

AGENDA FOR COUNCIL OF DEANS

BUSINESS MEETING

Monday, November 3, 1975
2 p.m. - 5 p.m.
Ballroom East
Washington Hilton Hotel
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

COUNCIL OF DEANS
 ANNUAL BUSINESS MEETING
 November 3, 1975
 2 p.m. - 5 p.m.
 Ballroom East
 Washington Hilton Hotel
 Washington, D.C.

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John D. Chase, M.D.
Chief Medical Director
Veterans Administration

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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 students and graduates in both the basic and clinical 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 criteria 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 should 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 only after the satisfactory completion of the core portion of a graduate medical education program.

V. Discussion Item

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.

Report of the Chairman of the
Council of Deans

The first item on the Business Meeting agenda is the Report of the Chairman to the Council. This year I have decided to prepare the report for printing in the agenda book so that it is available to members of the Council for perusal in advance of the meeting. This should permit a better opportunity for assimilating the information and will free up time at the meeting itself for discussion.

The activities of the Council of Deans can be divided into those which involve direct participation of the Council as a body and those which are handled primarily by the Administrative Board acting on behalf of the Council between Council meetings. The Council as a body meets twice a year: at the annual spring retreat and in conjunction with the Association's Annual Meeting.

Because of the gratifyingly large attendance at the COD Spring Meeting at Key Biscayne, I will simply highlight a few key points of that meeting. A Program Committee consisting of Julie Krevans and myself with the guidance of the Administrative Board and assistance of staff developed the theme and outline of presentations for the meeting which we titled, "Academic Decision-Making: Issues and Evidence". Each morning began with a keynote address. We were privileged to hear from William McElroy, Chancellor of the University of California at San Diego, on the first morning and from Steven Muller, President of the Johns Hopkins University and Hospital, on the second morning. The remainder of the program sessions were devoted to an examination of evaluation tools and techniques of potential assistance to deans in academic decision-making. In both planning the program and its implementation we relied heavily on Christine McGuire, Chairman of the AAMC Group on Medical Education and her colleagues in the field of educational measurement and research. Christine provided a conceptual framework for the program and integrated the substantive presentations by her colleagues on student assessment, faculty assessment and on program evaluation.

A substantial portion of the time in Key Biscayne which would otherwise have been free was devoted to the preparation and presentation of material on behalf of the Council of Deans to the President's Biomedical Research Panel. You have each received copies of the presentations as given to that panel. I think you will agree that the presentations were remarkably lucid and well received. I ascribe this to three factors: the dedication and hard work of the presenters, the iterative process which permitted both the Administrative Board and the Council of Deans as a whole

to review the points to be made, and finally the superb staff back up provided primarily by Marjorie Wilson.

The third evening of the meeting was devoted to a discussion with the AAMC President, John A. D. Cooper. This provided the Council with the opportunity to review in detail many of the activities of the Association and comment upon both the direction and the success of the various efforts underway.

The final morning was devoted to a business meeting in which we engaged in an extensive discussion of the implications of the Report of the Committee on Goals and Priorities of the National Board of Medical Examiners. An AAMC Task Force had prepared a set of recommended positions on the key elements of the report to which the Council responded in detail. I believe you will be satisfied that your views are reflected in the position of the Association prepared for final action by the Assembly at Tuesday's meeting.

In 1974 for the first time, the Council decided to print the proceedings of the program sessions at the Spring Meeting. This resulted in the document Zero Institutional Growth: Implications for Vitality and Leadership, which you have all received. The Administrative Board was pleased with the response to this publication and has decided to continue the practice and to print the proceedings of the 1975 meeting. The more elaborate audio-visual treatment of the topics at this year's meeting has delayed the final printing somewhat, but I am pleased to report that very shortly the proceedings will be available for distribution to each of you.

The Administrative Board acts on your behalf between meetings. I have appended to this report an outline of the specific actions of the Administrative Board on matters that pertain primarily to governance and policy making within the Association. While this outline is somewhat cryptic and lacks the details of the Board deliberations, it is a good list of matters considered. The more detailed report of the Board discussions is contained in the minutes. This year we have pursued the policy of sending each member a copy of the Administrative Board minutes. I would be pleased to comment on any matter included in the action item outline if you desire.

It is appropriate to point out that the Board has examined in considerable detail the implications of proposed AAMC policy and governance decisions on your behalf. Some of these were stimulated by the Council members, other reflected concerns arising out of the ongoing activities of the Association generally. On each, however, the Board considered the impact of these policy decisions on our individual institutions and the wisdom of the

Association proceeding according to the proposed course. I believe that this critical function has been performed well this past year and that the Board has taken seriously its task of developing positions on the issues which reflect the concerns of the Council as a whole.

One of the chief concerns of the Board and the entire Executive Council has, of course, been the Health Manpower Legislation. Much attention has been devoted to this set of issues. Under the leadership of our Association Chairman, Sherman Mellinkoff and our President, John A. D. Cooper, we have continually examined and reevaluated the position of the Association on various health manpower issues. I am aware that there is some concern on the part of members of the Council that the Association ought not be frozen into any position that it has taken, that it should respond to changes in the political and external environment as they occur if this be appropriate. I would like to reassure the members of the Council that at each meeting there is a deliberate review of our positions in light of changing circumstances. As an example, the last meeting of the Executive Council considered whether the Association ought to continue to endorse the concept that the number of housestaff positions in each specialty ought to be regulated at the national level. This provision had been eliminated from the version of the Health Manpower Legislation adopted by the House and was opposed by each of the other members of the Coordinating Council on Medical Education. The Executive Council which includes nine members of the Administrative Board voted overwhelmingly to reaffirm the previous position of the Association favoring the proposal for allocating the housestaff positions. The lack of change did not reflect an unwillingness to reevaluate but rather a conviction that the proposal represents sound social policy.

The Board this year devoted attention to establishing or maintaining good relations with other groups of significance to the Council of Deans. In April, the Board met in a social setting with the Board of the OSR. In June, we joined with the CAS Board to greet Don Fredrickson who was about to assume the Directorship of the NIH. In September, we invited the Administrative Board of the Council of Deans of the American Association of Dental Schools to join us to explore areas of mutual interest and possibilities for coordinated action. We commended to them our new approach for stimulating greater public understanding of the needs of health science institutions--the establishment of the National Citizens Advisory Committee on Medical Education. This approach was received with some enthusiasm and we look forward to collaborating with them on similar efforts in the future.

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As is reflected in the minutes which you have received, the Administrative Board has made a concentrated effort to anticipate important issues before they arise. Indications of this effort are the Delphi survey which was conducted in advance of the 1974 Spring Meeting and the current study which is underway to develop the perceptions of the Deans and those of the members of other Councils to highlight important management and governance issues. The Spring Meeting of 1976 will be in part determined by the response to the matters highlighted by this process. This is one means by which we have attempted to assure that the matters taken up at national meetings are of common concern to the medical schools.

The Board has also attempted to anticipate important issues through its participation in the program development for these meetings. This morning you heard Richard Wittrup discuss Consortia - New Patterns for Inter-institutional Coordination. This program was suggested to us by the Council of Teaching Hospitals and we felt it important to be kept current on new developments in the matter of medical school-teaching hospital relations. The second program which the Council is jointly sponsoring will be held on Wednesday afternoon from 2-5 p.m. It is entitled "Maximum Disclosure: Individual Rights and Institutional Needs". The Board is persuaded that a number of developments are taking place which require a keen understanding on our part of the social utility of various approaches to disclosure of information about the institutional and governmental decision-making processes and outcomes. We have two highly articulate spokesmen who will present varying perspectives on this matter: William Smith of the Children's Defense Fund, who will elaborate the perspective of a public interest group, and William Gerberding, Executive Vice Chancellor of the University of California, Los Angeles, who will present a somewhat different perspective arising from the context of an academic institution. I commend these programs to your attention. I hope that you will not only attend, but be an active participant in the discussions of these matters as that opportunity arises.

Any report such as this would, of course, be remiss if it did not take adequate note of the substantial contributions made to the effectiveness of the Council of Deans by the AAMC staff. We are all aware, of course, of the perceptive and energetic leadership given the staff by John Cooper. Marjorie Wilson is familiar to us in a number of contexts; her administration of the Management Advancement Program and her oversight of the Association staffing responsibilities for the Liaison Committee on Medical Education are particularly visible and impressive. No less important to us is her active oversight of the Council of Deans' activities and the staffing that goes into them. Finally, of

course, I should mention Joe Keyes, who bears the brunt of the agenda preparations, minute writing and meeting arrangements for the Council. Joe is also an active and an important contributor to the program and policy development activities of the Council and its Administrative Board.

This briefly summarizes some of the highlights of the Council of Deans over the year while I have been chairman. I would be pleased to discuss any of these matters with you at the Council meeting.

Ivan L. Bennett, Jr., M.D.
Chairman

October 1975

APPENDIX

COD ADMINISTRATIVE BOARD
ACTIONS

JANUARY - SEPTEMBER 1975

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

January 15, 1975

CCME REPORT ON THE FOREIGN MEDICAL GRADUATE

ACTION: The COD Administrative Board recommended that the Executive Council not approve the CCME Report, endorsing only the final recommendation (III/4) that the CCME sponsor as soon as possible a national invitational conference for which the CCME Report among others, would serve as a working paper.

REPORT OF THE AAMC TASK FORCE ON GROUPS

ACTION: The Board recommended to the Executive Council that the report of the Task Force on Groups be approved.

REPORT OF THE AD HOC COMMITTEE TO REVIEW THE JCAH GUIDELINES FOR MEDICAL STAFF BYLAWS

ACTION: The COD Administrative Board recommended that the Executive Council approve the Committee's recommendation on page 76 of the Executive Council agenda regarding the duality of professional appointments.

The Board proposed the following modifications to the Committee's recommendation on pages 79-80 for Executive Council action:

1. Page 79, Section IV., paragraph 2, lines 7 and 8--the word "whether" and the phrase "or from a medical-administrative position" should be deleted.

Sentence to read: "Procedural due process protections (the right to notice and a hearing, if desired) should be accorded to each person subject to removal from a medical staff appointment."

2. Page 79, Section IV., paragraph 3, underlined section--the phrase "should be separated" should be deleted and the following phrase should be substituted: "should ordinarily be separate, but interinstitutional agreements may appropriately provide for a joint process."

Page 80--the phrase "subject to a review and hearing if requested" should be deleted.

Underlined recommendation to read: "In conclusion the committee recommends that where an administrative

position is held by the same individual on the medical staff and in medical school, the appointment procedures should ordinarily be separate, but interinstitutional agreements may appropriately provide for a joint process. Further, the appointee may be removed only by the appointing authority."

PROPOSED REVISIONS TO CCME REPORT ON THE PRIMARY CARE PHYSICIAN

ACTION: The Board recommended that the Executive Council approve the modifications proposed by the Physician Distribution Committee as editorial changes.

OSR RESOLUTIONS

ACTION: After a discussion of each of the proposed resolutions with the OSR Chairman, the tenor of which was to recommend that the OSR reformulate the recommendations, enunciating the problem and their objectives more precisely and couching their recommendations in more general language, the OSR Chairman agreed to withdraw the resolutions from Executive Council consideration.

OSR RULES AND REGULATIONS

ACTION: The Administrative Board--

1. declined to approve the insertion of new language into the Rules and Regulations relating to the institutional process of selecting OSR representatives to the effect that "only students may vote" in that process,
2. agreed to review the COD Guidelines on the OSR with the object of strengthening the language urging institutions to provide students the chief role in the selection of OSR representatives,
3. reached an informal understanding that the OSR would revise its Rules and Regulations to require approval of four of the four regions to make regional actions result in a formal OSR action, and
4. approved the Rules and Regulations as proposed with the above noted exceptions.

REVIEW OF THE SURVEY OF DEANS' COMPENSATION

ACTION: The Board approved the Revised Annual Survey of Deans' Compensation with the suggestions of the Board incorporated in it.

MEDICAL SCHOOL GOVERNANCE PROBLEMS

ACTION: The Board reaffirmed that the AAMC cannot assume the role of advocate in internal disputes in medical schools. Although it expressed skepticism as to the feasibility of creating medical school governance guidelines, it did think it appropriate to pursue the identification of governance problems and consider the potential role of the COD and AAMC in dealing with them. A Delphi survey of COD on this matter was suggested.

PROPOSAL FROM AMERICAN ASSOCIATION OF DENTAL SCHOOLS

ACTION: The Board responded to a request of the AADS Executive Director that there be a joint meeting of the Councils of Deans of the two Associations with a proposal that the Administrative Board meet with its counterpart in the AADS.

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

April 3, 1975

RESIGNATION OF DR. GRULEE

ACTION: The COD Administrative Board recommends that the Executive Council appoint 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.

THE ROLE OF RESEARCH IN MEDICAL SCHOOL ACCREDITATION

ACTION: The Board recommends that the Executive Council does not approve the last paragraph of the statement for transmittal to the Liaison Committee on Medical Education. However, the Board does:

1. Recognize the importance of biomedical research to programs for the education of physicians.
2. Believes that accreditation as it is currently performed does take this into account and believes that 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.

OSR RECOMMENDATION TO ESTABLISH AN OFFICE OF WOMEN'S AFFAIRS

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 and that this report contain suggested approaches to how these activities might be appropriately highlighted to meet the perceived needs for visibility and accessibility of the efforts.

NATIONAL HEALTH INSURANCE AND MEDICAL EDUCATION

ACTION: The Board recommends that the Executive Council consider adding these positions to its policy on national health insurance and commenting on the recommendations to the CCME. It further recommends that a new task force not be appointed at this time.

On the basis of the discussion, the Board intends to devote its next meeting to a comprehensive review of the AAMC policies relating to medical health insurance.

HEALTH SERVICES ADVISORY COMMITTEE RECOMMENDATION

ACTION: With the stipulation that the Health Services Advisory Committee be consulted on the matter the Board recommends 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 recommends that the Executive Council consider supporting the development of this activity within the National Center for Health Statistics.

REPORT OF THE AAMC PILOT MEDICAL SCHOOL ADMISSIONS MATCHING PROGRAM

- ACTION:**
1. The COD Administrative Board recommends matching 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
 2. 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 recommends 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.

PROPOSAL ON MEMBERSHIP ON THE OSR ADMINISTRATIVE BOARD

ACTION: The Board recommends that 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 staff will prepare the necessary revisions to the AAMC Bylaws and OSR Rules and Regulations for consideration at the June meetings.

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

June 19, 1975

ELECTION OF PROVISIONAL INSTITUTIONAL MEMBER

ACTION: The Board endorsed the Executive Council recommendation of the election of the University of South Carolina School of Medicine to Provisional Institutional Membership by the Assembly, subject to the ratification of this action by the full Council of Deans.

CRITERIA FOR ELECTION TO PROVISIONAL INSTITUTIONAL MEMBERSHIP

ACTION: The Board recommended that the Executive Council modify its Prerequisites for Provisional Institutional Membership so as to substitute Provisional Accreditation by the LCME for (a Letter of) Reasonable Assurance of Accreditation.

COTH AD HOC MEMBERSHIP COMMITTEE REPORT

ACTION: The Board recommended that Assembly amend the Association Bylaws to establish a class of Corresponding Members. Such members would be nominated by each Council Administrative Board for election by Assembly.

Corresponding members would receive appropriate services such as those recommended in the COTH Ad Hoc Membership Committee Report and others as recommended by staff. In addition to the qualitative criteria to be developed by the Councils, one absolute requirement for becoming a subscriber would be ineligibility for any class of membership in the Association. Dues would be set at an appropriate level; the staff recommendation of \$500 per year appears reasonable as an accurate reflection of the level of services which will be received.

The committee report was approved with these modifications.

AMA POLICY ON ELIGIBILITY OF FOREIGN MEDICAL STUDENTS AND GRADUATES FOR
ADMISSION TO AMERICAN MEDICAL EDUCATION

ACTION: The Board recommended that the following statement be forwarded by the Executive Council to the LCGME for consideration by the LCGME at its next meeting in July:

The Executive Council of the Association of American Medical Colleges believes that the pathways into graduate medical education in the United States should be defined by the LCGME and forwarded to the CCME for approval and forwarding to the parent organizations for ratification.

AMENDMENT OF THE AAMC BYLAWS

ACTION: The Board recommended that the Executive Council approve the proposed amendment to the AAMC Bylaws regarding OSR representation (as stated on p. 47-48 of the Executive Council Agenda) and recommend its approval to the Assembly in November.

DEVELOPMENT OF AN AAMC POLICY ON THE NBME GAP REPORT

ACTION: The Board recommended that the Executive Council address the GAP Committee's recommendations one by one, attempting to resolve the differences in the recommendations of the various groups. Thus, an Executive Council position on each of these recommendations should be developed. The staff would then integrate the Executive Council's recommendations into a coherent report for the approval of the Executive Council in September and ultimate consideration by the Assembly in November.

The Board indicated its intention to support in the Executive Council deliberations the positions taken by the COD at its Spring Meeting.

REPORT OF THE NATIONAL HEALTH INSURANCE COMMITTEE

ACTION: While the Administrative Board of the COD agrees in principle with the LCGME/CCME recommendations with regard to National Health Insurance, it has difficulty

accepting the manner in which these are stated. The Board recommended that the report be rewritten with consideration given to an appendix containing a definition of costs rather than a repetition of allowable costs throughout the Preamble. The Board also recommended that the Preamble refer to the principles contained within it as ones already generally supported not as newly developed ideas. The Board requested an opportunity to review the reconstructed recommendations before they are made public.

The Board also recommended that consideration be given to the establishment of an AAMC group to study the possible alternatives to future funding of graduate medical education.

NOMINATION OF DISTINGUISHED SERVICE MEMBERS

ACTION: The Board authorized the Chairman to appoint a committee which would solicit from the COD membership suggested nominations for Distinguished Service Members. 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 committee would review the submissions and recommend such nominations as appeared appropriate to the Council of Deans, the Executive Council and the Assembly.

The Chairman appointed the following Committee:

J. Robert Buchanan, M.D., Chairman
Christopher C. Fordham III, M.D.
Robert L. Van Citters, M.D.

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

September 18, 1975

LCME PROCEDURES FOR LEVYING CHARGES TO SCHOOLS FOR EARLY STAGE ACCREDITATION
SITE VISITS AND PROVISIONAL ACCREDITATION

ACTION: The Board endorsed Executive Council approval of the principle that LCME levy charges for Letter of Reasonable Assurance site visits to developing medical schools.

LCME VOTING REPRESENTATION OF THE CANADIAN MEDICAL SCHOOLS

ACTION: The Board endorsed Executive Council approval of the seating of a representative of the ACMC as a voting member of the LCME.

ELECTION OF INSTITUTIONAL MEMBERS

ACTION: The COD Administrative Board endorsed Executive Council recommendation of the election by the Assembly of the University of South Florida College of Medicine and the Southern Illinois University School of Medicine to Institutional Membership in the AAMC, contingent upon ratification by the full Council of Deans.

AMENDMENT OF THE AAMC BYLAWS TO ESTABLISH A CATEGORY OF CORRESPONDING MEMBERS

ACTION: The Board suggested that the proposed amendments of the AAMC Bylaws be modified to read as follows:

Title I, Section 1, Paragraph I:

- I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education (in the United States) which do not meet the criteria established by the Executive Council for membership in the Council of Teaching Hospitals.

Title I, Section 3, Paragraph F:

- F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

ACTION: The Board also recommended the establishment of the subscriber service which would make available for a set fee AAMC publications and mailings.

THE ROLE OF THE FOREIGN MEDICAL GRADUATE

ACTION: The Board recommended Executive Council approval of the report on the Role of the Foreign Medical Graduate of the Coordinating Council on Medical Education with specific exceptions as appear on p. 40 of the Executive Council agenda.

The Board further recommended that the letter of conveyance of the Council's decision to the CCME indicate the judgment that these were matters of policy, not mere editorial suggestions.

REPORT OF THE NATIONAL HEALTH INSURANCE REVIEW COMMITTEE

ACTION: The Board recommended Executive Council approval of the Committee Report.

RECOGNITION OF NEW SPECIALTY BOARDS

ACTION: The Board recommended that the following statement (with indicated phrase deleted) be sent to the Coordinating Council on Medical Education and its member organizations as a position of the Executive Council:

"The Executive Council of the Association of American Medical Colleges believes that the authorization of the formation of new specialty boards and the development of accreditation programs for new specialties must be the responsibility of the Coordinating Council on Medical Education ~~and its parent organizations~~. The Coordinating Council, in conjunction with the Liaison Committee on Graduate Medical Education, should establish specifications and procedures for, the authorization of the development of new specialties certifying boards and residency accreditation programs."

MODIFICATION OF "RECOMMENDATIONS OF THE AAMC CONCERNING MEDICAL SCHOOL ACCEPTANCE PROCEDURES"

ACTION: The Board recommended the Executive Council's approval of the recommendations of the GSA Steering Committee.

PLANNING AGENCY REVIEW OF FEDERAL FUNDS UNDER THE PUBLIC HEALTH SERVICE ACT

ACTION: The Board recommended that the Executive Council approve the task force report. It further recommended that the matter be fully discussed at the Executive Council meeting, so that the grave implications of this legislation be fully recognized.

RECOVERY OF MEDICAID FUNDS AND SOVEREIGN IMMUNITY

ACTION: After consideration and discussion of the matter, the Board expressed its belief that institutions should be reimbursed for services delivered by them and that some way of accomplishing this should be established. However, the Board expressed its lack of expertise on the broader implications of the proposed legislation and recommended that the Association take no stand on it.

U.S. CITIZENS STUDYING MEDICINE ABROAD

ACTION: The Board acknowledged the importance of the subject of U.S. citizens studying medicine abroad, but did not believe that the two statements offered for its approval are appropriate for adoption by the Association at this time. The Board, therefore, recommended the Executive Council not approve those statements as shown on page 97 of the Executive Council agenda.

NOMINATIONS OF DISTINGUISHED SERVICE MEMBERS

ACTION: The COD Administrative Board recommended the following persons be nominated by the Executive Council for election to Distinguished Service Membership:

Lewis Thomas
Leon Jacobson
George Aagaard
Donald Anderson

Stanley Olson
Clifford Grulee
William Mayer

COD GUIDELINES FOR OSR

ACTION: The Board recommended that the COD adopt a resolution which encourages maximum involvement of the students in the selection of institutional representatives to the OSR.

SURVEY OF MEDICAL STUDENT LIABILITY INSURANCE COVERAGE

ACTION: The Board reviewed the questionnaire developed by the staff and made some suggestions for modification of the document.

IMPLEMENTATION OF THE AAMC DATA RELEASE POLICY

ACTION: The Board explored the document in detail and offered its advice on the appropriate classification of certain categories of data elements.

AMENDMENT TO AAMC BYLAWS

The Executive Council has recommended to the Assembly the adoption of several amendments to the AAMC Bylaws, a current copy of which appears on the following pages. These amendments have been proposed to achieve two specific purposes.

1. The COTH Ad Hoc Membership Committee recommended that a mechanism be provided for membership in the AAMC of hospitals which are involved in medical education but which do not meet the criteria for COTH membership. It was felt that the establishment of a new category of Corresponding Membership in the Association would be preferable to weakening the criteria for membership in COTH (which now require that a hospital have at least four approved residency programs, among other specific criteria). The Executive Council agreed with this proposal and recommends to the Assembly the amendments to the Bylaws necessary to establish a category of "Corresponding Members."
2. The OSR and COD Administrative Boards requested that the Bylaws be amended to allow the continued participation of OSR Administrative Board members who, because of mid-year elections or graduation, no longer serve as the primary representative of their school to the OSR. The amendment is necessary because no individual can sit on an Association governing board except in the capacity of representing his/her institution. Several corresponding modifications of the OSR Rules and Regulations have been approved by the OSR and COD Administrative Boards to be consistent with this proposed Bylaws change.

PROPOSED AMENDMENTS

Add to Title I, Section 1:

I. Corresponding Members

Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Add to Title I, Section 3:

- F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

Add the italicized language, as it appears below, to Title III:

There shall be an Organization of Student Representatives related to the Council of Deans, operated in a manner consistent with rules and regulations approved by the Council of Deans and comprised of one representative of each institutional member that is a member of the Council of Deans chosen from the student body of each such member. *Institutional members whose representatives serve on the Organization of Student Representatives Administrative Board may designate two representatives on the Organization of Student Representatives, provided that only one representative of any institutional member may vote in any meeting.* The Organization of Student Representatives shall meet at least once each year at the time and place of the annual meeting of the Council of Deans in conjunction with said meeting to elect a Chairman and other officers, to recommend student members of committees of the Association, to recommend to the Council of Deans the Organization's representatives to the Assembly, and to consider other matters of particular interest to students of institutional members. All actions taken and recommendations made by the Organization of Student Representatives shall be reported to the Chairman of the Council of Deans.

RECOMMENDATION

The Executive Council recommends that the Assembly approve the amendments to the AAMC Bylaws proposed above.

ELECTION OF INSTITUTIONAL MEMBERS

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduate a class of students, and are eligible for full Institutional Membership in the AAMC:

University of South Florida
College of Medicine

Southern Illinois University
School of Medicine

RECOMMENDATION

Pending approval by the full Council of Deans, the Executive Council recommends to the Assembly that the schools listed above be elected to Institutional Membership in the AAMC.

ELECTION OF PROVISIONAL INSTITUTIONAL MEMBER

The following school has received a letter of reasonable assurance from the Liaison Committee on Medical Education and is eligible for Provisional Institutional Membership in the AAMC:

University of South Carolina
School of Medicine

RECOMMENDATION

Pending approval by the full Council of Deans, the Executive Council recommends to the Assembly that the school listed above be elected to Provisional Institutional Membership in the AAMC.

ELECTION OF DISTINGUISHED SERVICE MEMBERS

Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any membership described under Section 1. (AAMC Bylaws, Article 1, Section 2B) (Section 1 establishes the classes of institutional, academic societies and teaching hospitals membership)

Distinguished Service Members will be recommended to the Executive Council by either the Council of Deans, the Council of Academic Societies, or the Council of Teaching Hospitals. (Article 1, Section 3E)

This year the Council of Deans Administrative Board established a new procedure for the nomination of Distinguished Service Members. A nominating committee consisting of the following members was appointed:

J. Robert Buchanan, Chairman
Robert L. Van Citters
Christopher C. Fordham III

The committee solicited recommendations from the general membership and, in accordance with the Board's direction, stipulated that each candidacy be supported by 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".

On the basis of the responses received and its own deliberations, the committee made the following recommendations which were subsequently endorsed by the Administrative Board and forwarded to the Executive Council:

George N. Aagard
Donald G. Anderson
Clifford G. Grulee
Leon O. Jacobson
William Mayer
Stanley Olson
Lewis Thomas

The Executive Council has recommended to the Assembly that these individuals be elected to Distinguished Service Membership in the AAMC.

Recommendation: That the Council of Deans ratify the action of its Administrative Board and the Executive Council.

THE RESPONSE OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE PRINCIPAL RECOMMENDATIONS
OF THE GOALS AND PRIORITIES
COMMITTEE REPORT
TO THE
NATIONAL BOARD OF MEDICAL EXAMINERS

The AAMC has long been engaged with furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This is a response to the National Board of Medical Examiners' Goals and Priorities Committee Report entitled, "Evaluation In The Continuum of Medical Education."

The responses recommended in this document are a consensus derived from a task force report which provided the basis for extensive discussion and debate by the Councils, the Organization of Student Representatives and the Group on Medical Education. The consensus was achieved through deliberation by the Executive Council and is now presented to the Assembly for ratification.

Assuming that the Report of the Goals and Priorities Committee, "Evaluation In The Continuum of Medical Education", has been widely read, an extensive review and analysis is not provided here. The Report recommends that the NBME reorder its examination system. It advises that the Board should abandon its traditional 3 part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the Board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam 'Qualifying A', and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The Committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as Qualifying B. This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: 1) assist individual medical schools in improving their capabilities for intramural assessment of their students; 2) develop methods for evaluating continuing competence of practicing physicians; and, 3) develop evaluation procedures to assess the competence of "new health practitioners."

RESPONSES

1. *The AAMC believes that the 3 part examination system of the National Board of Medical Examiners 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 students and graduates in both the basic and clinical science aspects of medical education.*

2. *The AAMC recommends that the National Board of Medical Examiners should continue to make available examination materials in the disciplines of medicine now covered in Parts I and II of the National Board exams, and further recommends that faculties be encouraged to use these materials as aids in the evaluation of curricula and instructional programs as well as in the evaluation of student achievement.*

3. *The AAMC favors the formation of a qualifying exam, the passing of which will be a necessary, but not necessarily sufficient, qualification for entrance into graduate medical education programs. Passage of Parts I and II of the National Board examination should be accepted as an equivalent qualification.*

The following recommendations pertain to the characteristics and the utilization of the proposed qualifying exam.

- a. *The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed.*
- b. *The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas.*
- c. *The exam should be criterion-referenced rather than norm-referenced.*
- d. *Scores should be reported to the students taking the exam, to the graduate programs designated by such students and to the schools providing undergraduate medical education for such students.*
- e. *The exam should be administered early enough in the students' final year that the results can be transmitted to the program directors without interference with the National Intern and Resident Matching Program.*

- f. *Students failing the exam should be responsible for seeking additional education and study.*
 - g. *Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.*
4. *The AAMC doubts that medical licensure bodies in all jurisdictions will establish a category of licensure limited to practice in a supervised education setting. Therefore, the AAMC recommends that the Liaison Committee on Graduate Medical Education should require that all students entering accredited graduate medical education programs pass the qualifying exam. The LCGME is viewed as the appropriate agency to implement the requirement for such an exam.*
 5. *The AAMC should assume leadership in assisting schools to develop more effective student evaluation methodologies and recommends that the Liaison Committee on Medical Education place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.*
 6. *The AAMC recommends that the LCGME and its parent bodies take leadership in assisting graduate faculties to develop sound methods for evaluating their residents, that each such faculty assume responsibility for periodic evaluation of its residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are ready to be candidates for board exams.*
 7. *The AAMC recommends that physicians should be eligible for full licensure only after the satisfactory completion of the core portion of a graduate medical educational program.*

RECOMMENDATION

The Executive Council recommends that the Assembly approve "The Response of the AAMC to the Principal Recommendations of the Goals and Priorities Committee Report to the National Board of Medical Examiners."

RESOLUTION REGARDING INSTITUTIONAL SELECTION
OF OSR REPRESENTATIVES

At its January 15, 1975 meeting the COD Administrative Board rejected a proposed amendment to the OSR Rules and Regulations which would specify that "only students may vote in the selection [of OSR Representatives at the institutional level]". This amendment was rejected in part because it appeared to conflict with the COD Guidelines for the OSR which provided that the process of selection should "facilitate representative student input and be appropriate to the governance of the institution".

It was the opinion of the Board that the COD should not mandate a change in existing institutional provisions for the selection of OSR representatives. One member suggested that the effect of this modification might be that the OSR would lose representation from the schools who do not select representatives solely on the basis of student vote.

The Board voted to maintain the wording as stated in the Guidelines and disapproved the OSR revision. It did, however, suggest that the section in the Guidelines referencing OSR selection might be revised to indicate a COD preference for student selection of OSR representatives, which would stop short of making it a requirement for OSR representation.

On reflection, it appeared to staff that it might be wise to retain the character of the Guidelines as an historical document for setting forth the ground rules for the establishment of the OSR, modifications to these expectations might best be reflected by other means. One such means is, of course, the approval of Rules and Regulations amendments.

The device which appeared to accomplish best the Board's purpose was the formulation of a resolution interpreting the intent of the Guidelines which the Board would recommend for adoption by the Council of Deans at its annual meeting.

Recommendation: The Administrative Board of the COD recommends that the Council adopt the following resolution:

"The Council of Deans reaffirms its intention that students play a major role in the selection of institutional representatives to the Organization of Student Representatives. The Guidelines for the Organization of Student Representatives adopted by the Council of Deans on May 20, 1971 expresses this intention in the following manner:

'A medical student representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will facilitate representative student input and be appropriate to the governance of the institution.'

While the Council is unwilling to mandate a particular method of student selection, it reaffirms the view that the appointment of the representative by the dean acting alone or by a committee in which the students do not have a major voice, or by any other means which precludes substantial student participation is inappropriate to the objectives of the AAMC in establishing the OSR. It is intended to be a vehicle for representative student input into the deliberations and decisions of the AAMC."

REPORT OF THE NOMINATING COMMITTEE--

ELECTION OF OFFICERS

The Council of Deans nominating committee was constituted as follows:

Frederick C. Robbins, Chairman
William R. Drucker
Ephraim Friedman
Donn L. Smith
C. John Tupper

The Committee has considered the responses of Council members to the March 31, 1975 memorandum soliciting recommendations for nominations to fill the offices of the Council of Deans and proposes the following slate:

For Chairman-Elect of the Council of Deans:

J. Robert Buchanan
Dean, Cornell University
Medical College

For Member-at-Large of the Council of Deans Administrative Board:

Andrew D. Hunt
Dean, Michigan State University
College of Medicine

Additional nominations may be made from the floor.

Recommendation: That the Council of Deans consider the proposed slate and such others as may be nominated and elect its officers for the coming year.

Addendum:

The nominating committee on considering the recommendations of the Council, recommended that the AAMC nominating committee charged with proposing a slate to the Assembly for Executive Council members and Association Officers nominate the following persons:

For Chairman-Elect of the Assembly & Executive Council:

Ivan L. Bennett, Jr.
Dean, New York University
School of Medicine

For COD Representatives to the Executive Council:

Robert L. Van Citters
Dean, University of Washington
School of Medicine

Clayton Rich
Dean, Stanford University
School of Medicine

William H. Luginbuhl
Dean, University of Vermont
College of Medicine

Chandler A. Stetson, Jr.
Dean, University of Florida
College of Medicine

INPUT INTO RETREAT AGENDA

During the second week in December, the Chairman and Chairman-Elect of the Councils and the Chairman and Chairman-Elect of the Assembly, will meet with selected AAMC staff to discuss AAMC activities and plan the Association's programs for the coming year. Areas of concern which members of the Council of Deans believe should be called to the attention of the Association officers should be brought up during the discussion of the Retreat Agenda. The Annual Report of the Association, which has been distributed to you, provides information regarding Association activities during the past year.

HEALTH MANPOWER

During the last twelve months since the last Annual Meeting of the Council of Academic Societies, there has been ongoing debate regarding federal support for medical education. Shortly after the 1974 Annual Meeting, an AAMC task force was appointed under the Chairmanship of Dan Tosteson and charged to review the Association's position on health manpower legislation and to develop specifications for an Association legislative proposal. Subsequently, a bill was drafted and introduced into both the House and Senate. The Association bill recommended that one-half of federal capitation be provided without any specific requirements in recognition of the fact that basic support of medical education is in part a federal responsibility. In order to qualify for the other half of capitation, schools would be required to initiate programs relative to public concerns regarding health manpower in several areas. These provisions for qualification provided sufficient flexibility that all schools could respond to public concerns in a manner best suited to their geographic, social and cultural opportunities. The bill also provided for the regulation of residency positions by the Coordinating Council on Medical Education under the authority of the Secretary of HEW.

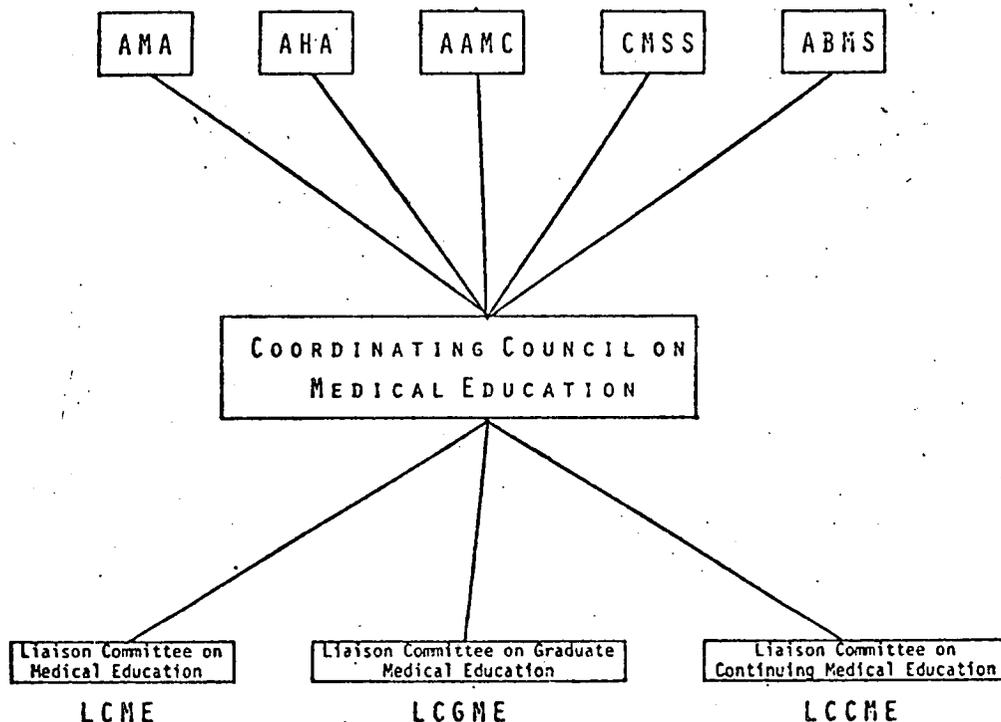
A House bill passed in July, H.R. 5546, restricted the options for capitation to a choice of two - increasing first or third year enrollments by five percent or ten students, or developing a plan for remote site training of undergraduate medical students. A provision in the House bill providing the Coordinating Council on Medical Education an opportunity to assume responsibility for the regulation of the number of residency positions was defeated by floor amendment.

The Administration bill requires that schools, in order to qualify for capitation, set aside twenty to twenty-five percent of first year class spaces for students willing to accept National Health Service scholarships, if offered. The bill also requires that schools establish an identifiable administrative teaching unit in primary care and increase residencies in primary care in affiliated teaching hospitals to thirty-five percent in FY 1977, forty percent in FY 1978 and fifty percent in FY 1979. Schools not opting to fulfill these conditions would receive capitation on a declining scale with complete phase-out of capitation support over a four year period. There is no provision for regulation of the distribution of residency positions in the Administration bill.

The Senate Health Subcommittee is presently drafting legislation.

COORDINATING COUNCIL ON MEDICAL EDUCATION
AND THE LIAISON COMMITTEES

The Coordinating Council on Medical Education was established by its five parent organizations in 1972. These are the Association of American Medical Colleges, the American Medical Association, the American Hospital Association, the American Board of Medical Specialties and the Council of Medical Specialty Societies. The purpose of the Council is to provide a forum for discussion of policy questions relevant to all phases of the continuum of medical education and to establish policies to be reviewed and ratified by the parent organizations. The CCME is particularly the body which reviews, approves and forwards to parent organizations, policies relating to the accreditation of medical education. Three liaison committees have been established under the umbrella of the CCME. These are the Liaison Committee on Medical Education (LCME), which has been responsible for the accreditation of institutions offering medical education leading to the M.D. degree in the U.S. and Canada since 1942; the Liaison Committee on Graduate Medical Education (LCGME), which is responsible for the accreditation of programs in graduate medical education; and the Liaison Committee on Continuing Medical Education (LCCME), which will be responsible for the accreditation of continuing medical education. Diagrammatically, the Coordinating Council on Medical Education and its liaison committees are represented below. Members of the Council and Liaison Committees are shown on pages four and five of this report.



- AMA - American Medical Association
- AHA - American Hospital Association
- AAMC - Association of American Medical Colleges
- CMSS - Council of Medical Specialty Societies
- ABMS - American Board of Medical Specialties

The Coordinating Council and the Liaison Committees have considered several policy issues during the past year.

COORDINATING COUNCIL ON MEDICAL EDUCATION

1. Primary Physicians - The CCME and the five parent organizations have approved a policy that fifty percent of graduating students from U.S. medical schools should develop careers in primary care.

2. Foreign Medical Graduates - The CCME has forwarded to the parent organizations a lengthy report and recommendations on foreign medical graduates. The major recommendations are that the exchange visitor program should be restricted to its original intent for graduates of foreign medical schools seeking graduate medical education in the United States by requiring bilateral agreements between the sending country and a U.S. medical school before the visitor is admitted for training. It is also recommended that the waiver provisions be removed for physicians in graduate medical education which currently allow their conversion of an exchange visitor status to a permanent immigrant status without returning to their country of last residence for two years. The parent organizations have not ratified all sections of the report. The Association of American Medical Colleges refused to ratify a section which supported the fifth pathway for U.S. FMGs and added a stipulation that the bilateral agreements for exchange visitors should be between the sending country, a U.S. medical school and an affiliated teaching hospital.

3. Financing Graduate Medical Education - A number of recommendations on future policy for financing graduate medical education under National Health Insurance have been forwarded to the parent organizations. To date, responses to these recommendations have not been received by the CCME. The major thrust of the recommendations is that investment in graduate medical education is a necessary cost of doing business for the Nation's health care system because future physician manpower must be developed continuously in order to provide the health services which the American people will expect from their health care system.

4. Regulation of Residency Positions - Current health manpower legislative debates have focused on the question of regulating available training positions in the various specialties. A section introduced into the House bill, which was removed by floor amendment, would have offered the Coordinating Council on Medical Education the opportunity to assume the responsibility for designating residency positions under the authority of the Secretary of HEW. In the Coordinating Council there was a division of opinion on this provision, with the AAMC strongly supporting the Coordinating Council's assuming the responsibility for residency designation and the four other parent organizations opposing the concept to varying degrees.

LIAISON COMMITTEE ON MEDICAL EDUCATION

The LCME, which accredits the 114 U.S. and 16 Canadian Medical Schools, developed no new policy statements during the year but devoted considerable attention to the development of interpretive material to clarify existing policy in three areas:

1. The relationship between reasonable assurance of accreditation, a status awarded in response to the requirements of Federal agencies as a condition of eligibility for Federal funds, and Provisional Accreditation, a status of approval awarded prior to the matriculation of students which extends to the graduation of the first class of students, was clarified.
2. The guidelines for accreditation, an elaboration of the requirements of the Function and Structure of a Medical School was revised and updated.
3. Guidelines for clinical campuses geographically separate from the parent school campus were developed.

The latter two documents are in draft stage and are subject to further review before adoption by the LCME.

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

1. The LCGME has revised its bylaws to provide for an appeal mechanism for program directors and institutions that desire to appeal adverse decisions by the LCGME. These bylaws are now in the process of being ratified by the parent organizations.
2. A committee of the LCGME/CCME with representatives from the Liaison Committee on Specialty Boards is now reviewing procedures and criteria for recognition of new specialties and the establishment of accreditation programs for training in new specialties. The Executive Council of the AAMC has adopted the position that the final authority for the recognition of a new specialty should be vested in the Coordinating Council.
3. A committee of the LCGME is now rewriting the General Essentials for graduate medical education.
4. A committee of the LCGME is now reviewing the problem of accrediting subspecialty fellowships. This committee's work particularly relates to mounting concerns from internal medicine, pediatrics and other primary boards which provide to individuals recognition of special competence in subspecialty areas.
5. The LCGME is revising the procedures for program review and approval of all Residency Review Committees and will attempt to make these procedures consistent for all RRCs.

LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION

This Liaison Committee will hold its first meeting in late November, 1975. It is charged to study and make recommendations on improving continuing medical education and to develop a mechanism for the accreditation of continuing medical education in the United States.

COORDINATING COUNCIL ON MEDICAL EDUCATION

American Board of Medical Specialties:

John C. Beck
Jack D. Myers
*John C. Nunemaker
John F. Roach

American Hospital Association:

*E. Martin Egelston
*Madison Brown
Donald J. Caseley
H. Robert Cathcart
David D. Thompson

American Medical Association:

Merrill O. Hines, M.D.
Tom E. Nesbitt
Bernard J. Pisani
*C.H. William Ruhe

Association of American Medical Colleges:

William G. Anlyan
Clifford Grobstein
John A.D. Cooper
*George R. DeMuth

Council of Medical Specialty Societies:

C. Rollins Hanlon
William A. Sodeman
*Robert G. Frazier
*William C. Stronach
James G. Price

Public Member:

Federal Government Representative:

Kenneth M. Endicott

Ex-Officio, Without Vote:

Bruce W. Everist
Joseph M. White
William D. Holden

*Staff Member, ex-officio, without vote

Liaison Committee on Medical Education

Council on Medical Education/AMA:

Louis W. Burgher
Bland W. Cannon
Patrick J.V. Corcoran
William F. Kellow
Joseph M. White
Chris J.D. Zarafonetis
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American Medical Association:

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John H. Killough
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Charles Verheyden
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Association of American Medical Colleges:

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Howard Horns

CONTINUING MEDICAL EDUCATION

Relicensure and Recertification

There is a rapid growth of interest in requiring physicians to participate in continuing medical education. State legislatures are moving towards requiring continuing medical education for physicians to maintain licensure. Thus far, the below-named states have set specific requirements:

Arizona	2 days per year
Florida	25 hours per year
Georgia	150 hours every 3 years
Maine	50 hours per year
Maryland	150 hours every 3 years
Michigan	50 hours per year
Nevada	10 hours per year
New Mexico	150 hours every 3 years
Ohio	150 hours every 3 years
Oklahoma	2 days per year
Pennsylvania	150 hours every 3 years
Rhode Island	20 hours per year
Tennessee	150 hours every 3 years
Virginia	50 hours per year
Vermont	2 days per year
West Virginia	2 days per year
Wisconsin	150 hours every 3 years

In at least three states, the licensing board has been empowered to establish requirements for continuing education for maintenance of licensure without specific credit hour requirements. These states are Kentucky, Kansas and Washington. Some state medical associations have made policy decisions which may require continuing education as a condition for membership in the future. These are:

- | | | | |
|------------|------------------|-------------------|-----------------|
| a) Alabama | d) Kansas | g) Minnesota | j) Oregon |
| b) Arizona | e) Kentucky | h) New Jersey | k) Pennsylvania |
| c) Florida | f) Massachusetts | i) North Carolina | l) Vermont |

The American Board of Family Practice requires recertification for maintenance of recognition as a specialist in Family Practice. The American Board of Internal Medicine has already offered a voluntary recertification exam, and the American Board of Surgery and the American Board of Pediatrics are considering similar voluntary programs. Several Boards are thinking of mandating recertification for future diplomates. The growth of either mandated or seriously encouraged continuing education for U.S. physicians to maintain licensure or specialty recognition is accelerating.

The Role of the Medical Faculties

This acceleration has implications for the academic medical faculties of the Nation, for the provision of educational services to practicing physicians ultimately devolves on the medical schools and their faculties. If it should occur that all 350,000 physicians in the United States were required to obtain fifty hours of continuing education per year, 17,500,000 contact hours could be needed. The average undergraduate medical student has 1,000 contact hours per year. Thus, a faculty demand equivalent to the establishment of seventeen medical schools could be added to the existing educational load.

Whether faculty input is through participation in lectures and seminars at their schools, at hospital staff meetings in their cities and regions, or at remote meetings at resorts and on cruises, the demand is rapidly increasing the educational responsibilities of the academic community. There are those who believe that continuing education can be accomplished through multimedia and self-instructional materials, but the participation by faculty in producing high-quality moving pictures or slide/tape self-instructional units can be even more time consuming than live lectures and seminars. A major issue, therefore, will be the time demand on the Nation's academic faculty, which is already heavily engaged in undergraduate, graduate education and the provision of educational services to other health professionals in their institutions.

Relevance

Of equivalent concern is the relevance of the educational services being offered for continuing medical education. The expectation of state legislators appears to be that requiring physicians to attend continuing medical education courses for a specified number of hours will improve medical practice in their states. Committee reports and floor debates in both the Michigan and Ohio legislatures this year indicated that the introduction of continuing medical education requirements is expected to decrease the rate of malpractice litigation. If continuing education is actually to have a direct effect on the quality of medical services provided, and thus improve consumer satisfaction, the conventional approaches to continuing medical education must be assessed to determine if they are likely to have any direct effect on the day-to-day performance of practicing physicians. The small amount of information available in current literature indicates that a direct improvement of practice is hard to demonstrate.

The conventional form of continuing medical education is to provide credit hour recognition to physicians for attending courses given by an institution or agency accredited by the American Medical Association. The criteria for accreditation do not require that the phy-

sicians attending the course be evaluated, either from the standpoint of what they learned or how what they learned was put into practice. During the past several years the American Medical Association has delegated to state medical associations the authority to accredit agencies providing continuing medical education within their states. This means that in at least 40 states, the state medical association is now empowered to approve for continuing medical education credit any institution or organization it chooses.

The Liaison Committee on Continuing Medical Education

The Liaison Committee on Continuing Medical Education (LCCME) is now being established under the authority of the Coordinating Council on Medical Education. Its charge is to review present approaches to continuing medical education and recommend changes to improve the education of practicing physicians. Its second charge is to assume responsibility for the accreditation of continuing medical education. Given the development of continuing medical education accreditation thus far, the LCCME will probably have to exert major force to modify the accreditation system and improve the standards for continuing medical education. This may require prolonged effort.

AAMC Policy

The AAMC in 1973 adopted the following policy statement for continuing medical education:

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to deliver care to patients throughout their professional lives.*
2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm.*
3. *Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.*

4. *Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice.*
5. *Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.*

Major Issues

This year finds academic medicine on the threshold of a burgeoning involvement with providing educational services to practicing physicians. The academic community must face several major issues and come to some agreement if continuing medical is to be both relevant to physicians' needs and provideable within the constraints of resources available.

- 1) Should the movement toward relicensure of physicians be supported?
- 2) Should the movement toward recertification by specialty boards be supported?
- 3) Should attendance at short courses provide credit toward relicensure or recertification?
- 4) Should participation in medical audit by individual physicians or groups of physicians become a key requirement in determining relevant educational needs?
- 5) Should regular participation in medical audit tied to an educational program be an alternative to accruing credit hours in short courses?
- 6) Should institutions providing release time to faculty for participation in continuing medical education be reimbursed for the lost faculty services to the institution?

7) Should funds for the support of research and development in continuing education in the medical schools be provided? If so, should they be provided through:

- A. Federal grants and contracts
- B. State government budgets
 - 1. derived from general tax revenues
 - 2. derived from a licensure tax on physicians
- C. State medical associations
 - 1. derived from an assessment for continuing education research and development
 - 2. derived from contributions linked to a lower malpractice insurance rate for those physicians contributing
- D. Specialty Societies

8) Should the medical schools ignore the continuing medical education movement and leave it to private entrepreneurs, state associations and specialty medical societies?

9) Should the AAMC and its constituent institutions and organizations develop policies to establish?

- A. Uniform standards which will make continuing medical education relevant to physicians' specific needs in order to improve their practice of medicine.
- B. Institutional guidelines for reimbursement for faculty participation in continuing medical education course offerings not sponsored by the medical school.
- C. Funding policies for research and development in continuing medical education at Federal and State government levels.

PRESIDENT'S BIOMEDICAL RESEARCH PANEL

The President's Biomedical Research Panel was created by Congress in mid-1974 and appointed February 1, 1975. At their spring meetings the Council of Academic Societies and the Council of Deans formulated opinions and presented testimony to members of the Panel. They emphasized their concern for the instability of research funding, the need for support of research training programs and basic biomedical and behavioral research, and the need for increased participation of the research community in the planning of future biomedical and behavioral research initiatives. The President's Panel set up a number of study groups of scientists whose responsibility is to examine the state of the art of 12 clusters of research endeavor and to advise the Panel what steps should be taken to conduct research more effectively in each area.

The Association took a leadership role with the staff of the President's Panel to assess the stability of research funding and the trends occurring in the pattern of federal involvement in the research effort. As a result, a study of the impact of federal research funding on the academic medical center has now been undertaken by a consortium of the AAMC, the American Council on Education and the Rand Corporation under contract with the Panel. Efforts to date have been the construction of a data base which will depict the dimensions and trends in funding of academic medical centers in the past decade. Construction of the computerized data base for addressing questions about the impact of research funding on academic medical centers is now completed.

This study of the impact of federal research funding will examine the federal role on not only research and research training support but also on faculty and student body size, construction, teaching, local management practices, and medical school curriculum change. Another related project in this study will be an exposition of present indirect cost policies and procedures at academic medical centers and universities. From the AAMC-ACE-Rand report the Panel will prepare its own report to the Congress.

COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS

The 93rd Congress created the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1974. Beginning in December 1974, the Commission has now held 11 two-day sessions. The Commission is composed of 11 members, including biologists, lay representatives, lawyers and ethicists; its Chairman is Kenneth Ryan of Harvard.

The Commission was initially charged to formulate new guidelines for fetal research by May 1, 1975. After several well-publicized and well-attended hearings, the Commission agreed to end the moratorium on fetal research under strict rules governing the research which would be allowed. After considerable debate the Commission forwarded these rules to the Secretary of HEW. The Secretary has now promulgated new regulations based on the Commission's recommendations, but departing from them in permitting for research purposes the artificial maintenance of the vital functions of a nonviable fetus. These regulations will probably go into effect in November, 1975.

In the past three months the Commission has turned its attention to several new studies which were required by the Congress. They are beginning the study of institutional review boards which review research grant applications for institutional compliance with regulations for the protection of human subjects. The Commission has also begun a study of the ethics of psychosurgery and of ethical guidelines for research in general as well as a series of tours of mental institutions and prisons. These tours are intended to inform the Commissioners about conditions under which research in these populations may possibly be conducted.

All meetings have been open to the public and debates, although occasionally acrimonious, have been consistently high in quality. It is probable that the Commission may become a permanent ethics review panel if legislation now before the Congress is approved.

MEDICAL COLLEGE ADMISSIONS ASSESSMENT PROGRAM

The Association is in the process of revising the Medical College Admissions Test and developing an extensive program for improving the advising of premedical students and the selection of students for entrance into medicine. There are three parts to the program.

Cognitive Assessment

This is a complete revision of the MCAT. In October of 1974 a contract was given to the American Institutes for Research (AIR) of Palo Alto, California to develop five tests. These are in Analytical Reading, Analysis of Quantitative Information, Biology, Chemistry and Physics. To accomplish this, AIR asked a panel composed of medical educators, physicians and students to rate the elements of knowledge and the skills necessary to enter medical education and to practice medicine. The ratings provided the specifications for the development of the new tests, and from these specifications test items are being produced. By early 1976 the new test forms will undergo preliminary trials and validation studies. The new test will be first administered in the Spring of 1977.

Noncognitive Assessment

Assisting the medical schools to improve their assessment of the personal qualities of applicants is a major goal of the Medical College Admissions Assessment Program. Many medical schools are now utilizing various instruments for assessing personal qualities but there is no well-organized, systematic approach to the application of these instruments to the selection of potential physicians. The Committee on Admissions Assessment, with the advice of a small working group, has set forth seven personal qualities which should be assessed in selecting students for medical school. Research teams and organizations involved in the development of personality and personal quality assessment instruments were approached to determine their interest in adapting existing test instruments or developing new instruments, to meet the needs of assessing medical school applicants. Four groups have come forward and have been cooperating with the Association staff and the Committee on Admissions Assessment to developing a proposal which will provide a variety of instruments that medical schools can select to utilize depending upon their particular needs. Funding for the development of the non-cognitive section of the assessment program will be sought in the near future.

An initial handbook describing the new testing program has been prepared and distributed to admissions officers, advisors and deans. In 1976 a more detailed handbook will be prepared which will present the test content specifications of the cognitive section and information about the developing non-cognitive test program. Detailed manuals for admissions officers, applicants and advisors, which will facilitate their interpreting the cognitive test results, will be prepared and distributed in early 1977. There will be a national workshop for admissions officers in 1976 to introduce them to the new cognitive assessment battery.

AAMC/NLM EDUCATIONAL MATERIALS PROJECT
AAMC DIVISION OF EDUCATIONAL RESOURCES

The Educational Materials Project continuing activities include: the development of a system for the appraisal of educational materials (audio-visual, and evaluation materials, simulations, etc.); the design and implementation of an information system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by users; and approaches to the study of effectiveness of materials. Beginning this year, a concerted effort will be directed toward the formation of standards and procedures regarding the classification and appraisal of computer based educational materials (CBEM). Ultimately, the goal is to make available an evaluated body of health related CBEM which will be organized and regulated to conform to library procedures.

One of the initial tasks undertaken was that of surveying the health professions education faculties in an attempt to ascertain what faculty members have identified as effective educational materials (either self-instructional or lecture support in format), whether they could be made available for panel review and whether they might be available for use by other institutions.

The responses to these queries have identified approximately 8,000 materials. These, added to the materials identified by a survey conducted by the American Association of Dental Schools (AADS) and those previously identified by professional groups and the National Medical Audiovisual Center (NMAC) total approximately 17,000 items which have now been identified for review.

Up to the present time, 36 interdisciplinary panels have been convened to review and appraise educational materials. These panels reviewed materials in the following areas:

neurosciences	oral diagnosis/oral medicine
cardiovascular system	human development
pathology	hematology
periodontics	removable prosthodontics
operative/restorative dentistry	integumentary
fixed prosthodontics	dental materials
behavioral sciences	immune system
musculoskeletal system	infectious diseases
reproductive systems	upper respiratory system
digestive system	anesthesia
orthodontics	rheumatology
pedodontics	occlusion/dental anatomy
respiratory system	pharmacology
oral surgery	histology/cytology
endocrine system	psychiatry/psychology

During these 36 reviews, 4,415 items have been appraised, of which 2,644 have been deemed acceptable for inclusion in the AVLINE data base. A "Highly Recommended" category was achieved by 413 of the accepted items.

The items recommended by the panelists will be included in the National Library of Medicine's data base designated as "AVLINE" which will be available in a format similar to the MEDLINE system. AVLINE was available for testing to selected sites on May 1, 1975. It is anticipated that the system will be fully operational in January, 1976. The process of adding to and updating the AVLINE data base is continuous as the Project seeks to identify, appraise, and make available information about recommended educational materials in the health professions.

Educational Materials Project

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AAMC DATA SYSTEMS

For a number of years the AAMC has maintained several data bases which provide information of considerable interest to faculty members and member institutions of the Association. Two of the most useful are the Institutional Profile System (IPS) and the Faculty Roster (FR). The IPS is a comprehensive, flexible, timely and accessible information exchange which is continuously being improved and updated. The system developed in response to needs for obtaining timely information from institutions without continually over-burdening these institutions. The data base now contains in excess of 1,500 data elements describing the U.S. medical school. Although some data is missing, the types of data currently maintained includes faculty, finances, student enrollments, financial aid, federal and other support, primary, ambulatory and family medicine programs, population density by school location, and other information. All of this information is now available for the past three years. In addition, as part of the contract for the President's Biomedical Research Panel, considerable information from NIH files concerning research and training grants, instruction, teaching support, etc. has been added to the data base. A large amount of information obtained annually from the institutions has been added to the data file. Additional data on facilities, curriculum, salaries and hospitals now is being added to the data file.

Individual institutional-sensitive information currently is, and in the future will be, guarded with appropriate passwords. This system, plus the requirement that all access to IPS be approved by the President of AAMC, guarantees confidentiality of sensitive data. Further information on the system may be obtained from Dr. Douglas McRae in the Division of Operational Studies.

The Faculty Roster data system is based on the Faculty Roster Master File. This file has been maintained since 1967 and includes information on more than 50,000 faculty members who are holding, or have held, salaried academic appointment at LCME accredited medical schools in the United States. The instrument used in data collection for the Roster is the Salaried Medical Faculty Questionnaire, a biographical instrument listing 298 data elements which each faculty member fills out at the time of his or her initial appointment. These questionnaires are returned to the AAMC for processing and cooperation has been sufficiently good that the Faculty Roster master file is now considered to approximate the total population of medical school salaried faculty.

Analyses of data in the Faculty Roster have been carried out by AAMC staff on projects approved by advisory committees and the Executive Staff of the Association. For more information about the Faculty Roster and for information from this source, contact Mr. Thomas Larson, Division of Operational Studies. A number of interesting and useful studies of the characteristics of the U.S. medical school faculty have recently been prepared from these systems and are available upon request.

A STUDY OF THREE-YEAR CURRICULA IN U.S. MEDICAL SCHOOLS

The Division of Educational Measurement and Research, under contract with the Health Resources Administration, Bureau of Health Manpower, Division of Medicine is conducting a study of three-year curricula in U.S. medical schools. The purpose of this study is to provide a description of the changes that were necessary within our institutions that converted from a four-year to a three-year program in undergraduate medical education.

Although the study will gather experimental data regarding all segments of the curricular process, one of the important goals of the project is to reflect the changes required of departmental chairmen and faculty in accomodating a change in the duration of the undergraduate program. We will be particularly interested in the impact of the conversion on: 1) the department chairman's assignment patterns of his faculty to the educational program, 2) the professional task and effort redistribution required of faculty as a result of teaching in a three-year program, and 3) the department chairman's overall administration. In the final analysis, it is extremely important for the study to document and express the concern and experiences of departmental chairmen and faculty who have participated in a three-year program.

Additionally, the study will gather information regarding: 1) the reasons the institution decided to convert to a three-year program and 2) the institutional process through which the conversion was accomplished. Attention will also be directed to gathering considerable data on students participating in three-year programs, i.e., entering profiles, rates of academic progress, and career choice patterns.

An in-depth analysis will be undertaken in approximately nine schools whereas more superficial data will be gathered from all other institutions that have offered three-year programs to their students. The Project staff is making every effort to describe institutional attitudes regarding three-year programs, and thus, welcomes suggestions and input from those involved in undergraduate medical education programs. Suggestions and further information may be obtained from Dr. Robert L. Beran, Project Coordinator, Three-Year Curriculum Study, Division of Educational Measurement and Research, (202) 466-4676.

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