Mary Littlemeyer

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

June 12, 1975

M E M O R A N D U M

TO : The Council of Deans Administrative Board

FROM: Joseph A. Keyes

Enclosed please find the agenda and related material for the Board's meeting of June 19, 1975. Please note that a substantial portion of the meeting will be devoted to Executive Council actions. Therefore, we ask that you bring that (blue) agenda with you.

The schedule of meetings for the Board is as follows:

On the evening of June 18, members are invited to attend either:

CAS - 6:30 p.m. cocktails
7:30 p.m. dinner

Maryland Room, Mayflower Hotel

Informal discussion with Dr. Donald Frederickson, Director-Designate, NIH

COTH - 6:30 p.m. Discussion with Bruce Hopkins, AAMC counsel, subject: Section 223 Regulations Suit
7:30 p.m. cocktails & dinner

Dupont Room, Dupont Plaza Hotel

June 19 - 9:00 a.m. to 1:00 p.m. - Administrative Board Meeting, AAMC Conference Room

June 19 - 1:00 p.m. to 6:00 p.m. - Joint COD/CAS/COTH/OSR Administrative Boards Luncheon; Executive Council Business Meeting, Dupont Room, Dupont Plaza Hotel

June 20 - 9:00 a.m. to 1:00 p.m.
Executive Council Meeting

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
June 19, 1975
9 a.m. - 1 p.m.
AAMC Conference Room

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

April 3, 1975
9 a.m. - 1 p.m.
Conference Room, AAMC Headquarters

PRESENT

(Board Members)

Ivan L. Bennett, Jr., M.D.
J. Robert Buchanan, M.D.
Ralph J. Cazort, M.D.
Neal L. Gault, M.D.
John A. Gronvall, M.D.
Clifford G. Grulee, M.D.
Andrew D. Hunt, M.D.
William H. Luginbuhl, M.D.
Robert L. Van Citters, M.D.

(Guests)

Mark Cannon
Steve Gressit
Cynthia B. Johnson
Roger O. Lambson, Ph.D.

(Staff)

Robert J. Boerner
John A.D. Cooper, M.D.
George R. DeMuth, M.D.
Suzanne P. Dulcan
James Erdmann, Ph.D.
H. Paul Jolly, Ph.D.
Joseph A. Keyes
Susan R. Langran
Diane Mathews
Thomas E. Morgan, M.D.
James R. Schofield, M.D.
John F. Sherman, Ph.D.
Bart Waldman
Marjorie P. Wilson, M.D.

ABSENT

Julius R. Krevans, M.D.

I. Call to Order

The meeting was called to order at 9:20 a.m. by Dr. John A. Gronvall, Council of Deans Chairman-elect, who chaired the opening portion of the meeting until the arrival of Dr. Bennett at 9:35 a.m. Agenda items III A - Approval of Minutes, III B 1 - Resignation of Dr. Grulee and III C Pilot Admission Matching Program were acted upon in Dr. Bennett's absence.

II. Chairman's Report

Dr. Bennett reported that the Board decision at the January meeting to mail out its draft minutes to the Council was greeted generally with approval by the COD, as evidenced by the letters and comments he had received from deans.

III. Minutes of the Previous Meeting

The minutes of the January 15, 1975 meeting were approved as circulated.

IV. Administrative Board Actions

A. Report of the AAMC Pilot Medical School Admissions Matching Program

At its meeting on November 3, 1972, the Council of Deans recommended that "the Association President and appropriate staff explore . . . the feasibility of a medical school admissions matching program." In February 1973 the technical subcontractors selected for this project completed a study which indicated that matching was technically feasible. Subsequently a pilot program, jointly sponsored by AAMC and the Henry J. Kaiser Family Foundation, was designed and implemented to test its practical feasibility. The eleven medical schools in California and Michigan participated in the pilot program which was conducted parallel to the 1973-74 application season (1974 first-year class). The methodology and results of the pilot program, together with conclusions and recommendations of the technical subcontractors, are presented in the "Final Report on the Pilot Implementation of a Medical Student Matching Plan" distributed to the COD Administrative Board in January 1975. In February meetings were held in Los Angeles and Detroit to discuss the results of the pilot program with representatives of participating schools.

The major findings of this intensive invesitgation into the feasibility of matching may be summarized as follows:

Advantages

1. For medical schools, the only discernable benefit of matching might be the reduction of paper work associated with sending letters of acceptance and keeping records of responses.

2. For applicants, matching might--if appropriately timed and used by a sufficient number of medical schools--reduce current levels of anxiety.

Disadvantages

1. Matching alone would not decrease the total volume of applications, which is the crux of what has been called the "admissions crisis".

2. Matching would require strict adherence to rigid deadlines for submission of rank order lists by both applicants and participating schools. School rank order lists would probably have to be submitted to the central processing office no later than April 1. It would therefore be necessary for all participating schools to have completed all application processing and interviews and to have ranked an appropriate number of applicants by that date. This might be a serious problem, particularly for schools which normally offer many more acceptances than there are places available in order to fill a class.

3. One aspect of the matching process which has assumed increasing importance during the course of the pilot program is that of "balanced classes." It is technically possible for the matching algorithm to take into consideration such applicant characteristics as sex, minority group, and state of residence. In order to achieve a desired mix of students according to these characteristics through matching it would, however, be necessary for medical schools to divide their applicant pools into appropriate subsets, in effect establishing quotas for each group. It is probable that this would be inconsistent with current legal trends.

4. It is estimated that the costs related to development, school and student education, programming and processing of an admissions matching system would total $500,000 at a minimum.

In summary, matching would seem to offer more disadvantages than advantages to medical school admissions processing. In addition, the introduction of admissions matching at this time would likely impose new stresses on a system which has begun to accommodate to the "crisis" conditions observed three years ago.

Suzanne Dulcan of the AAMC staff was present to answer questions concerning the report. She clarified for one Board member that the Early Admissions Program, another recommendation of the November 1972 Task Force report, was not a part of the Pilot Matching Program.

Dr. John Gronvall, Dean of the University of Michigan School of Medicine was asked to comment on his school's experience as one of the test schools. He said that, while he was not intimately involved in this pilot study, he did attend a meeting of Michigan's Council of Deans at the close of the program and that they expressed unanimity in their recommendation that it would be inappropriate to extend or continue the matching program.

Action:

The Board adopted the staff recommendation that: a matching program not be implemented or studied further as a solution to the admissions crisis or as an advantageous method of medical student selection for any reason, at this time; and given the continuing demands made on admissions staff by the processing of applications and of the efforts currently being made within the AMCAS and MCAAP programs to alleviate problems related to admissions, the COD Administrative Board recommended that all medical schools continue to monitor and refine admissions policies and procedures, internally and in cooperation with one another and with the existing programs of AAMC.

V. Executive Council Actions

A. Resignation of Dr. Grulee

Dr. Clifford G. Grulee has resigned as an Executive Council member, effective April 4, 1975, as a result of his leaving the deanship at LSU-Shreveport.

The AAMC Bylaws state: "In the event of a vacancy on the Executive Council, the remaining members of the Council may appoint a successor to complete the unexpired term . . . the Council is authorized at its own discretion to leave a vacancy unfilled until the next Annual Meeting of the Assembly."

Dr. Grulee's term will not expire until the Annual Meeting in 1976. To leave this vacancy unfilled until the elections at the Annual Meeting, the Board believed would create a void in the Board and the Executive Council for the June and September meetings and would upset the distribution of terms of the COD representatives since the Assembly would elect an individual for a full three years.

The Board, therefore agreed to recommend that the Executive Council appoint a replacement. After discussion it agreed to recommend Christopher C. Fordham III, M.D., Dean of the University of North Carolina School of Medicine to succeed Dr. Grulee and to complete Dr. Grulee's unexpired term on the Executive Council. Such a term would expire in November 1976.

Dr. Fordham has been an active participant in AAMC affairs, having served on several committees, and is currently Chairman of the Association's Health Services Advisory Committee. He has also served as Chairman of the Southern region of the COD.

B. The Role of Research in Medical School Accreditation

The statement appended to these minutes (Appendix I) was forwarded to the Association by the Association of Chairmen of the Department of Physiology. The CAS Administrative Board approved the statement and forwarded it to the Executive Council with the recommendation that it approve the last paragraph and transmit it to the Liaison Committee on Medical Education. That paragraph reads:

"WHEREAS, it is widely agreed that the conduct of biomedical research, both basic and applied, is an important function of a medical school and that exposure to such an activity and biomedical researchers is a vital part of the education of physicians, BE IT RESOLVED,

That the evaluation of medical schools for purposes of accreditation include an identifiable component which addresses itself to the quantitiy and quality of biomedical research and that the AAMC ensures that all accreditation survey teams include at least one recognized investigator in the biomedical sciences."

In discussing this statement it was generally agreed that biomedical research plays an important role in medical education. Some Board members, however, questioned the feasibility of implementing this statement with regard to the accreditation process. It was questioned whether one could quantify the qualitative aspects of a research program when making an accreditation decision. It would also be difficult to set standards when such great differences exist between research programs in new and developing schools vs. more well established schools. When asked if implementation would involve adding an extra member to the survey team, staff replied that presently the LCME was very careful to construct appropriately representative teams which usually included someone who could be accurately characterized as a recognized investigator.

Action:

The Board recommended that the Executive Council not approve the last paragraph of the statement for transmittal to the Liaison Committee on Medical Education. The position of the Board with respect to the resolution is summarized as follows:

1. The Board recognizes the importance of biomedical research to programs for the education of physicians, and believes that accreditation as it is currently performed does take this into account. This resolution is supportable to the extent that it highlights the importance of this relationship; it is inaccurate to the extent that it assumes that there is no attention presently being paid to this matter; it is not helpful to the extent that it does not propose an approach which addressed the current deficiencies and their remediation.

C. OSR Recommendation to Establish an Office of Women's Affairs

At its 1974 Annual Meeting, the OSR approved the following statement and asked that it be presented to the Executive Council for consideration:

The AAMC should establish an Office of Women's Affairs to perform the following functions:

a. Organize and make available data already collected by the AAMC about the status of women applicants to medical schools, women faculty members, and women physicians;

b. Coordinate interactions of and facilitate communication between members of the constituency and established agencies working with issues related to women in medicine;

c. Offer member institutions assistance in meeting affirmative action requirements;

d. Coordinate national policy planning through such organizations as Equal Employment Opportunities Commission;

e. Compile resource materials and conduct studies concerning the unique problems encountered by women pursuing medical careers;

f. Provide a national focus for individuals and institutions requiring information on various aspects of women in medicine.

AAMC staff in considering the OSR statement made the following recommendation to the Executive Council:

It is recommended that the Executive Council not approve this statement. It is felt that the Association's activities relating to women should remain decentralized among the

appropriate Departments and Divisions. For example, activities relating to the admission of women should remain in the Division of Student Programs, activities relating to affirmative action programs should remain in the Department of Institutional Development, and activities relating to the collection of data on women in medicine should remain in the Division of Operational Studies.

In discussion with the Board, Cynthia Johnson, Vice Chairperson of the OSR stressed that the intention of the OSR was not to stimulate a large effort by AAMC staff for a long period of time but rather to indicate the perception that there is a need for some expansion and coordination of AAMC's present efforts as well as an identifiable focus for both members of constituent institutions and outside groups to contact the Association for information and help.

Action:

On the basis of concerns expressed by the constituency, the Administrative Board recommends that the AAMC staff be requested to reexamine the problems and issues reflected in the statement of the functions to be performed by the proposed new office and that the staff report back to the Executive Council the present and projected activities of the Association directed toward these problems. This report should contain suggested approaches regarding how these activities might be appropriately highlighted to meet the perceived needs for visibility and accessability of the efforts.

D. National Health Insurance and Medical Education

At its last meeting the Executive Council asked that a new task force be appointed and charged with recommending to the Executive Council policy on the aspects of national health insurance which would have a major impact on educational programs. It was emphasized that this group should focus narrowly on these issues and should not repeat the in-depth examination of national health insurance which had been undertaken by the task force chaired by James Kelly.

In reviewing the report of the Kelly task force, the staff concluded that it addressed in a comprehensive manner most of the educational implications of national health insurance.

The CCME/LCGME Committee on National Health Insurance and Financing Medical Education has made recommendations which will be presented to the CCME at its March 24 meeting.

The staff identified two areas which the Executive Council might consider adding to supplement the existing Association policy, in lieu of appointing a new task force. These were:

1. Incorporating an option to pay housestaff salaries from Part B service fees (This is suggested by a CCME Committee recommendation which reads as follows:

The manner in which residents are paid shall be left to local option. Options may include:

a. Payment of stipend or salaries to residents within hospital budgets;

b. Payment to residents, out of fees earned for direct service to patients in accordance with the participation of residents in the practice plan of the teaching institution.)

2. Strengthening the reimbursement provisions to cover the cost of education in ambulatory care settings (This was suggested by a CCME Committee recommendation which reads as follows:

Any system of national health insurance should provide for ambulatory patient care. The recommendations 1-6 shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of graduate medical education in the ambulatory setting, including facilities, space and equipment, as well as personnel.)

The discussion began with a general indication of concern that the prospect of a National Health Insurance program held massive implications for the conduct of medical education and the health of academic medical centers. In light of this, it was stressed that the AAMC should closely monitor all legislative developments which relate to NHI and continually review Association policy to ensure that it dealt adequately with the concepts under consideration. Thus, the proposal that the AAMC reestablish a task force dealing with this subject matter was reviewed as attractive.

Dr. Cooper, supported by Dr. Van Citters, a member of the previous task force, expressed the view that the AAMC statement is very comprehensive, covers every conceivable issue upon which the diverse components of the AAMC could reach a consensus. They argued strenuously that it would be a mistake to completely reopen the matter after having arrived at an acceptable statement through much deliberation and compromise. This level of success appeared inconceivable after the first meetings of the task force and it was only through the skillful chairmanship of James Kelly that it was possible. If new concepts warranted inclusion in the statement it would appear more appropriate to consider these on their own merits.

On the items suggested as possible additions, one caveat was expressed: we have made the arguement, with some though not total success, that education is an activity worthy of support on its own ground and for its own sake. To propose that student "services" should be reimbursed would undercut this arguement and would encourage the proponents of supporting students indirectly and demanding services of students as a quid pro quo. We should therefore remain firm in our position that the educational process should be supported directly.

Dr. Luginbuhl indicated that he had not seen the full text of the AAMC policy statement, but that the summary provided in the agenda book caused him some concern*. A complete review of the AAMC position was deferred until the next Board meeting at which time the Board would indicate whether there were additional matters which it believed should be included.

Action:

The Board recommended that the Executive Council consider adding these positions to the AAMC Statement of Policy on National Health Insurance and commenting on the recommendations to the CCME in lieu of appointing a new task force**.

*Subsequently Dr. Luginbuhl has reviewed the statement and has concluded that it is as forthright and as comprehensive as the AAMC should be expected to develop.

**Subsequent consideration of the Executive Council resulted in a decision to appoint a small group to consider the implications of the items suggested for addition to the statement and to recommend an AAMC response to the CCME recommendations. This resulted primarily from the COTH Board consideration of the matter which offerred the suggestion that while these additions were framed in terms of being

E. Health Services Advisory Committee Recommendation

At its September 1974 meeting, the Executive Council voted not to approve a recommendation of the Health Services Advisory Committee that the AAMC support the development of a national health professions data base along the lines of Section 707 of S.3585. This provision should have authorized the Department of Health, Education, and Welfare to collect data on physicians and other health personnel relating to their age, sex, training, licensure, place of birth, place of practice, hospital affiliations and any other descriptive or demographic information desired. The basis of the Executive Council's action was a feeling that, while this information should be collected in one place, it should not be done by the Federal Government.

The Health Services Advisory Committee met on November 15 and recommended the following modification:

The Health Services Advisory Committee recommends to the AAMC that it support the establishment of a national health professions data base. Without such data base any approach to health manpower planning whether by public agency or by private institution will have little or no chance of success. Such a data base should be federally legislated and be constructed on uniform methods of reporting by state and territorial licensure boards. It should provide for the preservation of individual anonymity and be based in a quasi-governmental body such as the National Research Council under the direction of the Institute of Medicine of the National Academy of Sciences.

Should the Executive Council endorse this resolution, a subcommittee should be established to specify the types of data to be collected and the means for maintaining confidentiality.

Since that time, members of the staff have discussed with Dr. Edward Perrin, Director of the National Center for Health Statistics, the plans of that agency to seek funding to collect this information through the state licensing boards.

**"options" we should not support them because in these matters "options" have a tendency to disappear and alternatives unacceptable in some circumstances become the rule for all.

Action:

With the stipulation that the Health Services Advisory Committee be consulted on the matter, the Board recommended that the Executive Council approve in principle the recommendation that it support the establishment of a national health professions data base, constructed on uniform methods of reporting by state and territorial licensure boards. It further recommended that the Executive Council consider supporting the development of this activity within the National Center for Health Statistics.

IV. Discussion Items

The AAMC is proceeding with the development of a new medical college admissions assessment test to replace the present Medical College Admission Test (MCAT). This developmental program, called the Medical College Admissions Assessment Program (MCAAP) is lodged in the Division of Educational Measurement and Research (DEMR) and is being conducted with the advice of the Committee on Admissions Assessment appointed by the Executive Council. American Institutes for Research (AIR), in competitive bidding, has been awarded a contract to develop test specifications (consent outlines) and construct tests in reading, quantitative skills, biology, chemistry and physics. AIR has, with the advice of the AAMC, appointed two committees to advise it. The MCAAP Test Committee will be responsible for receiving test specifications and a Technical Advisory Committee will review technical questions of test quality. The membership of these committees as well as some detail regarding the progress of the program are contained in the DEMR Report which has been mailed to the COD. A draft document entitled "MCAAP - User Information Series - #1" describing the purpose of the materials being developed and their appropriate interpretation and use was distributed.

Dr. James Erdmann, Director of DEMR, presented a brief review of the program and responded to questions of the Board.

Dr. Erdmann was asked whether there would be any attempt to extrapolate the scores from past years on MCAT in order to provide a linkage with the new test. Dr. Erdmann responded that there was some danger in trying to attempt a one to one correspondence between scores due to the differing purpose of the two tests, but that a series of possible comparisons would be prepared to permit some indirect linkages between the two.

Presently, the time frame for the development and completion of the test calls for the specifications to be written and test items generated and field tested in time to permit its substitution for the present MCAT by Spring 1976. The Board cautioned that the time frame should be carefully reviewed to assure that it is not overly optimistic. A schedule which appeared overly hasty would prove to be counter-productive, both in regard to perfecting the test items and construction and in terms of acceptance of the test by the medical schools and faculty.

B. Follow-up on Institutional Governance Issues

At the January 15, 1975 COD Administrative Board Meeting, the Board considered the proposition advanced by Dr. Vanselow that the COD explore ways in which the AAMC might be of assistance in resolving problems related to medical school - center governance. It was suggested that a survey structured similar to last year's Delphi survey of the Council of Deans be considered to identify relevant issues for further examination.

In response to this suggestion, staff proposed to the Board the following outline for a survey of governance issues: Round 1 would involve asking each dean to identify the five most important organizational and/or governance problems that confront his institution. A second round would present a series of governance and/or organizational issues distilled from the first round responses. Each dean would be asked to rate the significance of each issue and assess the role of the Association with respect to it. Possible choices with respect to this latter question would include: 1) No role, 2) Provide a forum for discussion, 3) Gather data on current practices, 4) Undertake analytical studies, 5) Formulate public positions, 6) Negotiate with other organizations.

The staff believes that such a study would enhance investigative efforts of the AAMC staff by providing a focus on issues of greatest significance. The value of such a study would probably be considerably enhanced if it were to include the constituent Councils of the Association, the members of which will undoubtedly have varying perspectives on many of the matters under consideration.

One Board member expressed the belief that governance problems were so institutional-specific that a study of common problems would by its nature have to be so general as to be worthless.

Staff responded by outlining to the Board the work done to date in collecting data from school bylaws and organizational charts and the use of this data as a source for developing organizational clusters and types. Aware of these types and having extracted as much information as possible from these published sources, staff felt it was important to find out directly from the dean what sort of problems confront his institution.

The iterative techniques of the Delphi Survey would enable the staff to identify these common governance problems if they do indeed exist.

Staff explained that the term "Delphi" might not technically be an appropriate label for this study in the sense that it suggests forecasting the future, but it is appropriate when used to identify the open ended first round and feedback technique used in last year's survey.

The Board recommended support of the proposal for a "Delphi" Study of Governance and recommended that it be discussed with the Council at the Spring Meeting.

C. Study of the Dean's Office Organization and Staffing; Responsibilities of the Dean

AAMC staff presented to the Board a preliminary draft of a possible survey instrument which might be used to gather data from a small sample of institutions (fewer than 10) to elicit relevant material on the question, "How should the dean's office be staffed?"

Underlying the approach to this survey is the perception that the key matters to be addressed are 1) What are a dean's responsibilities? 2) What resources does he have to carry them out? 3) In the context of his institution, are these resources sufficient to his needs?

All medical schools have been classified and clustered according to a) their administrative typologies; b) their relationships to a university, hospital, and state support, and c) the health education components of the medical center. These clusters have been entered into the AAMC-Institutional Profile System (IPS) and student, faculty, and financial data for those clusters of schools have been analyzed. Similarly, profiles of the tenures of deans in each school have been developed for comparison with the IPS-school cluster data.

Based upon an analysis of the data attained above, it is proposed that representative medical schools be selected for further study of the dean's office organization and staffing patterns, and the responsibilities of the dean in relation to the administrative structure of the institution.

Board members believed that the deans would benefit from the results of such a survey and recommended that staff proceed with the questionnaire. One Board member, while volunteering his school for the pre-test, commented that he tried filling out the sample and thought some of the questions needed restructuring in order to facilitate easy completion of the questionnaire. Staff welcomed any such suggestions and urged Board members to examine the questionnaire and send their critique to the Division of Institutional Studies.

D. Report of OSR Actions and Discussions

Mark Cannon, OSR Chairperson, reported to the COD Administrative Board the results of the OSR Board Meeting held April 1 and 2. The OSR Board discussed and acted upon the items in the Executive Council Agenda approving all staff recommendations but two: 1) In reference to the Role of Research in Medical School Accreditation, the OSR reaffirmed its belief in the importance of biomedical research in medical education, but did not believe it necessary to alter the current accreditation process; 2) They affirmed their recommendation to establish an Office of Women's Affairs.

The OSR Board listened to a thorough description of the workings of the Liaison Committee on Medical Education from Dr. J.R. Schofield, Secretary of the LCME, and voted to create an Ad Hoc Committee on Accreditation within the OSR. Its purpose is two fold: 1) to insure that students are notified in advance of an accreditation site visit in order to prepare them for the survey team's questions and prepare their own comments and 2) to write a pamphlet detailing the accreditation process in order to prepare the student for the survey.

The OSR Board also discussed with Dr. Bennett the appropriate role of the OSR within the AAMC.

E. OSR Administrative Board Membership Problems

Because the working year of the Association does not coincide with the academic year, the OSR has recently experienced difficulty with continuity of membership on its Administrative Board.

Currently according to advice received from the Association's legal counsel, Williams, Myers & Quiggle, no member of the OSR Administrative Board can serve in a voting capacity unless that individual is the one official representative of his/her institution to the OSR throughout his/her term on the Board. The attorneys advise us that the AAMC Bylaws currently prohibit the designation of more than one member from an institution to the OSR. They also advise us that it is inherent in the Bylaws that members of the Administrative Board must be chosen from members of the Organization.

In order to work consistently within the guidelines set forth by the AAMC attorneys, it is proposed that:

1. The Association's Bylaws be amended to include a provision stipulating that schools having a student elected to the OSR Board may designate a second OSR representative. This would allow schools, at their discretion, to redesignate the Administrative Board representative as an official OSR representative and thus provide for his/her continued participation. The Association will bear the Annual Meeting expenses of Administrative Board members who are the second representative of their school.

2. The OSR Rules and Regulations be revised to provide that in order to be eligible for election to the Administrative Board an individual (at the time of election) must be currently an OSR representative or must have already been designated to become at the conclusion of the Annual Meeting an OSR representative. The OSR Rules and Regulations must retain the clause stating that each officer shall be an official representative to the OSR throughout his/her entire term of office. Since schools having a student on the Administrative Board would be allowed to appoint a second representative, these students, if so certified, would be able to serve. Section 3A of the OSR Rules should be modified to read, "Members of the OSR shall be representatives designated in accordance with the AAMC Bylaws by each institutional member that is a member of the Council of Deans, chosen from the student body of each such member, and selected by a process appropriate to the governance of the institution...."

It was agreed that the OSR Board member no longer eligible to serve because of the disjuncture between the bylaws and the school's election process would be funded to attend meetings of the OSR Administrative Board and to sit as a member of the Board without vote until the Annual Meeting.

His vacant spot as a voting member of the Board will remain unfilled until the Annual Meeting.

The Board recommended that the Association's Bylaws be amended to include a provision stipulating that schools having a student elected to the OSR Board many designate a second OSR representative. This would allow schools, at their discretion, to redesignate the Administrative Board representative as an official OSR representative and thus provide for his/her continued participation. The staff will prepare the necessary revisions to the AAMC Bylaws and OSR Rules and Regulations for consideration at the June meetings.

F. Council of Deans Spring Meeting Program

Board members were presented with the final program for the Council of Deans Spring Meeting set for April 27-30 at the Sonesta Beach Hotel in Key Biscayne, Florida. It was agreed that there would be a COD Business Meeting the evening of April 28 to brief the Council on the presentations planned for the President's Biomedical Research Panel which has invited the Council to meet with it on April 29 at a hotel adjacent to the Sonesta Beach. A general business meeting will also be held the morning of April 30 to discuss such matters as the GAP Report.

G. President's Biomedical Research Panel

The Board devoted substantial time to a discussion of the issues to be covered in its presentations to the Panel and to the identification of the appropriate presenters. The conclusions of this discussion are reflected in the program for that meeting appended to these minutes.

V. Adjournment

The Board meeting was adjourned at 12:50 p.m.

NOMINATION OF DISTINGUISHED SERVICE MEMBERS

The letter which follows has been received from Dr. James Pittman of the University of Alabama nominating Dr. Richardson Hill for election to Distinguished Service Member of the Council of Deans of the AAMC. In previous years, the Administrative Board has authorized its chairman to appoint a nominating committee to develop a roster of appropriate candidates for election to this office. It would appear appropriate for the Board to take similar action this year. In addition, it is suggested that the Board establish a regularized procedure for soliciting annually from the Council suggestions for nomination to distinguished service membership. Such a solicitation should require that the responses include a description of the "active and meritorious participation [of the candidate] in the affairs of the AAMC while a member of the Council of Deans". The nominating committee could then review the suggestions submitted and make recommendations to the Administrative Board for nomination to the Council of Deans through the Executive Council.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

WASHINGTON: 202: 466-5175

April 22, 1975

James A. Pittman, Jr., M.D.
Executive Dean
University of Alabama
School of Medicine-Birmingham
University Station
Birmingham, Alabama 35294

Dear Jim:

I have received your letter nominating Dick Hill for Distinguished Service Membership in the Association of American Medical Colleges. I will forward your letter and supporting material to the Council of Deans Administrative Board, which must recommend the election of any former members of the COD to Distinguished Service Membership.

Best regards.

Sincerely,

John

John A. D. Cooper, M.D.

bcc: J. Keyes w/incoming

the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294
the Medical Center / SCHOOL OF MEDICINE / OFFICE OF THE DEAN / April 2, 1975

John A. D. Cooper, M.D., President
American Association of Medical Colleges
One Dupont Circle
Washington, D. C. 20036

Dear John:

I am writing to nominate Dr. S. Richardson Hill, Jr., M.D., currently Vice President for Health Affairs, University of Alabama Medical Center, Director of the Medical Center, and Director, University of Alabama System Medical Education Program, for Distinguished Service Member of the AAMC. Dr. Hill was Dean of the University of Alabama School of Medicine from 1962-1968, when he became Vice President for Health Affairs. During that period he was, of course, a member of the Council of Deans and in that capacity served to build the prestige of that body. For example, he was the first Chairman of the AAMC-VA Liaison Committee and in that position led to considerable improvement in the relations between the VA and the nation's medical schools. Later he became Chairman of the VA's Exchange of Medical Information Committee and a member of the Medical Education Committee. Finally, he served as a member of SMAG (the congressionally mandated Special Medical Advisory Group of the VA) and was invited to become chairman of SMAG, an invitation he had to decline because of other commitments. Some of these activities were summarized in an address which Dr. Hill gave at the 80th Annual Meeting of the AAMC in Cincinnati in November 1969 (Journal of Medical Education, 45:564-570, 1970). He was also an active participant in the other activities of the Council of Deans during his tenure as Dean of the University of Alabama School of Medicine.

Dr. Hill has held prominent posts in a number of other national organizations. For example, he was national president of the American Federation for Clinical Research (AFCR) in 1961-62; and in 1973 he was President of the Association of Academic Health Centers. He currently serves on the Scientific Advisory Board of the American Medical Association.

I am attaching a curriculum vitae and bibliography. I believe it would be a mutually beneficial appointment for Dr. Hill to be designated a Distinguished Service Member of the AAMC and will look forward to your response.

Many thanks.

Sincerely,

James A. Pittman, Jr., M.D.
Executive Dean
University of Alabama School of Medicine
Birmingham-Tuscaloosa-Huntsville

Enclosure

CV #10

CURRICULUM VITAE

SAMUEL RICHARDSON HILL, JR., M. D.

Birth:	May 19, 1923
Place:	Greensboro, North Carolina
Married:	Janet Redman, October 28, 1950
Children:	Susan Dustin Hill Samuel Richardson Hill, III Elizabeth Hamilton Hill Margaret Hanes Hill
Residence:	3337 East Briarcliff Road Birmingham, Alabama 35223
Education:	Riverside Military Academy, Gainesville, Georgia 1937-1939
	B. A. Duke University, 1939-1943
	M. D. Bowman Gray School of Medicine of Wake Forest University, 1943 - December 1946

PROFESSIONAL EXPERIENCE:

1/47 - 7/47	Survey European Medical Schools
7/1/47 - 6/30/48	Intern in Medicine, Peter Bent Brigham Hospital, Boston, Mass.
7/1/48 - 6/30/49	Assistant Resident in Medicine, Peter Bent Brigham Hospital; Teaching Fellow in Medicine, Harvard Medical School
7/1/49 - 6/30/50	Assistant in Medicine, Peter Bent Brigham Hospital; Research Fellow in Medicine, Harvard Medical School; Dazian Medical Foundation Research Fellow
7/1/50 - 6/30/51	Chief Resident in Medicine, North Carolina Baptist Hospital; Instructor in Medicine, Bowman Gray School of Medicine
8/51 - 11/53	Chief, Medical Service (Major) USAF Hospital, Keesler Air Force Base, Mississippi
12/53 - 11/54	Assistant in Medicine, Harvard Medical School and Peter Bent Brigham Hospital
12/54 - 1957	Assistant Professor of Medicine and Director of Metabolic and Endocrine Division, Medical College of Alabama; Chief, Metabolic Division, Veterans Administration Hospital, Birmingham, Alabama

PROFESSIONAL EXPERIENCE:
(Cont'd)

10/57 - 8/31/62	Associate Professor of Medicine and Director of Metabolic and Endocrine Division, University of Alabama Medical College and V. A. Hospital, Birmingham, Alabama
9/1/62 - 10/31/68	Dean and Professor of Medicine, University of Alabama Medical College, Birmingham, Alabama
11/1/68 - Present	Vice President for Health Affairs, University of Alabama Medical Center, Director of the Medical Center, Birmingham, Alabama, and Professor of Medicine, University of Alabama in Birmingham

CERTIFICATION: American Board of Internal Medicine, October, 1954.

HONORS:

Alpha Omega Alpha
Omicron Kappa Upsilon (Honorary Member) Phi Phi Chapter, April, 1969
Outstanding Alumnus Award: Bowman Gray School of Medicine - 1961
University of Alabama, 1964
Wake Forest University, 1966
Bowman Gray School of Medicine, 1971

Distinguished Service Award: Community Service Council of Jefferson County, 1970

Award of Service from American National Red Cross, Birmingham Regional Blood Center, February,1971

PROFESSIONAL ASSOCIATIONS:

American Board of Internal Medicine, Diplomate
American Association for the Advance of Science (Fellow)
American College of Physicians (Fellow)
American Federation for Clinical Research (National Counselor, President, 1961-1962)
American Medical Association
American Thyroid Association
The Endocrine Society (Award Committee, 1962-1966; Chairman, 1967)
Massachusetts, Alabama and North Carolina Medical Societies
New York Academy of Sciences (Fellow)
The Royal Society of Medicine (Fellow)
Sigma Xi
Society for Experimental Biology and Medicine
Southern Society for Clinical Investigation
American Diabetes Association

COMMITTEE AND BOARD MEMBERSHIPS:

1. National:

NIH Pharmacology & Endocrinology Fellowship Review Panel, July 1, 1964 - June 30, 1967

White House Conference on Health, 1965

Health Sciences Advancement Award Review Panel - NIH, 1967.

VA-AAMC, Liaison Advisory Subcommittee, 1967-1969

Research Career Program Committee, National Institute of Arthritis and Metabolic Disease, NIH, September 1967 - June, 1972

Medical Advisory Committee of the Social & Rehabilitation Service, DHEW, January 31, 1968 - 1970

VA, Special Medical Advisory Group, 1968 - 1970, Chairman, 1970

American Medical Association, Advisory Committee on Medical Sciences, 1970-74

Executive Committee, Association for Academic Health Centers, 1970 - Present
President-Elect, Association for Academic Health Centers, 1972
President, Association for Academic Health Centers, 1973

Regional Medical Library Program Evaluation Committee, National Library of Medicine, Department of HEW, 1972 - Present

2. State

Chairman, Academic Health Affairs Committee, Veterans Administration, District #14

Member, Alabama Advisory Council for Comprehensive Health Planning (314-A) 1968 - Dec. '73
Chairman, Special Health Services Committee
Member, Health Manpower committee
Members, Health Education and Research Committee

Board of Directors, Lurleen B. Wallace Memorial Cancer Hospital Funds, Inc. 1969-Present

Coordinator, Alabama Regional Medical Programs, January 1970 - Present

Counselor, Medical Association of the State of Alabama, 1970 - 1977.

Member, Advisory Board of the Division of Vocational Rehabilitation & Crippled Children, 1970 - Present

3. Local:

Board of Directors, Crippled Children's Hospital & Clinic, September, 1968-Present

Community Health Planning Commission of Community Services Council of Jefferson County, 1968
Executive Committee, 1969-June, 1970

Board of Directors, Jefferson County Family Counseling Association, 1969-Present

Board of Governors, Indian Springs School, 1969-Present
Chairman of Education Committee, Indian Springs School, 1972-Present

Member, Professional Advisory Committee of Jefferson-Blount-St. Clair Mental Health Authority, October, 1969-Present

Board of Directors, Birmingham Area Chapter of American Red Cross
Chairman, Regional Blood Program Medical Advisory Committee, 1969-1970
Executive Committee, Regional Red Cross Blood Program, 1970-Present

Board of Directors, Methodist Hospital, July 1969-1971

Community Services Council of Jefferson County, Co-Chairman, Committee for Health Services to the Poor, 1969-1971

Board of Directors, Community Services Council of Jefferson County, June 1970 - Present

Board of Directors, Birmingham Festival of Arts Association, 1971-Present

Board of Directors, Freedom House, January 1, 1971-1972

Board of Directors, Birmingham Area Chamber of Commerce, January 1, 1972-1976

GSA-NIRMP SURVEY
BACKGROUND INFORMATION

The GSA-NIRMP Survey was developed by the GSA Ad Hoc Committee on Professional Development and Advising and AAMC staff in response to concerns expressed primarily by student affairs deans and medical students about the increasing numbers of violations to NIRMP procedures. The GSA-OSR Monitoring Program was initiated in 1974 and 54 of 71 schools who responded to a September 1974 questionnaire reported that they had either established or planned to establish a committee to receive reports of violations during the 1974-75 academic year. Despite the development of this program, there was growing concern voiced by several constituent bodies that students continued to be pressured by program directors to enter into advance agreements outside NIRMP. A second impetus for the survey stemmed from the desire expressed by both students and GSA members to assess the usefulness and adequacy of various counseling systems established by schools to aid students in making graduate medical education program choices.

The survey instrument consisted of two questionnaires--one which was to be completed by all graduating students and one which was to be completed by student affairs deans. The student questionnaire focused on such questions as whether they had been contacted by program directors to make agreements in violation of NIRMP guidelines, whether they had actually entered into such agreements, and whether they had received adequate counseling about program choices and the matching process. GSA members were then asked on a separate form to compile their school's student responses and also to provide data on their school's counseling system and NIRMP monitoring mechanism.

Sixty-three (63) schools responded to the survey which represents approximately 60% of medical schools with a 1975 graduating class. An average of 50% of the students at those 63 schools had completed the student questionnaire.

In any analysis of the responses, it is important to consider the probable characteristics of the respondent pool. It is unlikely that the respondents represent a random sampling of all graduating students since at most schools the questionnaires were distributed on matching day in conjunction with the distribution of match results. Therefore, many students who did not participate in NIRMP did not receive the questionnaire.

In regard to the section of the survey about the types of programs which pressured students to enter into advance agreements, a weakness in the survey methodology should be mentioned. Students were asked to cite the types of programs which had pressured them to make agreements outside NIRMP but were not asked specifically to indicate the number of times each type of specialty program had contacted them. When GSA members compiled the student responses, they may have indicated that twenty of their students reported being contact by program directors and that the types of programs involved were surgery and ENT. It was not possible to extract from the surveys returned to AAMC the precise numbers of violations initiated by each type of program. The list of specialties in the attached report should not, therefore, by interpreted as an accurate "ranking" of programs which are involved in NIRMP violations. It provides, rather, some indication of those program types which are most frequently cited by students as having put pressure upon them to enter into advance agreements outside NIRMP.

GSA-NIRMP SURVEY RESULTS

As of May 20, 1975, 63 schools had returned their GSA-NIRMP Questionnaires. Based on an approximate 60% school response and an average student response at each school of 50%, the following data has been compiled.

98% of students responding participated in NIRMP.

6% of students responding went through the motions of participating in NIRMP after having made a private advance agreement with a program director.

Of those students who did not participate in NIRMP:

11% were married or engaged students who opted to secure an appointment with spouse before matching day

54% secured a military hospital appointment

4% secured a Canadian hospital appointment

15% withdrew from NIRMP after having made a private advance agreement with a program director outside NIRMP

6% secured an appointment with an affiliated hospital that does not participate in NIRMP

1% secured an appointment with a non-affiliated hospital that does not participate in NIRMP

9% did not participate in NIRMP for other reasons (e.g., early graduation, no clinical plans, entering Ph.D. program, secured appointments in unfilled, affiliated slots, etc.)

444 students or 14% of students responding to the questionnaire were contacted by program directors to make a private, advance agreement. Of those 444, 62 were contacted in writing; 61 were contacted more than three times; 198 were subjected to follow-up pressure by mail; and 201 were required to notify programs of a decision by a specified deadline.

In response to the question regarding counseling systems, the following numbers of respondents indicated those systems which proved most helpful.

280	Dean's Office
75	Graduate Medical Education Advisory Committee
394	Individual Faculty Advisors
178	Reference Materials Compiled by School
438	Other (i.e., advise of housestaff, peers, externship experiences, interviews, etc.)

Students were requested to list those types of programs which put pressure on them to make a private, advance agreement outside NIRMP. The following numbers of schools listed the following programs at least once on the GSA-NIRMP Questionnaire:

30	Surgery
25	Psychiatry
24	Family Practice
19	Pediatrics
19	OB-GYN
17	Internal Medicine
13	Anesthesiology
10	Medicine
7	Pathology
6	ENT
6	Ophthalmology
5	Radiology
3	Orthopedics
2	Urology
2	PM&R

In question 5a of the GSA-NIRMP Questionnaire, schools were asked to indicate the types of programs with which students matched who had "gone through the motions" of participating in NIRMP after making an agreement with a program director. The following numbers of schools listed the following programs at least once on the GSA-NIRMP Questionnaire:

17	Psychiatry
14	Surgery
9	OB-GYN
9	Pathology
8	Pediatrics
7	Family Practice
6	Internal Medicine
5	Anesthesiology
4	Medicine
3	Ophthalmology
2	ENT
2	Radiology
2	PM&R
2	Neurology
1	Urology
1	Orthopedics

Of the students who responded to the questionnaire, 2% withdrew from NIRMP after having made a private, advance agreement with a program director. The average percentage of students who matched in the five choice categories was as follows: 58% - 1st choice/ 14% - 2nd choice/ 10% - 3rd choice/ 12% - 4th choice or lower/ 6% - No Match. This breakdown did not vary significantly according to the counseling systems used. At schools where "other" systems were reported as being most helpful, slightly fewer students "went through the motions" or withdrew from NIRMP after having made a private, advance agreement with a program director.

Monitoring Committee Information:

38 of the responding schools have some type of monitoring committee or mechanism.

16 of the responding schools have not established a monitoring committee or mechanism.

24 violations were reported to monitoring committees of the responding schools. The types of programs involved were as follows:

Surgery
Psychiatry
Internal Medicine
Pediatrics
Pathology
OB-GYN
Orthopedics

5/28/75 - DM

JOINT MEETING OF THE AAMC AND AADS

COUNCIL OF DEANS ADMINISTRATIVE BOARDS

The Board of the AADS Council of Deans was unable to meet with this Board on the first occasion which we suggested, June 18, 1975. By the attached letter, AADS Executive Director, Harry W. Bruce, Jr. indicates the availability of the Board to meet on the evening of September 17, 1975. This is the Wednesday evening preceeding the next Board meeting. Shall we schedule the meeting? Do we have agenda items to suggest?

AMERICAN ASSOCIATION OF DENTAL SCHOOLS
1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036
202/667-9433

May 29, 1975

JUN 0 1 1975

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

Dear Dr. Wilson:

All members of our Council of Deans Administrative Board have indicated that they will be available for a joint meeting of the AADS and AAMC Deans Boards on the evening of September 17.

Sometime before that date, I will be in touch with you regarding an agenda.

We look forward to a productive meeting.

Sincerely,

Harry W. Bruce, Jr., D.D.S.
Executive Director

HWB:sd

SPRING MEETING PROGRAM
REVIEW AND PREVIEW

Traditionally, a portion of the first Administrative Board meeting following the Spring COD meeting is devoted to a review and critique of the meeting just held, and some thought is given to planning the following year's program. A program committee is appointed which is charged to work with staff in developing the details of the program and to report back periodically to the board.

At this year's meeting there seemed to be a substantial consensus that next year's program focus on governance issues.

Recommendation: That the Board critique this year's spring meeting, discuss the attributes in next year's program and facilities which they would desire and appoint a program committee.

COUNCIL OF DEANS ACTIVITIES AT THE ANNUAL MEETING

	SUN-11/2	MON -11/3	TUES -11/4	WED -11/5	THURS-11/6
AM	Misc. Societies Other Misc.	Council Meetings Group Mtgs Other Misc.	PLENARY SESSION	PLENARY SESSION	Misc. Meetings Group Mtgs
PM	Misc. Societies Other Misc.	Council Meetings Group Mtgs Other Misc.	ASSEMBLY	COUNCIL PROGRAMS Other Misc.	Misc. Meetings Group Mtgs

The following activities have been scheduled for the Council of Deans:

Monday: 7:30 a.m. - "New Dean's Breakfast" (New Deans & Executive Council)

9:30 a.m. - 11:30 a.m. - Joint COD-COTH Program: Tentative Title "Consortia Development"

12:00 p.m. - 1:30 p.m. - Administrative Board Luncheon Agenda Preview of Council Meeting

2:00 p.m. - 5:00 p.m. - Council of Deans Business Meeting

Tuesday: 7:30 a.m. - Deans of New and Developing Schools Breakfast

9:00 a.m. - 12:00 p.m. - Plenary Session

1:00 p.m. - 4:00 p.m. - Assembly

Wednesday: 7:30 a.m. - Deans of the Midwest-Great Plains Breakfast

9:00 a.m. - Plenary Session

2:00 p.m. - 5:00 p.m. - Joint Program of the COD-CAS-COTH--"Maximum Disclosure: Individual Rights & Institutional Needs"

Titles & speakers preliminary & tentative

"Sunshine is the Best Antiseptic"--
William Smith, Children's Defense Fund of the Washington Research Project

"Sunlight May Burn"--
Edward Levi, Attorney General of the United States

1975 ANNUAL MEETING

OSR, GSA AND MINORITY AFFAIRS PROGRAM SCHEDULE

SATURDAY, NOVEMBER 1

9:00 am - 11:00 am	OSR Administrative Board Meeting
12:30 pm - 2:30 pm	OSR Orientation and Business Meeting
3:00 pm - 5:00 pm	OSR Regional Meetings
7:00 pm - 9:30 pm	OSR Business Meeting
9:30 pm - 11:00 pm	OSR Reception

SUNDAY, NOVEMBER 2

9:00 am - 11:30 am	OSR Discussion Session
1:00 pm - 3:00 pm	OSR Group Dynamics and General Discussion
1:00 pm - 5:00 pm	Minority Affairs Officers Meeting
3:00 pm - 6:00 pm	OSR Business Meeting
6:00 pm - 8:00 pm	Minority Affairs Committee Dinner Meeting
8:00 pm - 10:00 pm	OSR Program Session

MONDAY, NOVEMBER 3

8:30 am - 10:00 am	OSR Regional Meetings
9:00 am - 12:00	MSIS Committee Meeting
2:00 pm - 4:00 pm	Financial Problems of Medical Students Committee Mtg.

TUESDAY, NOVEMBER 4

1:30 pm - 4:00 pm	GSA Business Meeting
4:30 pm - 6:30 pm	Minority Affairs Program
8:00 pm - 10:00 pm	GSA Program Session

WEDNESDAY, NOVEMBER 5

7:30 am - 9:00 am	GSA Steering Committee

LIABILITY INSURANCE COVERAGE FOR MEDICAL STUDENTS

The question of liability insurance for medical students is one of growing concern among medical school deans, student affairs deans and medical students. Of particular concern is liability coverage for the student when outside the home school. In the spring of 1973 the Group on Student Affairs drafted a series of recommendations pertaining to sending and/or receiving students from other medical schools. These recommendations on extramural academic experiences, which were modified and approved by the Council of Deans in June 1973, stated that schools should agree beforehand whether the liability coverage for the student would be the responsibility of the home or the visiting institution.

During the fall of 1974 and the spring of 1975, the AAMC Division of Student Programs has received a large number of requests for information about the liability insurance coverage most medical schools have for their students and about the policy of the AAMC on liability insurance for medical students. At the Western and Northeast region meetings of the Group on Student Affairs in the spring of 1975 a request was made during the business sessions that the AAMC provide guidelines for all schools about the recommended scope of such coverage.

The only data which presently exists has been provided through a survey of Dr. David C. Mock, Associate Dean for Medical Affairs at the University of Oklahoma College of Medicine. In answer to a simple yes or no question about whether they had liability insurance coverage for their students, 40 percent of the 90 schools which responded indicated that they did have such coverage.

A STUDY OF MEDICAL SCHOOL-TEACHING HOSPITAL RELATIONSHIPS

The Division of Institutional Studies is in the early stages of developing a protocol for the review and analysis of the relationship between medical schools and their teaching hospitals. This study is supported by the contract with the Bureau of Health Manpower and is undertaken with the cooperation of the staff of the Department of Teaching Hospitals. Dr. Walter Rice recently the Planning Officer for the University of Michigan and now in private practice in Augusta, Georgia has been engaged as a consultant to assist with this project. The attached material is a synopsis of the planning efforts undertaken to date.

A STUDY OF MEDICAL SCHOOL-TEACHING HOSPITAL RELATIONSHIPS

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STUDY DESIGN: MEDICAL SCHOOL-HOSPITAL RELATIONSHIP

I. Statement of Purpose

To examine systems of clinical facilities utilized for undergraduate and graduate medical education with the objectives of: 1) identifying the areas of interface between the medical schools and teaching hospitals of critical significance to the successful management/governance of the combined endeavor; and 2) illuminating the advantages and disadvantages as well as costs to both parties associated with varying approaches to resolving the issues which arise in this relationship.

II. Background of Study

In the last ten years since Cecil Sheps published his definitive monograph--"Medical Schools and Hospitals - Interdependence for Education and Service"--the pressures to resolve many of the issues he identified in 1965 have increased. In the last 5 years, in part due to 1) increased enrollment, and 2) the trend toward primary care, which often means teaching outside the "core facility", the demand from the community for "outreach" care facilities, and the nearly prohibitive cost of building a university hospital, medical school-hospital affiliations have both increased in number and become more widely dispersed. In the same period, both the university or the core hospitals and the affiliated hospitals have had to respond to increased federal regulation and the pressures of third party payers: the educational objective is no longer justification for the initiation of new services or programs; limits are being placed on the ability of hospitals to directly finance educational programs. In response to the current concern of the Council of Deans and what is perceived as an important set of unresolved management problems, this study will attempt to go beyond purely descriptive studies of the past, and examine what works and why, in a "real" system of clinical medical educational facilities. It is not intended to describe a normative system nor to be prescriptive.

Expansion of dependence upon affiliations to meet clinical teaching obligations results in a system rather than a series of one-to-one relationships. One affiliation agreement is conditioned by all other affiliation agreements which the school has with the hospital, or which hospitals have with medical schools. The concept of a system of interdependent affiliations is a new development.

Congruence between the degree of interdependence among components of the system and the level of integration of the system is a key determinant of the effectiveness of the system. The perception by an affiliated hospital that it is a "second class" citizen may affect its ability to mount a "first class" program for educating physicians. A test of a successful affiliation is the degree to which existing practices, costs and benefits correspond to the expectations of the parties to the agreement.

III. Objectives

A. To define operationally the medical school-hospital governance relationship

B. To compare the operational patterns to the agreements (formal organization)

C. To compare the operational patterns with the expectations of relevant constituent groups

D. To examine problem areas and their relations to organizational patterns both formal and operational.

E. To ascertain: 1) the degree of interdependence among components of the educational/care system(s) studied, 2) the degree of integration among components of the educational/care system(s) studied, 3) the relationship between the degrees of interdependence and integration to the magnitude or existence of unresolved problems in the relationships among the components

F. To assess the implication of number E 1, 2, and 3 to the management/governance/organizational design of the system/components of the system

IV. Approach

To analyze data obtained 1) by the study of formal documents of agreement and organization, 2) by questionnaire and 3) by interview, in order to understand a) expected, b)formal, and c) operational relationships between the medical school and clinical facilities. In accomplishing this the study team will identify and collect data on critical incidents as a method to identify problem areas; to supplement the data on relationships, and to assist in analysis.

V. Scope of Study

The following areas have been identified as key issue areas:

Area 1. Undergraduate education: the academic level, type and quantity of educational experience which is to be provided for medical students.

Area 2. Housestaff: the selection, appointment, assignment, termination and financing of houseofficers.

Area 3. Clinical faculty: the selection, appointment, assignment, promotion, termination and financing of faculty and the relationship of faculty position and privileges to medical staff position and privileges.

Area 4. Programs: the initiation, design, expansion and termination of clinical programs, i.e. patient care involving education.

VI. Critical Incidents

For example, with respect to issue area number 2, the following questions might be posed:

1. What arrangements has your medical school made for graduate medical education (internship and residency programs)?

   A. Are there any GME programs for which the medical school is the accredited sponsor?

      1) In what specialties?

      2) What clinical facilities are utilized?

   B. With respect to each program either sponsored by your school or affiliated with it, provide the following information:

      Please list the number of house officers at the hospital:

	Name of Sponsoring Inst.	Positions Approved	Filled by grads of: U.S. & Canad.	Foreign Schools
Internships: Rotating				
Family or Gen. Pract.				
Straight				
Total				
Residencies; (list by specialty)				

2. With respect to each GME program, describe the role of each participating institution in:

   A. Determination of the number of positions offered

B. Selection of candidates

C. Design of educational program

D. Assignment of Housestaff

E. Promotion and Certification of Housestaff

F. Financing of Housestaff (payment of stipends; financing educational program)

Please include in description what role, if any is played in each of these matters by: medical school dean, full time clinical faculty of medical school, medical school department heads; hospital director, medical staff of hospitals, chiefs of service, chief of staff, hospital director of medical education.

Are these arrangements specified by written agreements?

SURVEY OF MEDICAL SCHOOL APPLICATION FEES
A COMPARISON OF AMCAS AND NON-AMCAS SCHOOLS

On the following page is summary information compiled at the request of the OSR comparing the average supplemental application fees charged by AMCAS schools with the application fees for non-AMCAS schools for the applicants to the classes entering in 1970 through 1976. In situations where there were different fees for in-state and out-of-state applicants, or where there were fee ranges as with the University of Texas System, an average fee for each school was computed.

The average fee paid by applicants to non-AMCAS schools has increased from $11 in 1969 (applicants to 1970 entering class) to $20 in 1975 (applicants to 1976 entering class). During the same period, the average supplemental application fee for all schools participating in AMCAS has increased from $10 to $14.

If the 1974 average of 7.5 applications per applicant remains true for 1975 applicants to the 1976 entering class, then the average fee paid to AMCAS for applications to AMCAS schools will be $7.33. Since the average supplemental AMCAS application fee is $14, the total cost of application to an AMCAS school would be just over $21 if all AMCAS applicants paid the supplemental fee. However, approximately 56 of the schools participating in AMCAS for selection of the 1976 class will request a supplemental fee from only those applicants who pass a preliminary screening. (15 AMCAS schools charge no supplemental fee; 15 charge a supplemental fee from all applicants.) For applicants to the 1974 entering class, available data suggests that the number of applicants from whom a supplemental fee is requested ranges from 20% to 80% of the total applicants to AMCAS schools which screen applicants before charging a fee. Clearly, therefore, the actual amount of supplemental fees paid by applicants to AMCAS schools is substantially less than $14 per school. Complete data on this aspect of AMCAS applications for applicants to the 1974 entering class are now being collected.

SURVEY OF MEDICAL SCHOOL APPLICATION FEES

A COMPARISON OF AMCAS AND NON-AMCAS SCHOOLS

ENTERING CLASS

AMCAS SCHOOLS	1976-77	1975-76	1974-75	1973-74	1972-73	1971-72	1970-71
Total Supplemental Application Fees	$ 1218	$ 1111	$ 920	$ 716	$ 596	$ 582	$ 68
Number of Schools	86	83	75	70	59	56	7
Average Supplemental Fee Per School	$ 14	$ 13	$ 12	$ 10	$ 10	$ 10	$ 10

NON-AMCAS SCHOOLS							
Total Application Fees	$ 575	$ 542	$ 653	$ 708	$ 691	$ 646	$ 1014
Number of Schools	29	31	39	44	50	51	95
Average Fee Per School	$ 20	$ 17	$ 17	$ 16	$ 14	$ 12	$ 11

ACADEMIC MEDICAL CENTER PROBLEM
IDENTIFICATION SURVEY

Attached is a draft of a survey of the Council of Deans being undertaken by the Division of Institutional Studies to identify problems in academic medical center governance. Round I is an open-ended request for contributions to an issues list. Round II will request that each issue be rated on several dimensions.

By copy of this memorandum the Administrative Boards of the CAS and the COTH are invited to evaluate this survey in terms of the potential interest of their Councils in participating in Round II of this survey.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

June 9, 1975

M E M O R A N D U M

TO : Members of the Council of Deans

FROM : Joseph A. Keyes, Director, Division of Institutional Studies

SUBJECT: Delphoid Governance Issues Identification Survey

This is Round I of the survey to identify problems and issues in the organization, administration, management and governance of the medical school/academic medical center. You will recall that this survey was discussed at the spring meeting of the Council and endorsed by the deans at that meeting.1/

The format of this survey will be similar to that employed in last year's Delphi Forecast of the Future of Medical Education. That is, we will commence with this, an open-ended first round soliciting individual responses of key issue areas. This will be followed by one or more rounds which will request that you rate the significance of issues on a composite list derived from round I on several dimensions. Our target is to report the results of this study to the Council meeting in November and to use the results as input to the program planning for next year's spring meeting.

In this round, we are asking you to perform two discrete tasks. The first is to contribute to the issue list. The second is to verify or correct our classification of your institution: organizational structure, components of the medical center and institutional characteristics.

1/Further details regarding the background of the survey and the deliberations leading to the decision to undertake a study of this nature are contained in the agenda book for the Council's April 30 meeting and in the minutes of the COD Administrative Board meetings of January 15 and April 3, 1975.

Please return your responses to both questionnaires in the envelope supplied by _____.

Thank you for your cooperation.

Round I Questionnaire

List five key problems or issues which your institution faces or expects to face in the near future in the area of medical school/ medical center organization/administration/management/governance. In considering your response take the broadest latitude in interpreting the scope of this inquiry. For example, you may wish to indicate problems in the area of administrative structure (e.g. role definition of dean, hospital director and university vice president), faculty organization and governance, relationship of components within the medical center, relationship to the university or relationship to affiliated hospitals. Please describe the problem with a level of specificity which would permit another institution to judge whether it shared a common concern.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Name _____

School _____

Round II

List of Issues	Questions about issues 1. 2. 3. 4. 5.
1.	
2.	
3.	
4.	
5.	

Questions

1. Is this a problem in your institution? (yes or no)
2. If no, it is not now a problem because:
   A. It has been solved successfully
   B. It has never arisen
   C. It is not applicable to our situation
   D. It is a problem - see #1
3. Though it has never arisen:
   A. We are confident that we are prepared to handle it.
   B. We are probably fairly vulnerable and would require either substantial insititutional work or outside assistance to solve it should it arise.
4. Irrespective of whether or not this is now a problem, how would you rate the significance of this issue to academic medicine?
   (1=No importance, 5=Extremely important) 1 2 3 4 5

5. With respect to this issue, what would you judge to be the most appropriate role of the AAMC?

   A. No Role

   B. Keep track of national level developments

   C. Gather data on current institutional practices

   D. Undertake analytical studies

   E. Provide a forum for discussion

   F. Formulate public positions

UNIVERSITY OF ALABAMA
FACULTY SALARY SURVEY

The letter which follows with its enclosures was sent to the eight institutions listed in Enclosure C by the University of Alabama Vice President for Health Affairs. The letter characterizes this as an effort to "provide more useful and valid salary data than any previous survey" in order to overcome the deficiencies of the AAMC which is "generally acknowledged" as "not particularly valid".

the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294

the Medical Center / OFFICE OF THE VICE PRESIDENT FOR HEALTH AFFAIRS / April 28, 1975

Dear

The University of Alabama School of Medicine has been requested by its Board of Trustees to provide appropriate comparison data regarding faculty salaries. Although the AAMC Annual Study data have been used for comparison purposes, there is general acknowledgment that these data are not particularly valid for many reasons. The lack of valid comparison data has prompted us to undertake a special salary survey of a small group of schools which Dean Pittman believes are particularly similar to Alabama in several respects. We are writing to enlist your cooperation in developing comparative salary information which we may all share.

The salary survey format was developed by our school in conjunction with the West Virginia University School of Medicine. West Virginia University has distributed this salary survey to the universities listed on Enclosure "B". We are distributing the same questionnaire (with some minor refinements) to the medical schools listed on Enclosure "C".

We believe that the enclosed documents provide more useful and valid salary data than any previous survey. We hope that you will view the documents in the same light and will be willing to provide salary information regarding your faculty. Although the survey may seem cumbersome, there is no other apparent way to obtain appropriate background information regarding the various aspects of total salary compensation which is needed for practical comparisons. Salary data are to be provided only as the high and low salaries, and the average, by rank, by particular department. The departments included in the survey are listed, and the AAMC definitions regarding strict full-time versus geographic full-time faculty should be followed. The survey document entitled "Part II" should be completed for each department for each category of faculty; i.e., all strict full-time faculty in the Department of Pathology should be included on one "Part II" sheet, whereas all geographic full-time faculty in that department should be included on another "Part II" form.

The Office of the Vice President for Health Affairs will receive the completed survey documents and no medical school, including the University of Alabama Medical School, will have access to the salary information that you provide. Only the general results (ranges and means) will be provided to all schools participating. Confidentiality is important to insure your confidence, and confidentiality will be provided.

Please review the survey documents. If you have questions or interpretation difficulties, call Dr. Stephen Smith at 205-934-3405. If you decide that this survey is a satisfactory instrument and that your school will participate, please have the completed forms returned to my office as soon as possible, but no later than May 26th. If you feel the need to explain or footnote any of the salary information provided, please feel free to do so on the documents provided.

Thank you very much for your willingness to participate in this salary survey comparison. As soon as all of the responses are accumulated, the data will be summarized and returned to your office for your review and use (possibly with your Trustees).

Sincerely,

S. Richardson Hill, Jr., M.D.
Vice President for Health Affairs

SRH/hw

Enclosures 4

ENCLOSURE A

NATURE OF EMPLOYMENT DEFINITIONS

The definitions of full-time and part-time salaried medical school faculty comprise the following classes of faculty:

SFT A. Strict full-time medical school faculty are those who receive their entire professional income as a fixed annual amount from funds controlled by the medical school or its parent institution, who devote their full time to the programs of the medical school, and whose professional activities are under the direct auspices of the medical school.

SFTA B. Strict full-time affiliated faculty are those who receive their entire professional income as a fixed annual amount from one or a variety of sources (medical school, parent institution, owned or affiliated institutions and their parents), devote their full time to the programs of the medical school, but whose professional activities are not under the direct auspices of the medical school.

GFT C. Geographic full-time medical school faculty are those who receive a guaranteed base salary all or most of which is paid from funds controlled by the medical school, but who may earn income from professional activities, who conduct all of their professional work in the institution(s) paying the base salary, and whose professional activities are under the direct auspices of the medical school.

GFTA D. Geographic full-time affiliated faculty are those who receive a guaranteed base salary and who are paid their base salary from one or a variety of sources (usually affiliated hospitals) and may earn some income from professional activities, and whose professional activities are not under the direct auspices of the medical school.

PTS E. Part-time salaried medical school faculty are those who receive regular payment for part-time professional activity from funds controlled by the medical school, and whose professional activities are under the direct auspices of the medical school. (Other professional activities and other income are outside the jurisdiction of the medical school.)

PTSA F. Part-time salaried affiliated faculty are those who receive regular payment for part-time professional activity by a medical school-owned or affiliated hospital or institution, and whose professional activities are not under the direct auspices of the medical school. (Other professional activities and other income are outside the jurisdiction of the institution(s) from which reimbursement is received.)

ENCLOSURE B

Alabama, University of, in Birmingham

Arkansas, University of

Duke University

Kentucky, University of

Louisiana State University

Medical College of Virginia

Medical University of South Carolina

Ohio State University

Pittsburgh, University of

Virginia, University of

West Virginia University

ENCLOSURE C

Columbia University College of Physicians & Surgeons

Cornell University Medical College

Albert Einstein College of Medicine of Yeshiva University

Mt. Sinai School of Medicine of the City University of New York

University of California at San Francisco School of Medicine

University of Chicago

University of Miami

University of Washington School of Medicine

MEDICAL SCHOOL FACULTY SALARY SURVEY

It is increasingly necessary for medical schools to have factual and realistic information about faculty salaries for comparison and faculty recruitment purposes. Limitations are quite evident in using the AAMC's Annual Medical School Faculty Salary Survey because, in most cases, salaries reported are supplemented by undisclosed bonuses, grants, private practice incomes, etc. It is our purpose with this survey to go beyond the flat salary information reported by the AAMC and to gather information about total compensation of medical school faculty members.

INSTRUCTIONS

Use the AAMC employment definitions (Enclosure A).

Report each full-time faculty member and administrator only once in the category which requires his greatest allegience.

Report salaries of full-time people-on-board only; exclude any budgeted positions which are open.

Fill out a Part II survey form for each of the following appropriate divisions below (These categories are based on West Virginia University School of Medicine. Please include additional forms for any other departments at your institution if you wish to see date pertaining to them for comparison with data of other schools in the survey. Please lump divisions together only where necessary.):

1. Administration (Dean's Office)
2. Anatomy
3. Anesthesiology
4. Behavioral Medicine and Psychiatry

5. Biochemistry
6. Community Medicine (Preventive Medicine)
7. Family Practice
8. Medical Technology
9. General Internal Medicine
10. Endocrinology and Metabolism
11. Gastroenterology
12. Hematology
13. Dermatology
14. Cardiology
15. Pulmonary Diseases
16. Rheumatology
17. Nephrology
18. Allergy
19. Infectious Diseases
20. Microbiology
21. Neurology
22. Obstetrics and Gynecology
23. Pathology
24. Pediatrics
25. Pharmacology
26. Physical Therapy
27. Physiology and Biophysics
28. Radiologic Therapy (Diagnostic)
29. Nuclear Medicine
30. Surgery (General)
31. Thoracic and Cardiovascular Surgery
32. Otolaryngology
33. Orthopedic Surgery
34. Neurosurgery
35. Opthalmology
36. Urology
37. Plastic Surgery
38. Other

Completed by _____, For _____ University, School of Medicine

PART I

1. What was effective date of your last salary adjustment for full-time medical school faculty? _____

2. Did your faculty each receive an upper limit for total annual compensation at that time? Yes _____ No _____
Did each receive an upper limit for annual institutional salary? Yes _____ No _____

3. Does you school have a medical faculty practice plan, or plans, for distributing professional fee income earned by medical school faculty members?
Yes _____ No _____

4. If you have a practice plan, is participation required _____ or voluntary_____?
(Note: If you have several plans, please refer to that plan which effects the greatest number of your faculty.)

5. Participating faculty receive patient-generated earnings in addition to, or as part of, a fixed institutional salary. Yes _____ No _____.

6. Is there a limit to the amount of personal salary dollars a faculty member may earn because of plan participation? Yes _____ No _____
Does the plan provide for diminishing returns i.e., "the more you earn the less you receive?" Yes _____ No _____

7. Are faculty salaries periodically supplemented by a bonus award that redistributes funds earned through the practice plan? Yes _____ No _____

8. Please estimate the total amount of dollars allocated from this practice plan(s) during the last fiscal year as salary supplement for clinical faculty.
$_____ (nearest $100,000)

9. Are full-time faculty permitted to practice outside the auspices of a medical faculty practice plan? Yes _____ No _____
Is such income reported to your school? Yes _____ No _____

10. Are total salaries of full-time faculty assigned to affiliate hospitals and/or clinics reported to your school? Yes _____ No _____

11. Do research funds (institutional, endowment, state, or federal) replace _____ or supplement _____ faculty salaries?

12. Do faculty have opportunities for personally controlled outside clinical specialty consultations? Yes _____ No _____

13. Do faculty receive personal expense accounts as part of their practice plan agreement or as part of their appointment policy? Yes _____ No _____
Are these expense accounts in addition to total compensation? Yes _____ No _____

In completing Part II of this survey, please include as "salary," the total compensation your faculty receive from all sources (including those noted in items 2 through 11 above.)

PART II

Faculty Salary Survey for _____ University, School of Medicine

Department _____; Category _____

Please enter the requested salary information for faculty with full-time appointments. A separate Part II form should be used for each department and for each AAMC category of faculty within a department. Considering the income opportunities listed in Part I, as well as all base salary, please list the total salary (all sources) that faculty in your institution can be expected to receive during fiscal 1975, i.e., their "agreed-to" annual salary compensation.

FACULTY RANK	SALARY MAXIMUM	SALARY MEAN	SALARY MINIMUM	FACULTY NUMBER
Chairman				
Professor				
Assoc. Professor				
Asst. Professor				
Instructor				

* Categories: Definitions for the AAMC categories of faculty are listed on the next page

PLEASE MAKE XEROX COPIES AS NECESSARY

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS BUSINESS MEETING

Minutes

April 30, 1975
8:30 a.m. - 12:00 Noon
Biscayno Room, Sonesta Beach Hotel
Key Biscayne, Florida

I. Call to Order

The Council of Deans Business Meeting was called to order by its Chairman, Ivan L. Bennett, M.D., at 8:30 a.m. The presence of a quorum was noted.

II. Approval of Minutes

The minutes of the November 12, 1974 Business Meeting were approved without change.

III. Chairman's Report

Dr. Bennett reported that the Council of Deans would continue to receive its Administrative Board's draft minutes and welcomed agenda item suggestions from the Council for the Board's consideration at their quarterly meetings. He indicated that correspondence regarding questions on draft Board minutes or possible discussion topics for Board meetings be conveyed to Dr. Marjorie P. Wilson, Director, Department of Institutional Development, AAMC.

IV. Action Item

Consideration of the AAMC Task Force Report on the recommendations of the NBME GAP Committee

The Council of Deans examined each of the GAP Committee's major recommendations in light of the Task Force's response and the subsequent reaction of the CAS and OSR.

Council discussion of each GAP Committee recommendation is as follows:

Recommendation #1: The NBME should abandon its three-part system of examination for certification for licensure.

Discussion of this recommendation by the Council reflected varying points of view regarding the continued usefulness of the three-part NBME examination for licensure.

Those who believed it should not be immediately abandoned cited the need for a single national standard for licensure and the importance of a nationally accepted standard of quality that medical schools can point to when defending medical education to the public, courts, and legislature. The acceptability of the exam as a standard, one council member suggested, has not been eroded, as many critics claim, as evidenced by the increase in the number of medical schools requiring the National Boards for graduation from 22 to 33.

Part I of the exam was praised for its practical use as an evaluative tool, both for use in "weeding out" undesirable students and for use as an indicator of acceptability for transfer after 2 years for students from foreign medical colleges to U.S. colleges.

Supporters of the National Board exam admit that it may have deficiencies but indicate that mechanisms exist for revision and that if modified, it can continue to perform its function as a criteria for licensure.

Proponents for abandonment of the National Board three-part exam believe that the exam has outlived its usefulness and no longer fulfills the function of being the sole standard for licensure. They point to the fact that the FLEX exam has become accepted in forty-eight states as an authoritative examination for licensure.

Part I was criticized for its tendency to require conformity to a standard kind of basic science curriculum. It thus discourages experimentation and innovation with basic science curricula. Additionally, it reinforces an attitude among students that basic sciences can be put aside and "forgotten" after 2 years of study. It was suggested that a test which examined a student's knowledge of basic medical science given at the time of awarding the academic degree would be an advance toward solving these problems.

Dr. Janeway, a member of the Advisory Committee for Undergraduate Education for the National Board, described the advisory committee's position regarding the GAP Task Force report. The committee concluded and recommended to the National Board that the three-part examination continue to

be made available as is suggested in the Task Force Minority Report by Carmine Clemente. The Advisory Committee also considered the feasibility of the formation of a criterion-referenced evaluative qualifying examination designed to assess clinical competency and related basic science knowledge for entrance into graduate medical education. Although the exam would not be related to the licensure process, Dr. Janeway admitted that, if the new exam proved effective and became generally accepted, the three-part exam might be in effect "abandoned". It was Dr. Janeway's opinion that the uniform adoption of a single set of pathways related to licensure, whether it be FLEX or another exam, would be the best way to come to grips with assessing quality in the educational process.

It was the consensus of those deans present that the maintenance of a national standard for quality and licensure was important and therefore whatever its defects the three-part system should not immediately be abandoned.

ACTION: On motion, seconded and passed, the Council of Deans voted to concur with the CAS substitute recommendation which reads, with a COD wording change (see underlining), as follows:

> The Task Force believes that the three-part system should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school <u>students and</u> graduates in both the basic <u>and clinical</u> science aspects of medical education.

Recommendation #2: The NBME should continue to make available norm-referenced exams in the disciplines of medicine now covered in Parts I and II of the National Board.

The CAS recommended that if one agrees with the substitute recommendation in #1, then by reason of logic, #2 should be deleted.

ACTION: On motion, seconded and passed, the Council of Deans voted to delete GAP Committee Recommendation #2.

Recommendation #3: The AAMC, NBME and other interested agencies should assist the schools to develop more effective student evaluation methodologies.

Discussion centered on whether the Council should adopt the Task Force recommendation which concurs with and extends the Committee recommendation by emphasizing the role of the LCME in examining methods of student evaluation in the accreditation process or adopt the CAS substitute recommendation which also emphasizes the role of the LCME but which would require schools to provide evidence to the accrediting body of the schools utilization of external evaluation in the assessment of the educational achievement of their students.

It was the CAS phrase "external evaluation data" that concerned many deans.

Dr. D. Kay Clawson, who was a member of the CAS Administrative Board when this recommendation was formulated, described the underlying rationale for the inclusion of an "external" check on medical schools.

The CAS concern was not with the well established medical school with a history of careful review of student performance by its faculty but with what appears to be the development of new medical schools whose origins have a "political" base and not a firm university base. In these schools the CAS felt that an external check would encourage and set criterial for appropriate quality assessment of both faculty and student performance.

Although a minority of deans expressed agreement with the CAS recommendation and many approved the sentiment behind it, a majority of deans believed that the recommendation was misdirected. It was the feeling of the Council that the AAMC would in reality be approving the establishment of an external standard for medical school assessment and open the door for increased political interference in the evaluation process.

ACTION: On motion, seconded and passed, the Council of Deans voted to accept the Task Force response which reads:

The Task Force concurs [with the GAP Committee recommendation] and recommends that the LCME place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

Recommendation #4: The NBME should develop an exam to be taken by students at their transition from undergraduate to graduate education for the purpose of determining students' readiness to assume responsibility for patient care in a supervised setting.

The Council of Deans in discussion of recommendation #4 addressed itself to two basic questions. The first, whether there should be created a qualifying examination for determining entrance into graduate medical education was discussed and acted upon at the 1974 Spring Meeting in Phoenix in the narrower context of the FMG Report which had as one recommendation that a standard qualifying examination be created and required as a prerequisite to entrance into intern or residency programs in the U.S.

At that time, the Council acted in favor of this recommendation. Dr. Bennett suggested that the Deans carefully consider the idea of requiring a qualifying exam both in light of the FMG and the GAP Report so that the Council could formulate a consistent position on this much debated question.

In the discussion which followed some important questions surfaced which were of major concern to the Council and for which no ready answers were apparent:

1. Since the qualifying exam would not be linked to the licensure process, what are the alternatives for an American graduate who fails the qualifying exam and goes directly into practice without additional education in those states not requiring an internship for licensing? What impact will this have on the health care system?

It was suggested that the examination be given early enough so as to permit adequate time for remediation for those not passing the exam.

2. Who bears the burden of remediation? If the schools were to bear the burden and set up special programs then they would have to be notified of the scores. Yet the OSR and others urge that the school not be informed of the results. Is it realistic to expect the student to bear the burden? As a practical matter, it was suggested that it would fall to the schools to look after their own graduates until they had passed.

3. What about the FMG's who do not pass? Should there be a Fifth Pathway? Is it a responsibility of American medical schools to offer remediation to FMGs? Do we let them practice without the needed experience gained from a graduate program?

4. Should passing the qualifying exam be made mandatory for only FMGs or also a prerequisite for American students? It was suggested that in the interests of fairness and a desire for a national standard of quality the exam should be given to all students.

5. If mandatory for all then what will be the fate of Part I and Part II of the NBME exam which is required in many schools? Will students be required to take both?

6. If allowed the option of substituting one for the other then what kind of legal problems surface when one substitutes a norm-referenced exam for a criterion-referenced exam?

7. What effect will a qualifying exam have on the mechanics involved in applying for entrance into graduate medical education programs and subsequent acceptance? What effect will it have on the matching program?

8. Does one pass or fail the test or will it be purely evaluative--similar to a "super" MCAT?

9. What will be the effect of the qualifying exam on the present movement toward emphasizing continuing education?

After substantial discussion of these questions, not all of which appeared resolvable, Dr. Bennett framed a series of questions for a vote.

1. Should such a qualifying exam be developed?

ACTION: Unanimous approval

2. Should this examination be a "necessary but not necessarily sufficient" condition for entry into graduate medical education programs?

ACTION: Unanimous approval

3. Should this examination when developed be interchangeable with the National Board Parts I and II?

ACTION: Unanimous approval

After these actions, the question was raised whether the Council had intended that a passing grade be required, or only that the exam be taken, with the score being one criteria upon which admission to graduate programs would be based. Discussion disclosed disagreement and a vote was taken.

4. Should a passing score be required?

ACTION: Yes, by a margin of 2.5 to 1.

Thus, the action on this matter can be summarized:

> The Council of Deans voted to approve the formation of a qualifying examination, passing of which, will be a necessary, but not necessarily sufficient qualification for entrance into graduate medical education program. Passage of Parts I and II of the National Boards may be accepted as an equivalent qualification for passage of such an exam when it is developed.
>
> N.B. The requirement that a passing grade on such an exam be achieved as a prerequisite to entrance into graduate medical education was the most vigorously contested element in the COD recommendation.

Recommendation #5: The Federation of State Medical Boards and their members hould establish a category of licensure limited to caring for patients in a supervised graduate medical education setting.

ACTION: The Council of Deans generally favors the Task Force and the CAS response. The LCGME is viewed as the appropriate agency to implement, through its accrediting activities, the requirement for such an examination as is recommended under #4.

Recommendation #6: The NBME and other agencies should assist graduate faculties to develop sound methods for evaluating the achievements of their residents.

ACTION: On motion, seconded and passed the Council of Deans voted to accept the Task Force response which reads:

> The Task Force concurs and recommends that graduate faculties assume responsibility for periodic evaluations of their residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are really to be candidates for board exams.

Recommendation #7: Certification for licensure for independent practice should be based on certification by a specialty board.

Debate on recommendation #7, centering on the Task Force response, dealt with the question as to whether it was within the purview of the COD to take a stance on the question of specialty certification as a mechanism for licensure. It was agreed that because of the Council's involvement in promoting graduate medical education that the Council should act only on the second sentence of the Task Force's response.

ACTION: On motion, seconded and passed, the Council of Deans voted to accept the second part of the Task Force response with a COD wording change (see underlining) which reads now as follows:

> The Task Force recommends that physicians should be eligible for full licensure <u>only</u> after the satisfactory completion of the core portion of a graduate medical education program.

V. <u>Discussion Item</u>

Proposed Survey to Identify Institutional Governance Issues

Dr. Bennett referred the Council to the proposed governance study included in the agenda book. Dr. Marjorie Wilson commented that the term "Delphi" was not technically accurate in that we were not using the technique as a forecasting tool. Rather the term was meant to be descriptive of our intention to use the same format as last year's survey. It will involve an open-ended first round and subsequent iterations which will require that a list of items be rated on several dimensions.

Dr. Bennett urged that the deans respond promptly to the questionnaire when it is sent out. It is hoped that preliminary results can be prepared for presentation at the November Business Meeting in order to determine if the data could serve as a basis for next year's Spring Meeting program.

Dr. Bennett welcomed other Spring Meeting topic suggestions and requested that they be put in writing and sent to Dr. Wilson at the AAMC.

The following suggestions were made at the meeting:

1. A follow up to this meeting which would deal with the managerial strategies which a dean could use to implement effective evaluation strategies.

2. A meeting devoted to clarifying what is meant by governance and the appropriate role of the various actors in the university community in governance.

3. Relations between medical schools and affiliated hospitals.

4. The role of a school in providing ambulatory care.

5. The responsibility of the school to respond to community needs and demands.

VI. Information Items

Dr. Bennett suggested information items A-E be considered at the deans' leisure after the meeting. Those items were:

A. Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

B. Invitational Conference on Foreign Medical Graduates

C. IOM Social Security Studies

D. Confidentiality of Research Protocols -- An AAMC Legislative Proposal

E. Proposed (Revised) Regulations Implementing Section 223 of P.L. 92-603: Schedule of Limits on Routine Costs for Hospital Inpatient Service

VII. Adjournment

The meeting was adjourned at 12:00 noon.