programs Please Note*	HOURS ALLOCATABLE TO CWRU	AFFILIATED HOSP
Bed Utilization Comm.	Patient Serv.		20
Hematology Subj. Comm.	Undgrad. Med. Ed.	30	
Blood Bank Comm.	Patient Serv.		20
General Fac. Meetings	--	10	
Dept. Staff Meetings	--	50	

*i.e., Bed Util. Comm. is assignable to Pat. Serv., while Fac. Senate is not assignable to any specific program.

CODES FOR SECTION 7

ACTIVITY CODES

0 - Private patient care with no students
1 - Rounds, spec. consults, private care with students, Hse. Off. supervision on wards
2 - Outpatient activities
3 - Lab, radiologic, path. & other service functions
4 - Clinical conferences, grand rounds
5 - Operating or delivery room
6 - Other (Identify)

MD CURRICULAR COMPONENT CODES

0 - None
1 - Clinical Science
2 - Options, Phase I
3 - Options, Phase II
4 - Options, Phase III
5 - Clinical Clerkships

PRIMARY PURPOSE FACULTY ASSIGNED CODES

1 - Teach MD students
2 - Teach house staff
3 - Teach other students
4 - Render patient service

Planning Office
6-12-72

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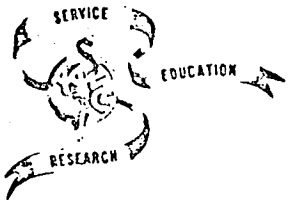
VI. Admissions Problems, Follow-up - Visitations Meeting

On February 16, 1973 the AAMC sponsored a Conference on Visitations to Undergraduate Colleges Concerning Health Professions Admissions Problems. The memorandum which follows is a summary of the proceedings and the conclusions of the group regarding the proposal. Dr. Grulee, who represented the COD at that meeting may wish to expand upon that report.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain – 6 mos. ☐
1 yr. ☐
5 yrs. ☐

Permanently ☐
Follow-up Date

DATE February 27, 1973

TO: Department of Academic Affairs

FROM: Dr. Jarecky

SUBJECT: Conference on Visitations to Undergraduate Colleges Concerning Health Professions Admissions Problems - February 16, 1973

The purpose of the meeting was to determine whether team visitations to selected undergraduate campuses should be organized so that students and faculties might be advised of the realities of securing admission to health professions schools. The 15 invited participants (see attached list) plus some 10 AAMC staff members considered this question in small group meetings during the morning and in full session during the afternoon.

None of the groups presented a strong endorsement of the visitation concept. Reactions ranged from a view of faculty advisors as having little power and therefore being unable to do much with data provided by a visiting team to a recommendation that a basic position paper, presenting a strategy to deal with the current difficulties of admission to schools of the health professions, be evolved. Other suggestions included the development of a detailed handbook for health professions advisors, forums to educate deans and administrators about the importance of health professions advising, and ways in which undergraduate curricula could be made more flexible. Some participants felt that standards of advising will not be improved until such time as the quality of advisory programs is directly related to accreditation. A philosophical objection to team visitations was that this approach, essentially negative in its goal to reduce the number of applicants to health professions schools, might be seen as an attempt to dictate career choices to students whose freedom to seek admission to professional schools ought not to be limited by inadequacies in the educational facilities themselves. All participants believed that steps should be taken to communicate as straightforwardly as possible with applicants to health professions schools concerning admissions problems, but there was no enthusiasm for direct campus visitations to accomplish this goal.

From the variety of comments and attitudes expressed, two positive suggestions evolved:

1. A detailed brochure including current statistics on the "demography" of application and admission to medical and perhaps

dental schools should be provided to health professions advisors as a supplement to The Advisor. Advisors could then request copies as needed for distribution to their students.

2. A meeting of representatives of health professions school staffs and associations of undergraduate colleges and universities should be convened to consider the problems created by excessive numbers of applicants for both colleges and health professions schools. The general concern of such a conference would be to consider ways of reducing or forestalling such tensions.

Enclosure

RKJ/mc

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Participants in
Conference on Visitations to Undergraduate Colleges
Relative to Health Professions Admissions Problems
February 16, 1973

C. G. Grulee, Jr., M.D.
Dean
Louisiana State University

Robert L. Tuttle, M.D.
Associate Dean for Academic Affairs
University of Texas, Houston

George H. Adams, M.D., Ph.D.
Assistant Dean for Student Affairs
University of Arizona

Lester Kieft, Ph.D.
Department of Chemistry
Bucknell University

Charles J. Chantell, Ph.D.
Department of Biology
University of Dayton

Harvey I. Scudder, Ph.D.
California State College at Hayward

Frederick E. Mapp, Ph.D.
Premedical Advisor
Morehouse College

Dr. Robert M. Tomlinson
Head, Health Occupations Programs
University of Illinois

Thomas J. Ginley, Ph.D.
Assistant Secretary
American Dental Association

Mr. Gary Moore
Assistant Secretary for Student Affairs
American Association of Dental Schools

Thomas Piemme, M.D.
Group on Medical Education Correspondent
Association of Physicians Assistant Training Programs

Dianne Klepper, M.D.
Assistant Dean, Admissions and Student Affairs
University of New Mexico

Paul Elliott, Ph.D.
Director and Assistant Dean
Florida State University

Ms. Marlene Leonard
Research Associate
Association of Schools of Allied Health

Ms. Susan Weiss
Project Director - Jr.-Sr. College Allied Health Inventory
Association of Schools of Allied Health

VI. Admissions Problems, Follow-up
Matching Plan Meeting

An ad hoc advisory panel is being convened on March 12, 1973 to review a feasibility study for a medical student admissions matching program. Attached are the letter of invitation to that meeting and a list of invitees. Dr. Grulee will summarize the conclusions of that group for the Administrative Board.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

The purpose of this letter is to invite your participation in a meeting of an ad hoc advisory panel to review a feasibility study for a medical student admissions matching program, scheduled to meet in Washington, D. C., ~~Friday~~ MONDAY, March 12.

The Association was asked by the Council of Deans to consider the feasibility of a matching program as one of the approaches to deal with the admissions crisis. The Council of Deans formalized this request in the form of a resolution passed at their meeting in Miami at the AAMC Annual Meeting. This study has been conducted by an AAMC staff committee chaired by Bob Thompson with technical assistance from a private consultant group.

The Project Committee is concerned with answers to the kind of questions enumerated on the attached list prepared by Dr. Davis G. Johnson. May I ask that you give this list your careful study and add to it your own concerns and questions in preparation for the meeting.

Participants should plan to arrive on Thursday evening so that we may begin our discussion promptly at 9:00 a.m. the following morning in the AAMC Conference Room at One Dupont Circle. We will adjourn at approximately 4:00 p.m. The Association will provide for travel expenses.

Please complete the enclosed reply form and return it to Dr. Thompson at your earliest convenience. Should you have any questions, you may contact him at (202) 466-5154.

Sincerely yours,

August G. Swanson, M. D.
Director of Academic Affairs

Enclosures

cc: AAMC Executive Staff
Members of the Project Committee

INVITEES TO AD HOC ADVISORY PANEL ON THE FEASIBILITY OF A MEDICAL STUDENT ADMISSION MATCHING PROGRAM

Clifford G. Grulee, Jr., M. D.
Dean
Louisiana State University
School of Medicine in Shreveport

Harold C. Wiggers, Ph. D., Sc. D.
Executive Vice President and Dean
Albany Medical College of Union University

John G. Freymann, M. D.
Director of Education
Hartford Hospital

John Watson, Ph. D.
Associate Dean, Student Affairs
University of California
School of Medicine

Jack M. Colwill, M. D.
Associate Dean
University of Missouri
School of Medicine

Robert L. Simmons, M. D.
Associate Dean
Student Affairs and Admissions
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William Fleeson, M. D.
Associate Dean
University of Connecticut
School of Medicine

Bernard Nelson, M. D.
Associate Dean for Education
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Lester Kieft, Ph. D.
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Bucknell University

Charles J. Chantell, M. D.
Premedical Advisor
University of Dayton

Harvey I. Scudder, Ph. D.
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Frederick E. Mapp, Ph. D.
Premedical Advisor
Morehouse College

Mr. Patrick N. Connell
Class of '74
University of Arizona
College of Medicine

Ms. Rebecca Backenroth
Class of '74
Boston University
School of Medicine

Mr. Billy B. Rankin, Director
University of Texas System
Medical and Dental Application Center

Sam L. Clark, Jr., M. D.
Chairman, Department of Anatomy
University of Massachusetts
Medical School

Mr. A. Geno Andreatta
Dean for Student Affairs
State University of New York
Upstate Medical Center

2/1/73

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Possible Questions to be Explored in
Proposed Feasibility Study of Admissions Matching Plan
(Prepared by Davis G. Johnson, Ph.D.)

1) What are the objectives of an admissions matching plan?
   a) maximizing chance for applicant and school to get top choices
   b) ability to consider entire pool at once
   c) end of indecision as to when will learn whether accepted and where
   d) end of some applicants holding several places
   e) end of "musical chairs" at end of admissions season

2) Are there better ways (i.e. less costly, time consuming and cumbersome) of meeting the above objectives?
   a) via a single common acceptance date?

3) Is a matching plan mechanically possible?
   a) Can it adequately include the school's desire for a balanced class as regards state of residence, college attended, major, minority group representation, etc?

4) What effect would plan have on number of applications filed?
   a) Is there any way of controlling plan so number of applications doesn't rise greatly?

5) What effect would matching plan have on "Early Decision Programs?"
   a) Would the two programs be compatible or would one preclude the other?

6) What effect would matching plan have on the quality of applicants matched with the less competitive schools?

7) To what extent should a matching plan be combined with AMCAS?

8) How much would it cost to operate a matching plan?
   a) How would this cost be shared by the applicant and by the school?
   b) How much personnel, space, computer service, etc. would be needed to operate a matching plan?

9) What effect would a matching plan have on the admissions timetable?
   a) To have a match early enough for applicants to make their future plans (e.g. March 1st) rank order lists might have to be filed by January 15 (according to NIRMP precedent) which would probably mean an application deadline of around November 15.
   b) Would communication with applicants be a significant problem?

Continues . . . . . .

10) How would financial aid awards be incorporated into a matching plan to insure that students were admitted who could be supported by aid available at the given school?
   a) Would each student's financial need have to become a part of the matching criteria?

11) Would a "dry run" be necessary?
   a) If so, how much would it cost and who would pay for it?
   b) Would it involve all applicants and all schools or a smaller sample (e.g. applicants to all the schools in New York State)?

12) Would a matching plan invite additional lawsuits and/or demands that a school justify its total ranking of applicants?

13) Would a matching plan result in more reliance on grades and test scores and less emphasis on non-cognitive factors?

14) How would "alternate lists" be established and used to fill the places of accepted students not actually entering medical school?

15) What would the emotional impact be of having over 20,000 applicants notified simultaneously of their rejections to medical school? Would this be better or worse than the present gradual system of notification?

VII. Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibilities for Graduate Medical Education

The AAMC Committee on Graduate Medical Education has prepared the above entitled report which appears on the following pages. The Executive Council will be asked to act upon this report at its March 16, 1973 meeting. It appears in this agenda to permit full COD Administrative Board discussion prior to the Executive Council meeting.

Recommendation: That the COD Administrative Board adopt the report of the Committee on Graduate Medical Education.

THE GRADUATE MEDICAL EDUCATION COMMITTEE

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GUIDELINES FOR ACADEMIC MEDICAL CENTERS PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

CONTENTS

FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist faculties seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It was not intended that a single best solution be promulgated.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieveing a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academicians in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.[1] In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.[2] In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.[3,4]

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialism in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the polcies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must develop sufficient financial resources for supporting educational programs to ensure that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for patient services delivered in the teaching setting by both faculty and advanced residents is appropriate and essential. Funds so generated should be collected and managed in such fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

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VIII. Report from the Ad Hoc Committee on Continuing Education

One matter considered by the Board as deserving priority attention by the Association is the matter of the role of the Association and its constituents in continuing education. Attached is a report of the Association's Committee on Continuing Education. The Executive Council will be asked to act on this document.

Recommendation: That the COD Administrative Board endorse the report of the AAMC Committee on Continuing Education.

FOREWORD

The *Ad Hoc* Committee on Continuing Medical Education was charged with advising the Association of American Medical Colleges regarding the role that the Association and its constituents should play in continuing education in the future. Implicit in that charge was the view that continuing education has not been effective in accomplishing its imputed purpose--to make physicians of all ages optimally effective in the performance of their professional duties.

Data on performance of physicians (including those holding full- and part-time academic appointments) are difficult to acquire, but the information available suggests that there are significant defects in performance. In the opinion of the committee, there are two main reasons for these deficiencies which are of importance to medical faculties.

The first is that the behaviors imparted during the academic years do not, apparently, persist long into the practice years. The pressures of practice envelop the physician before he has an opportunity to adapt to the discipline required to continue his learning.

Secondly, despite a complete lack of evidence of effectiveness, the "shotgun" approach continues to be the pattern of continuing education as provided by medical faculties and associations. The committee questions the effectiveness of short courses, audio-tapes, video-tapes, and even books and

journals when they are considered in the light of the documented behavioral changes experienced by the majority of physicians after they become involved in the delivery of health care.

Measurements of continuing education, such as certificates of attendance, recognition rewards, and possibly recertification and relicensure by examination, are not measurements of the end objective--improving patient care by changing the behavior of physicians--and have no greater correlation with this objective than do grades and class rankings in medical school with performance during clinical graduate training.

Therefore, it is the thesis of this committee that continuing education cannot and should not be separated from the initial formal education and that medical faculties must strive to incorporate into the basic and graduate training years those continuing education methods which have been shown to be effective.

The committee report develops this position and also emphasizes that the AAMC and its constituents must make plans for instituting educational policies which bear directly on the problem of making physicians continually responsive to the changing knowledge and technology of medicine in the context of their daily responsibilities for patient care.

INTRODUCTION

The committee determined that fulfilling its charge required that it consider continuing education not in the context of the past or present but in the context of future. There was a consensus that there will be increasing expectations by the public for professional accountability (that is, that high quality care be obtainable at reasonable cost).

A modified Delphi technique was utilized to obtain opinions of the entire committee regarding the trends and characteristics of the health care delivery system during the next 10 years.

In the aggregate the committee believes that:

1. Physicians will continue to have the major responsibility for patient care, although they will be increasingly associated with and assisted by other health professionals.

2. Group practice will increase until by the end of the decade at least 50%--and perhaps as high as 80%--of all physicians will be members of organized medical groups.

3. These groups will increasingly be associated with a specific hospital.

4. Forty to seventy percent of physicians will receive at least three-fourths of their professional incomes from salaries.

5. There will be systematized methods of assuring an acceptable quality of physician performance. The responsibility for defining accountability will be shared by:

(a) practicing physicians and medical educators,

(b) the federal government,

(c) third-party insurance carriers, and

(d) consumers.

The committee believes that the definition of the parameters of quality will be predominantly initiated by practicing physicians and medical educators.

6. Efforts to control quality of medical practice will include:

(a) Audit systems such as the Professional Standards Review Organizations already enacted into law.

(b) Relicensure and recertification with recertification being distinctly favored.

(c) Periodic updating as a condition for continued employment in both private and public clinics.

(d) Requirement for continuing education credit even though there is little evidence that this is effective in assuring that physicians will responsibly modify their practices as knowledge and technology advance.

7. With increased demand for public accountability, there will be an increasing emphasis on educational programs for physicians by hospitals and clinics.

The committee's recommendations must then be interpreted with the knowledge that medical practice in the future is expected to be conducted by physicians predominantly working in organized groups with the majority rewarded through a salary in a social system demanding accountability for control

of quality and with hospitals and professional organizations placing an increasing emphasis on staff education.

RECOMMENDATIONS

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to demonstrate that they are competent to deliver care to patients throughout their professional lives.*

The form in which students and physicians will be asked to demonstrate competence will vary as their careers evolve. Initially, written cognitive examinations will play an important part in evaluation; but these will become less frequent as skills, attitudes, and ability to deduce appropriate conclusions from given data are tested. In practice the quality of care actually being delivered may be the method by which physician competence is constantly monitored.

2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm.*

Before educational goals can be defined and plans laid, it is essential that the real educational needs of physicians be identified. Needs must relate to specified deficiencies

in knowledge, skills, attitudes, and medical care delivery organizational structures which are impairing optimal patient care. This effort cannot be unilateral. The academic staff must be as willing to examine and correct its own deficiencies in patient management as it is to criticize management by members of the nonacademic community of physicians. Students must see that their mentors are willing to participate in rigorous criticism of their own clinical activities. The development of positive and responsive attitudes of open dialogue among physicians must be imprinted as early as possible. Faculty examples of disregard of criticism may be a significant factor in imprinting and molding later regressive behaviors in physicians, impairing their willingness to participate in lifelong learning.

In developing criteria, both the processes of patient care and outcomes must be scrutinized. Although the patient population and the mission of academic hospitals vary from nonacademic hospitals, the committee urges that equivalent standards for ensuring optimal quality be required for all health providers in a community.

Initially, both the establishment of criteria and the development of a feedback system must be modest in scope, but ultimately criteria for all disciplines and subdisciplines of clinical medicine should have a systematized methodology. The areas where the efficacy of two or more approaches to the same problem is unresolved must be identified and flexible allowance made for differing professional opinions.

3. Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.

There is too often an undue preoccupation with form which obscures function in continuing education. The development of educational programs should be directed toward fulfilling the physician's own desire to improve his performance as rapidly and as effectively as possible. Consideration should be given to principles of adult education concerning variations of learning styles, objective-directed learning, and the necessity for interchange of ideas during the learning process. Where learning new skills requires an on-the-job setting, provisions should be made to bring physicians to the appropriate site for the needed period. This may require the provision of substitute personnel in the physician's practice; the academic centers are urged to work particularly with organized groups that have planned for this need.

4. Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice. Depend-

once upon subjective evaluation of participants and/or cognitive evaluation may be spurious and misleading.

Experimental protocols and research applications failing to provide methods for data collection would not survive any current scientific review process. So too, with educational exercises at undergraduate, graduate, and continuing education levels, there should be methods for assessing objectively that specific desired learning outcomes have been achieved. As the student progresses in his professional education and career, these methods become increasingly sophisticated, time-consuming, and expensive but are, nevertheless, critical to the success of the educational system. Continuing education should be looked upon as a pragmatic effort to improve professional practice and can thus only be evaluated in the real practice setting. If the deficiencies toward which an educational program was directed persist, the content, mode of presentation, and motivational impetus for the learners may be re-examined.

Recommendations 1 through 4 set forth the broad principles upon which the committee believes the Association and its constituents should base their efforts in continuing education. The subsequent recommendations are directed toward specific areas of concern.

5. *Medical faculties should evolve auditable records.* Assessment of both the process and outcomes of patient

management requires a written clinical record which clearly sets forth the problems identified and attacked, the logic of the diagnostic and therapeutic decisions made, and the outcomes of these decisions. Academic faculties are encouraged to evolve clinical record systems which meet these needs. Students should learn from their very first clinical experience how to develop such records and should grow to expect that their records will be reviewed throughout their professional lives. Faculty willingness to accept review and criticism from colleagues in their own and other disciplines is essential for inculcating responsible professional attitudes in the students whom their attitudes influence. A uniform patient record system involving all affiliated institutions in a center would greatly assist in education and in the measurement of the quality of patient care.

6. *Medical faculties should endeavor to apply computer technology to patient record systems, diagnostic and therapeutic decision-making, and educational feedback systems.*

Computers have undeveloped potential for clinical data management in a real time sense. Notable experiments are in process, and much can be learned from these. Resistance to the application of computers to clinical problems and adherence to the handwritten records of the past is a position which must be carefully reassessed. Because of high costs for both developmental and operational computer applications, resource sharing among centers will be essential.

7. Educational planning and implementation should be carried out with the direct involvement of individuals skilled in educational methodologies.

The development of systems for establishing patient management criteria and educational goals and objectives and for evaluating the impact of education on the learner require skills not necessarily inherent in all medical academicians. Both initial and continuing education require the assistance of individuals who may or may not be physicians but who have had the necessary training to develop and implement modern, goal-directed educational programs. The services of these individuals will do much to improve medical education throughout its continuum.

8. Whenever appropriate, the members of a health team should be educated together.

As the team concept of patient care grows, management and skills of delegation are becoming more important. Educational programs directed toward the improved attainment of team care should be developed and directed toward the activities of the entire team. Interdisciplinary development of criteria of quality of care is a method by which educational programs in which the team members learn together may be encouraged.

9. Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.

Continuing education must be financed from several sectors. Traditionally, these programs have been self-supporting. The process of evaluation of the efficacy of programs in terms of altered physician behavior and/or improved patient care is sophisticated, time-consuming, and expensive. As with any other sector of education, stable base funding from states, professional societies, and the federal government is essential in order to ensure the development of a skilled cadre of individuals to direct, lead, and evaluate such programs.

The committee believes that education of health professionals, and particularly their continuing education, must be directed toward the goal of the constant improvement of health care throughout the nation. Special funds, obtained on a competitive basis, are necessary in order to stimulate the development and implementation of new ideas in this area. Tuition derived from the students must also be continued in order to both provide support for ongoing programs of proven worth and to create an attitude of personal investment by the learner.

CONCLUSION

These nine recommendations do not represent extraordinary departures. All of them have been developed and implemented to varying degrees both in academic centers and in community hospitals. They do not set continuing education apart from the formal academic programs for students still in their

medical school or clinical graduate years but rather attempt to meld these years into the full professional life span.

The recommendations are pragmatic and are based upon defensible predictions of the characteristics of the health care system during the next decade. If the AAMC and the academic centers embark upon policy development which implements these recommendations in a spirit of cooperation with practicing physicians, much of the criticism currently being leveled at the health care system may be allayed.

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IX. Federal Relations

B. RMP-CHP - AAMC Position Regarding Legislative Extension

The attached material consists of an AAMC Legislative Proposal and statement of principles relating to the extension of RMP-CHP developed by an ad hoc committee of the AAMC convened for this purpose. The Executive Council will be asked to adopt the principles listed therein.

Recommendation: That the COD Administrative Board endorse the principles enumerated.

AAMC RMP-CHP LEGISLATIVE PROPOSAL

At a May 1972 meeting of the Association's Health Services Advisory Committee, John A.D. Cooper, M.D., AAMC President, proposed the establishment of an ad hoc committee to consider the implications for the Association in connection with the legislative authorizations for the Regional Medical and Comprehensive Health Planning programs, which expire June 30, 1973.

Committee membership included Dr. Stuart Sessoms, chairman; Dr. William S. Jordan Jr.; Dr. Alexander M. Schmidt; Dr. William Stewart; Dr. James V. Warren; Dr. William R. Willard; and Dr. Andrew Hunt. The committee was asked to give consideration to the following issues:

1. What do RMP and CHP do now, and how does that affect the Association constituency;

2. What does the Association think RMP and CHP should do, and how should that affect the Association constituency; and

3. What steps would be necessary to achieve this, with particular reference to a possible legislative proposal.

The committee has held a number of meetings, has questioned numerous experts in the field, and has received assistance from the Association staff, including reports on site visits to a number of CHP and RMP programs or agencies. Among the persons who appeared before the committee were John R.F. Ingall, M.D., Director, Regional Medical Program of Western New York, representing the RMP Coordinators Association; and Mr. Larry Newell and Mr. William Hiscock, representing the American Association of Comprehensive Health Planning. The major findings and conclusions of the committee are represented in the accompanying Outline of Proposed Legislation.

In essence, the Association's legislative proposal is based on the following principles:

1. There should be established a Council of Health Advisers in the Executive Office of the President to advise him on national health policy, on preparation of appropriate legislative proposals, and on preparation of a biennial Report on the Nation's Health. The Council should be assisted by a National Advisory Commission on Health Planning.

2. There should be established a program of grants to states for health planning and services which would be carried out by state health agencies which, in turn, would be comprised of a planning unit (providing comprehensive health planning at both the state and area level) and a health services unit (combining a number of existing federal health service development programs, the most important of which is RMP). The principal function of the health services unit should be to support programs to tranfer more effectively the advancing knowledge in medicine and biomedical technology from the academic health centers to the practicing community. Block-grant financing should be provided through allotments to states of federal funds for health planning and health services. Public participation should be provided through appropriate advisory groups. State health planning and services should be required to meet federal standards

which the HEW Secretary would develop with the review and approval of a National Advisory Council on Health Planning and Services.

3. There should be a focus at the federal level on health services research and development which would be accomplished by providing for a permanent, open-ended authorization of appropriations for the National Center for Health Services Research and Development, whose authority is to expire June 30, 1973.

It is hoped that the Executive Council will study and comment on the Outline of Proposed Legislation, which follows, and take the following action.

RECOMMENDATION

It is recommended that the Executive Council adopt the principles listed above as Association policy on the extension of RMP-CHP legislation.

Outline of Proposed Legislation

Title I

Council of Health Advisers

Require the President to submit to Congress a biennial Report on the Nation's Health which shall include information on the status of the nation's health; on trends in the quality, management and utilization of health services; on the adequacy of the nation's health care resources; on the effect of government programs in the nation's health; and on methods or legislation for meeting identified deficiencies.

Establish in the Executive Office of the President a three-person Council of Health Advisers, comparable to the Council on Environmental Quality.

Authorize the Council to employ necessary officials and to fix their salaries, and also to employ necessary experts and consultants.

Specify the duties and functions of the Council --

(1) to assist and advise the President in the preparation of the Report on the Nation's Health;

(2) to gather timely and authoritative information concerning the conditions and trends in the nation's health both current and prospective, to analyze and interpret such information for the purpose of determining whether such conditions and trends are interfering, or are likely to interfere, with the improvement of the nation's health and to compile and submit to the President studies relating to such conditions and trends;

(3) to review and appraise the various programs and activities of the federal government for the purpose of determining the extent to which such programs and activities are contributing to the improvement of the nation's

health, and to make recommendations to the President with respect thereto;

(4) to develop and recommend to the President national policies to foster and promote the improvement of the nation's health to meet the social, economic, health, scientific, ethical, and other requirements and goals of the Nation;

(5) to conduct investigations, studies, surveys, research, and analyses relating to health care resources and health services delivery;

(6) to document and define changes in the health of the nation and to accumulate necessary data and other information for a continuing analysis of these changes or trends and an interpretation of their underlying causes;

(7) to report in alternate years to the President on the state and condition of the nation's health; and

(8) to make and furnish such studies, reports thereon, and recommendations with respect to matters of policy and legislation as the President may request.

Establish a 19-person National Advisory Commission on Health Planning to assist and advise the Council, which shall be composed of five members appointed by the President protempore of the Senate, five members appointed by the Speaker of the House, and nine members appointed by the President.

Require the Council to consult with the National Advisory Commission on Health Planning and to utilize other, nongovernment resources as appropriate.

Provide that the members of the Council shall be full-time employees and fix their pay rate in the Executive Schedule.

Authorize appropriations to carry out the title of $300,000 in fiscal 1974, $700,000 in fiscal 1975, and $1,000,000 in fiscal 1976.

Title II

Health Planning and Services

Findings and Declaration of Purpose

Describe the general need for the legislation and the purposes for it --

(1) promote the establishment of more efficient and effective health service systems, assure coordination among all federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the planning thereof;

(2) assist in the support of state programs of health planning, public health services, the initial support of new health services, and the support of health services meeting particular needs;

(3) provide support for research and development (including demonstration and training) related to improving the organization, planning, and delivery of health services; and

(4) provide support for demonstrations and experiments in the integration and coordination of federal health programs, and appropriate related programs, leading to the development of improved health systems extending high quality care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by federal health programs.

Grants to States for Health Planning and Services

Describe conditions to be met in order for a state to be eligible for assistance under the section: designation of a state agency to carry out the state's health planning and health service assistance functions (with

the option at the Secretary's discretion of separate agencies being so designated); provision for a state health planning and service assistance advisory council, a majority of whose membership shall be health care consumers; provision of assurances to the Secretary that the state agency will have authority to carry out its functions and that federal funds will increase state health spending rather than supplant it; provision of appropriate methods of administration, fiscal controls and reporting procedures. Provide that interstate compacts may also qualify for assistance.

State Health Planning

Describe the state health planning function. Planning shall be conducted according to criteria established by the Secretary and shall give first consideration to identification of acute problems and development of means to overcome them. State health planning shall be carried on in cooperation with education, welfare and rehabilitation agencies. State health planning shall include the relationship between the health needs of the people and the capability of the health care system to deliver health services; the development and distribution of health personnel; the establishment of methods of measuring the quality of health care provided in the state; and the evaluation of health care planning and services in the state. The state health planning agency shall review and approve applications for all health related projects in the state to be assisted under the Public Health Service Act, the Social Security Act, or other appropriate provisions of law, except that it shall not consider applications related to biomedical research or health professions education. Require the state planning agency to review its plans at least annually. Require the state health planning agency to work with health care facilities in the state on a capital expenditure program. Require the Secretary to carry on a continuous program of health service planning in consultation with state planning agencies and provide for federal takeover of state health planning if the

state agency does not carry out its responsibilities. Exclude planning with respect to the national supply of professional health personnel from the general emphasis on state-by-state planning.

State Health Service Assistance

Describe the state health service assistance function. The state health service agency shall be responsible for providing adequate health services to the people of the state. Services assisted or provided shall meet criteria as to their scope and quality prescribed by the Secretary and shall be in accordance with state health plans. If a state designates separate planning and assistance agencies, then the approval of the planning agency must be obtained prior to approval of a project by the service assistance agency. The priority of projects to be assisted is to be based on the relative need as determined in the state health plan. Except for assistance with respect to the national supply of professional health personnel, health services assistance shall proceed primarily on a state-by-state basis. If the designated state agency does not carry out its responsibility, the Secretary shall assume responsibility for coordinating the service assistance functions within the state. Applications for health services assistance may be made by any public or nonprofit private entity or combination. No application shall be disapproved by the state action agency until the agency has afforded the applicant an opportunity for a hearing. The state health service assistance agency may make grants or enter into contracts for any of the purposes currently provided for in existing Public Health Service Act sections 304 (health services research and development); 314(c) (health services development); 904 (establishment and operation of HMPs); 910 (multiprogram services); 314(d) (public health services).

State Allotments and Payments to States

Provide for the allotment of appropriated funds to states on the basis of the population, per capita income, and the extent of the need for

health service assistance, provided that no state would receive less than one percent of the appropriation. Funds may be reallotted by the Secretary if not fully used by the state to which they were initially allotted. From each allotment, the state shall be paid from time to time the federal share of expenditures incurred in carrying out the state's health planning and health service assistance functions. The federal share is to be 90 percent for states which designated a single agency to carry out the two functions, 75 percent for states which designated separate agencies, and 80 percent for states with separate agencies but also with certificate of need legislation.

Project Grants for Areawide Health Planning

Provide for project grants by the state health planning agency to other public or nonprofit private agencies or organizations for areawide health planning, similar to the planning currently authorized in existing section 314(b). There must be an areawide health planning council, a majority of whose membership must be health care consumers; and the areawide health planning agency is to assist health care facilities in the development of a capital spending program.

Project Grants for Training, Studies and Demonstrations

Provide permanent, open-ended authorization for project grants by the state health planning agency to any public or nonprofit private agency, institution, other organization, or combination to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward development of improved or more effective comprehensive health planning.

Withholding of Payments

Provide for the withholding of funds by the Secretary when he determines after reasonable notice and opportunity for hearing that there is a failure to comply substantially with either the applicable provisions of the law, the state health plan, or applicable regulations.

Definitions

Define terms used, including the terms regional medical program, medical center, clinical research center, hospital, nonprofit, and construction.

Annual Report

Provide for an annual report to the Congress from the Secretary on the effectiveness of the activities carried out under the legislation, on the relationship between federal and nonfederal financing for activities undertaken under this legislation, and on recommended changes in the law.

Authorization of Appropriations

Authorize appropriations of $600 million in fiscal 1974, $700 million in fiscal 1975, and $800 million in fiscal 1976 for this program of grants to states for health planning and services, and provide that no funds shall be available to pay for hospital care except in connection with research, demonstration or training carried out under the program.

General Provisions

Provide such general provisions as are necessary to make the new program of grants to states for health planning and services conform to routine Public Health Service Act and DHEW legislative requirements.

Federal Standards

Provide a mechanism under which the Secretary, with the participation and approval of the newly established National Advisory Council on Health Planning and Services, shall provide for the development of federal standards for health planning and services, in cooperation with appropriate regional, state and local review organizations as determined by the Secretary. Require state health planning and health service agencies to meet such standards. Provide for the development of interim standards, pending the development of permanent standards.

National Advisory Council on Health Planning and Services

Establish a 23-member National Advisory Council on Health Planning and Services to advise and assist the Secretary in the preparation of general regulatio

for, and as to policy matters arising with respect to, the administration of this program of grants to states for health planning and services, with particular attention to the relationship among comprehensive health planning, the improved organization and delivery of health services, and the financing of such services. The Council shall review at least annually the grants made under the program to determine their effectiveness in carrying out their purposes. The Council is to be comprised of four ex-officio members -- the Secretary, the Chairman of the Council of Health Advisers, the chief medical officer of the VA, and a medical officer designated by the Defense Secretary -- and 19 members appointed by the Secretary, a majority of whom are to be representatives of health care consumers. The appointed members are to be selected from among leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery and financing of health care, officials in state and areawide health planning agencies, leaders in health care administration, or state or community or other public affairs, who are state or local officials, or representatives of consumers of health care. The Secretary is to be chairman of the Council, and it is to meet at least four times a year. Appointed members of the existing National Advisory Council on Comprehensive Health Planning Programs (which the new Council replaces) may serve at the Secretary's discretion as additional members of the new Council until their existing terms expire.

Other Amendments to the Public Health Service Act

Amend section 304(a) (research and demonstrations relating to health facilities and services) to provide a permanent, open-ended authorization for the National Center for Health Services Research and Development.

FINAL PROGRAM

CONFERENCE ON THE IMPACT OF LARGE CENTER CATEGORICAL GRANTS ON THE ACADEMIC HEALTH CENTERS

Sponsored by the Council of Academic Societies of the
Association of American Medical Colleges and the
National Heart and Lung Institute

Thursday, March 29, 1973
Mayflower Hotel
Washington, D. C.

MORNING SESSION - 8:30 a.m. - Chairman, Robert Petersdorf, M.D., University of Washington

8:30-8:40 a.m.	Introduction and Welcome - John A. D. Cooper, M.D., Ph.D., Association of American Medical Colleges
8:40-9:20 a.m.	The relationship between the source of funding and the institution being funded - Thomas Kennedy, Jr., M.D., NIH
9:20-9:50 a.m.	The impact of center grant programs on the institution - Linda Wilson, Ph.D., Washington University
9:50-10:30 a.m.	Discussion and Coffee
10:30-12:00 noon	Experience and concerns from two medical centers
10:30-11:00 a.m.	Impact on the institution - Julius Comroe, M.D., University of California, San Francisco
11:00-11:30 a.m.	Impact on medical education - A. McGhee Harvey, M.D., Johns Hopkins University
11:30-12:00 noon	Discussion
12:00-1:30 p. m.	Luncheon
	Speaker - The Honorable Paul G. Rogers, U. S. House of Representatives
	Presentation on changing patterns in federal funding of biomedical research as viewed by the legislature

AFTERNOON SESSION - 1:30 p.m. - Chairman, Ronald Estabrook, M.D., University of Texas, Southwestern

1:30-4:00 p.m.	Center grants versus investigator-initiated research
1:30-2:00 p.m.	The challenge of center research - Robert Ringler, Ph.D., National Heart and Lung Institute
2:00-2:30 p.m.	Preparation for a center research program - J. Palmer Saunders, Ph.D., National Cancer Institute
2:30-3:00 p.m.	Presentation on the effect of large center programs on investigator-initiated research - Russell Ross, D.D.S., Ph.D., University of Washington
3:00-4:00 p.m.	Discussion and Coffee
4:00-4:30 p.m.	Implications of large program grants for institutional management and fiscal responsibility - Robert Stone, M. D., University of New Mexico
4:30-5:00 p.m.	Peer review, quality control and performance guarantee - Kenneth Brinkhous, M.D., The University of North Carolina
5:00-5:30 p.m.	General discussion
5:30 p.m.	"No host reception"

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

CAS WORKSHOP ON INDIVIDUALIZED MEDICAL EDUCATION

The Mayflower Hotel, Washington, D.C.

March 29-31, 1973

Thursday, March 29

6:00 p.m.	Reception.

Friday, March 30

8:30 a.m.	Welcome. Dr. August Swanson, AAMC Staff.
8:35 a.m.	"The Range of Individualization now Provided in Medical School Curricula." Dr. Thompson Bowles, AAMC Staff.
9:00 a.m.	Discussion.
9:15 a.m.	"An Evaluation of Experiences at the Ohio State Pilot Medical School." Dr. Robert Folk, Ohio State U.
9:45 a.m.	Discussion.
10:00 a.m.	"An Evaluation of Experiences with an All-Elective Curriculum at Stanford." Dr. Oleg Jardetzky, Stanford U.
10:30 a.m.	Discussion.
10:45 a.m.	Coffee Break.
11:00 a.m.	"An Evaluation of Experiences with Early Career Tracking at the University of Washington." Dr. Gary Striker, U. of Washington.
11:30 a.m.	Discussion.

11:45 a.m.	"Individualization for Students with Unusual Backgrounds at the University of California, San Francisco." Dr. John Wellington, U.C., San Francisco.
12:15 p.m.	Discussion.
12:30 p.m.	Lunch.
2:00 p.m.	Workshops convene.
5:30 p.m.	Workshops adjourn.
6:30 p.m.	Reception.
7:30 p.m.	Free Evening.

Saturday, March 31

8:30 a.m.	Workshops reconvene for summary discussion and approval of final report.
10:00 a.m.	Coffee.
10:15 a.m.	Plenary Session. Recorder's reports on workshops.
11:45 a.m.	General Discussion.
12:30 p.m.	Adjourn.

SIMULTANEOUS WORKSHOPS

Friday, 2:00-5:30 p.m.

Saturday, 8:30-10:00 a.m.

WORKSHOP #1

"Developing an Array of Electives which Meet Student Needs."

Chairman - Dr. D. C. Tosteson, Duke U.

Vice-Chairman - Dr. Oleg Jardetzky, Stanford U.

Recorder - Dr. Thompson Bowles, AAMC Staff.

WORKSHOP #2

"Academic and Career Counselling."

Chairman - Dr. John Wellington, U.C., San Francisco.

Vice-Chairman - Dr. Mitchell Rosenholtz, U. Missouri, Columbia.

Recorder - Dr. Roy Jarecky, AAMC Staff.

WORKSHOP #3

"The Present Need and Future Means for Assessment of Achievement."

Chairman - Dr. William Schofield, U. Minnesota.

Recorder - Dr. James Erdmann, AAMC Staff.

WORKSHOP #4

"Self-Instructional Program Development."

Chairman - Dr. Merrel Flair, U. North Carolina.

Vice-Chairman - Dr. Douglas Eastwood, Case Western Reserve.

Recorder - Dr. William Cooper, AAMC Staff.

SIMULTANEOUS WORKSHOPS
Continued

WORKSHOP #5

"Articulation with the Undergraduate College Experience."

Chairman - Dr. Paul Elliot, U. Florida, Tallahassee.

Vice-Chairman - Dr. Joseph Gonnella, Jefferson Medical College.

Recorder - Dr. Davis Johnson, AAMC Staff.

WORKSHOP #6

"Extending Individualization Across the Boundary Between Medical School and Graduate Medical Education."

Chairman - Dr. William Enneking, U. Florida, Gainesville.

Recorder - Dr. Michael Ball, AAMC Staff.

WHO Study on International Migration of Health Manpower

Background

International migration of health manpower, particularly of physicians and nurses, has assumed major proportions and has important implications for donor and recipient countries. Background data on the movement of these professionals and their motivating factors, and the consequences of their movement for health care in affected countries are not available. In order to provide basic information necessary for an assessment of the situation in different countries and for gaining an understanding of its dynamisms, the World Health Assembly of 1972 requested the director-general of WHO to undertake a comprehensive study. Plans and instruments for this study have been developed in Geneva under the direction of Dr. Alfonso Mejia.

Objectives

The study has the following objectives:

1. To determine dimensions and patterns of migration of physicians and nurses.

2. To identify characteristics, motivation, satisfaction and dissatisfaction of those who migrate.

3. To determine economic and non-economic factors which cause physicians and nurses to migrate.

4. To identify in the affected countries the economic and non-economic effects of migration.

5. To postulate alternative strategies for monitoring and intervening, if necessary, in the process of migration.

Methods

The study will assemble existing information and conduct five surveys using questionnaires. The content of the five surveys is:

1. Health services subsystem using random sampling of health care institutions.

2. Health manpower subsystem using random sampling of physicians and nurses.

3. Health professional education subsystem.

4. General survey of migration.

5. Subject survey of migrant physicians and nurses in the format of selected case studies.

In each country selected for participation a sponsoring agency will be identified and a project director and advisory committee will be appointed.

It is expected that the study will require approximately two years for completion.

Countries

Out of the proposed countries between 15 and 25 will be selected for participation. Presently, the following countries are proposed:

Donors

Africa	Cameroon, Ghana, Kenya, Madagascar, Senegal, Tanzania
The Americas	Argentina, Colombia, Jamaica, Mexico, Trinidad, Tobago
Eastern Mediterranean	Iran, Lebanon, Pakistan, Israel
Europe	Greece, Italy, Portugal, Spain, Turkey
Southeast Asia	India, Republic of Sri Lanka, Thailand
Western Pacific	Malaysia, New Zealand, The Philippines Singapore, South Korea, South Pacific Islands

Recipients

Federal Republic of Germany, France, Sweden, U.S.

Donors and Recipients

Australia, Canada, United Kingdom

Cost

Assuming 20 participating countries, the total cost is estimated to amount to U.S. $650,000. For each additional country, approximately $20,000 must be added.

Recommendation

In view of the general importance of the issue of the FMG in the U.S. and of the expectation that this study will provide valuable data, it is recommended that AAMC endorse the proposed study by WHO and offer its participation without incurring any financial responsibilities unless funds can be obtained by outside sources.

International Consortium for the Advancement of Female Health

Background

AID, through its Bureau of Population and Humanitarian Assistance, is proposing to develop a program aimed at worldwide improvement of female health as an effective mechanism for raising the standard of health of the family and particularly, the child. The proposed project consists of the following three component programs:

1. To develop an international system for continuing education of Ob-Gyn leaders in medical schools and in practice in the area of reproductive biology, demography, maternal and child health, and fertility control;

2. To initiate a network of female health clinics by the trained specialists;

3. To establish a supply system for equipment and materials used in these clinics.

In order to develop a program of continuing education which can reach Ob-Gyn faculties at their request in countries accessible to AID and which may make best application of modern educational technology, it is proposed to establish an international consortium which will assume responsibility for all these phases of the project.

Specific Project

Since it is widely recognized that medical school faculties are an important and frequently the only resource for leadership and innovation, the participation of Ob-Gyn faculties, medical schools and their national and international associations or federations is important. Thus, AID is turning to AAMC for assistance in establishing the international consortium for the project. Specifically, AAMC has been requested to assume the responsibility for the initiation and establishment of the consortium which then will receive five years of guaranteed support for the implementation of the project. The contract with AAMC will be limited to 12-18 months depending on the progress in the initial negotiations.

Recommendation

Since AAMC serves as a consultant to AID in the area of international health and since the purpose of the contract is limited to initiating the engagement of health professions education institutions in the project effort, it is recommended that AAMC authorize negotiations of a contract.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 31, 1973

Dr. Sherman M. Mellinkoff, Dean
University of California-Los Angeles
School of Medicine
Los Angeles, California 90024

Dear Sherm:

Our Division of Educational Measurement and Research is beginning implementation of certain critical phases in the development of a Medical College Admissions Assessment Program (MCAAP), the name we have given to the effort involving the revision and expansion of the current Medical College Admission Test. I am writing to you as Chairman of the COD to invite the participation of the Deans in the planning and development of such a program to the fullest extent they wish. We obviously feel the need to keep the COD as fully informed as possible as to progress and to obtain its support of program objectives. We have what we believe to be a workable plan to obtain this kind of feedback and would welcome your candid reactions.

Specifically, this is what we have in mind. With the approval of your regional chairmen and their cooperation, our Division of Educational Measurement and Research and specifically its MCAAP Staff will attempt to arrange appropriate consideration at your regional meetings related to priorities and direction for program development. A representative for each region will also be identified to serve three principle functions:

1. Serve as recorder for regional meetings, coordinating ideas and opinions into a statement best representing the concerns of that region.

2. Represent this position at a regional conference sponsored by AAMC following all the Spring meetings, where representatives and chairmen from each council or group will be invited (with open invitation to any of the membership) to sit down at a common table to begin melding the ideas and opinions expressed into a common statement for the group.

3. Represent the organization on a task force, including members-at-large, which will meet following the AAMC regional conferences with the express objective of developing a final consensus for program development.

It is our intention to make this approach to the membership a sincere and thorough effort. Your cooperation and support will be essential to the program's success. In just a few days, Jim Erdmann will be contacting regional chairmen by letter asking for their participation, and we hope that it can be with your full endorsement.

Thank you,

August G. Swanson,M.D.
Director
Department of Academic
Affairs

AGS/sh

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 2, 1973

Dr. Christopher C. Fordham III, Dean
The University of North Carolina
School of Medicine
Chapel Hill North Carolina 27514

RE: Southern Region COD Participation in MCAAP Development

Dear Dr. Fordham:

Enclosed is the copy of a letter that Gus Swanson has recently sent to Sherm Mellinkoff as chairman of the COD. As you will note, Gus's purpose was basically to alert him to this letter, to obtain his reactions, and to enlist his cooperation for the proposed activity.

You have, no doubt, obtained some type of information related to the AAMC's concern and plans for the testing program it sponsors. Without going into a detailed history of the various steps taken thus far related to MCAT modification, the following significant events have occurred:

1. A survey of the entire AAMC community in February of 1972 regarding a specific proposal for "A Program of Pre-Enrollment Assessment."
2. An invitational workshop to discuss the feedback from the survey.
3. News items and announcements in various AAMC publications together with discussions by staff at various regional and national meetings.

The Division of Educational Measurement and Research had used its existing staff to conduct all of the above activities, and it was not until November 1, 1972 that staffing dedicated exclusively to MCAT Research and Development could be obtained.

The Division is very happy to announce that as of that date, Mr. James L. Angel joined the Association and the Division as the Program Director for the Medical College Admissions Assessment Program (MCAAP). Jim was formerly the president of the Educational Records Bureau, and prior to that Supervisor of Testing Services for the state of Ohio. His responsibilities are generally those of program development, including the continuing identification of needs, definition of program objectives, and the corresponding development of instruments essential for the program.

The first step in the realization of the long range goal of updating and expanding the current testing program is to define as precisely as possible the objectives of such a program of assessment. Such definition, to our way of thinking, must involve the constituency much more extensively and with much more obvious consensus than has currently been achieved.

Accordingly, Jim Angel will be following this letter with personal contact in which he will propose our suggestions for achieving the desired feedback.

We sincerely invite your full participation individually, and as an organization. We would hope that you will feel encouraged to direct your reactions and suggestions to us at all phases of our developmental activity.

The success of the program depends on an intensive cooperative effort. We hope that enough time can be dedicated by each of you in working with AAMC to achieve our desired goals.

Cordially,

Dr. James Erdmann, PhD.
Director
Division of Educational
Measurement and Research

JBE/sh

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OFFICE OF THE DEAN
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

February 6, 1973

Dr. August G Swanson
Director, Academic Affairs
Association of American Medical Colleges
One Dupont Circle NW
Washington, D.C. 20036

Dear Gus:

Many thanks for your letter regarding the MCAAP. While I am in sympathy with your grand strategy and am willing to leave the tactics up to you, I would like to raise a question for your consideration:

Is it wise to have groups of deans discussing this technical subject when the people who really know something about the subject and upon whom I, at least, would have to rely for advice and decisions, are the Student Affairs Deans, Chairmen of Admissions Committees or of Admissions Policy Committees, and such experts in the field of testing as psychiatrists or behavioral scientists? (My grandmother used to advise against "showing a fool a job half finished", and I qualify as a fool; otherwise I would not be in this office!).

With best regards,

Sincerely,

Sherm

SHERMAN M. MELLINKOFF, M.D.

SMM:jcm

FEB 09 1973

February 16, 1973

Sherman M. Mellinkoff, M.D.
Office of the Dean
School of Medicine
The Center for the Health Sciences
University of California
Los Angeles, California 90024

Dear Sherm:

I am responding to your letter of February 6 regarding recommendations for deans to serve on the advisory committee of the Medical College Admissions Assessment Program.

I share with you some of your views that most deans are not terribly skilled nor probably terribly interested in the area of testing and assessment. However, the advisory committees have been developed so as to provide broad representation from the entire AAMC constituency including the deans. Student affairs deans, individuals involved in admissions, and individuals involved in special areas of medical education will also be serving on the panels. I will be glad to work with Dave Johnson and others to try to identify one or two deans who have expressed an interest to us in being engaged with the development of the MCAAP.

Sincerely yours,

August G. Swanson, M.D.
Director of Academic Affairs

AGS/sd

cc: Dr. Erdmann
Mr. Angel