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

September 7, 1976

MEMORANDUM

TO : Members of the Council of Deans Administrative Board

FROM : Joseph A. Keyes J.A. Keyes.

SUBJECT: Enclosed Material for September 16 Meeting

Enclosed is the agenda and background material for the COD Administrative Board Meeting. Included are: 1) the red COD Agenda; 2) a letter from Dr. Van Citters suggesting an agenda item; 3) a booklet containing the program proposals for the COD Annual Meeting Program "Current & Choice: Developments in Medical Education", and 4) the pink OSR Board Agenda. Please note that a number of Board items are included in the blue Executive Council agenda book; this is being forwarded under separate cover. We ask that you please bring it to the Board meeting.

JAK/jsp

UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 98195

School of Medicine
Office of the Dean

2 September 1976

John A. Gronvall, M.D.
Chairman, Council of Deans
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D. C. 20036

Dear John:

This letter is to request that opportunity be provided on the agenda of the forthcoming meeting of the Administrative Board COD to discuss one of the ramifications of the FMG problem, namely the question of how an individual medical school can go about assessing the quality of the educational program in a foreign medical school. The question arises out of the experience which we have had these past several months, and which, I'm sure, is common to a number of other schools as well.

Over the past several years many residents of this state, having been unsuccessful in their attempts to gain admission to this School, have elected to attend medical schools in foreign countries. Most of these individuals aspire to return to the United States, acquire licensure, and practice. Around the country a variety of procedures have been established to enable them to do so; most of these require or involve national board examinations, transfer to an accredited US school with advanced standing, or participation in a special program or clinical pathway sponsored by a school of medicine. At the present time only a few schools of medicine are involved in these processes.

For the most part these special arrangements have been mandated by legislation. Such legislation has come about because of pressure by organized groups of US citizens in foreign medical schools. A very well organized group from Guadalajara made presentations to Senate and House subcommittees designed to stimulate legislation which would force this school to sponsor students for national boards, to transfer students from foreign schools with advanced standing and to provide the requisite additional year of clinical training

for FMG's. The effort was skillfully carried off, with highly emotional presentations by the students, supporting roles by members of the families (constituents of the committee members) and an able assist from an associate dean from Irvine who extolled the virtues of Guadalajara in general, their products in particular, with special emphasis on his own program for their rehabilitation. At one point in the hearings this contingent had convinced the legislators that there were great cost benefits which could be realized by addressing the health manpower needs of the state via this route; i.e., the medical school could drop its undergraduate program and need only provide the single year of clinical training.

Our hearings concluded with the very reasonable concurrence that specific legislation would not be enacted provided that this School would indeed consider applications from students at foreign schools on a competitive and space available basis provided, of course, that the facilities, faculty, and budget required would be made available to carry out such a program. My guess would be that similar arrangements, or legislative mandates, will take place in several other states in the near future.

One of the major problems, of course, is that we don't know what we are dealing with in terms of the quality of the foreign student's educational experience. In some cases we will have available to us the unsuccessful application filed with us by the student before he was rejected and attended the foreign medical school. However, we have subsequently learned that some of the students in these foreign schools have never fulfilled premed requirements for US schools, but would be applying for advanced study. We have studied carefully the published records of the performance of foreign medical students on a variety of standard US medical examinations and have noted with dismay the unacceptably high rate of failure. In spite of the convincing testimony offered to our legislature by the associate dean from Irvine on behalf of the Gaudalajara students our own limited experience has been that such students are more typically not competitive with our own. We have also reviewed the published materials issued by some foreign medical schools and on the whole these tend to resemble advertisments for a proprietary enterprise rather than the catalog of a professional school. We do not at this point have at our disposal any means for evaluating the course content of the offerings or the relevance of such courses to a modern medical education as

offered by accredited US schools. The bottom line, then, is that our Admissions Committee must attempt to compare candidates from any given foreign medical school with candidates from US schools without access to rational or objective criteria by which this can be carried out. The same would hold as regards selection of the limited number of candidates for whom a special clinical year might be arranged.

We have discussed internally the means by which we might be able to get some handle on evaluating the quality of the educational process at these schools and have not come up with anything short of an on site inspection. It has been proposed, for example, that this School delegate a small group of faculty members to visit Guadalajara, since that school was clearly the focus of most of the current activity. It scarcely seems an appropriate role for any single school to undertake what amounts to accreditation of foreign schools. The AAMC per se has previously taken the posture in informal discussions of not wishing to become involved in accreditation of foreign schools. In spite of this, however, the AAMC is actively involved in accrediting Canadian schools. Indeed, were the candidates in question from Canadian schools there would be no problem in evaluating their credentials or in granting their admission.

I believe that most of the medical schools in this country have been or will soon be confronted with the question of how to deal with applicants from foreign medical schools. In many cases they will do so under a legislative mandate. All of our selection committees would be well served to have more nearly authentic means of approaching the evaluation of these students. I would therefore like to suggest that this issue be approached in a discussion at the forthcoming meeting of the Administrative Board. The question is not going to go away and I think all of us would be well served to have a more nearly common approach to it.

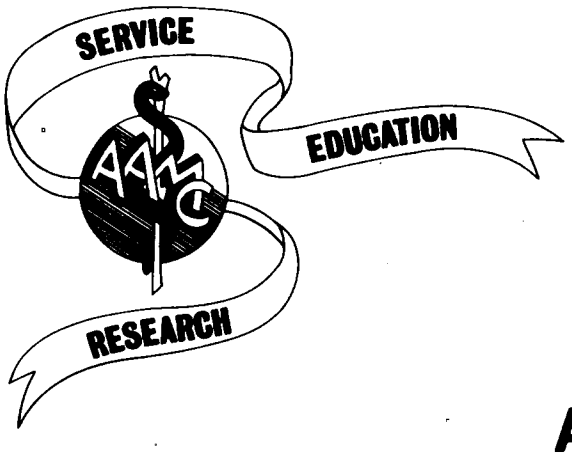
Sincerely,

Robert Van Citters

Robert L. Van Citters, M.D.
Dean

RVC:jo

cc: Joseph Keyes
John Cooper



AGENDA

FOR

COUNCIL OF DEANS

ADMINISTRATIVE BOARD

THURSDAY, SEPTEMBER 16, 1976

9:00 AM - 1:00 PM

KALORAMA ROOM
WASHINGTON HILTON HOTEL
WASHINGTON, DC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

AAMC Annual Meeting
San Francisco Hilton Hotel

November 11-15, 1976

FUTURE MEETING DATES
1977

COD Administrative Board----------January 13, 1977
Executive Council----------January 14, 1977

COD Administrative Board----------March 31, 1977
Executive Council----------April 1, 1977

COD Administrative Board----------June 23, 1977
Executive Council----------June 24, 1977

COD Administrative Board----------September 15, 1977
Executive Council----------September 16, 1977

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
September 16, 1976
9 a.m. - 1 p.m.
Kalorama Room
Washington Hilton Hotel

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

June 24, 1976
8 a.m. - 11:30 a.m.
Edison Room
Washington Hilton Hotel

PRESENT

(Board Members)

J. Robert Buchanan, M.D.
Christopher C. Fordham III, M.D.
Neal L. Gault, M.D.
John A. Gronvall, M.D.
Andrew D. Hunt, M.D.
Julius R. Krevans, M.D.
William H. Luginbuhl, M.D.
Clayton Rich, M.D.
Chandler A. Stetson, M.D.
Robert L. Van Citters, M.D.

(Staff)

Robert J. Boerner
Judith Braslow
John A. D. Cooper, M.D.
George R. DeMuth, M.D.
Joseph A. Keyes
Diane Newman
Jaimee S. Parks
James R. Schofield, M.D.
Bart Waldman

(Guests)

Ivan L. Bennett, Jr., M.D.
Thomas A. Kennedy, Jr., M.D.
Thomas A. Rado, Ph.D.
Richard S. Seigle

I. Call to Order

The meeting was called to order at 8:10 a.m. by John A. Gronvall, M.D., Chairman.

II. Chairman's Report

Dr. Gronvall asked for and received the Board's authorization to appoint a small committee to solicit nominations for Distinguished Service Membership. A request will be sent to the entire Council and results will be reported to the Board in September and the full Council at the Annual Meeting in November.

Drs. Gronvall and Bennett reported on meetings they and Dr. Wilson had with Ed Roberts and Gary Hirsch of Pugh-Roberts Associates to develop a "Medical Manpower Model" (appendix A) to help develop a better understanding of the factors that influence the need or demand for health manpower. Both felt the model had been developed to the point at which it would be worthwhile to form a small steering committee from the Board to take a look at what has been done and to develop possibilities for funding the project. The Board authorized the Chairman to move forward with the project.

III. Minutes of the Previous Meeting

An error on page 9 of the minutes of the March 25, 1976 meeting was pointed out and corrected (para. 3, l. 3 "contract physician" should read "contact physician"). The minutes were subsequently approved.

IV. Executive Council Actions

A. Election of Subscribers

At its last meeting, the Executive Council established criteria for Subscribers and a subscription fee of $500 per year.

Dr. Cooper has written to all new and developing schools and to all member medical schools with branch or multiple campuses informing them of the availability of these subscriptions. Those who had previously received these services without charge have been notified that they may apply for Subscriber status.

Action:

The Board recommended that the Executive Council approve the following subscribers:

The Abraham Lincoln School of Medicine

University of Alabama School of Primary Medical Care (Huntsville)

University of Florida College of Medicine --
Program in Medical Sciences--Tallahassee
Pensacola Educational Program
Jacksonville Hospitals Educational Program

University of Kansas School of Medicine--Wichita

Northeastern Ohio Universities College of Medicine

University of Oklahoma College of Medicine--Tulsa

West Virginia University School of Medicine--Charleston

B. Report of Joint CCME/LCGME Committee on Financing Graduate Medical Education

An earlier version of this report was reviewed in detail and significant modifications were recommended. The following recommendations of the Joint Committee were put before the Board for approval:

RECOMMENDATIONS OF THE
JOINT CCME/LCGME COMMITTEE ON
FINANCING GRADUATE MEDICAL EDUCATION

I. The costs of approved programs of clinical postdoctoral education in teaching institutions shall be included as allowable costs (a cost of doing business) for purposes of reimbursement from all sources. The recognition of the costs of such approved programs in clinical postdoctoral education as allowable costs shall be acknowledged and paid by all purchasers of services for health care. The allowable costs of clinical postdoctoral education include, but are not limited to, the stipends and related costs of clinical postdoctoral trainees (residents and fellows) and payment to supervisors and teachers for educational activities, and are applicable to both inpatient and outpatient services, as well as costs of space, equipment, and supplies. Revenue from grants, endowments and other funds restricted by the donor to clinical postdoctoral medical education should be deducted from total costs prior to determining reimbursement costs.

II. Reimbursement mechanisms should provide for and encourage clinical postdoctoral medical education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory care must include the additional cost of clinical postdoctoral education in the ambulatory setting including facilities, space and equipment as well as personnel.

III. The manner and amount of stipends and related costs for clinical postdoctoral residents and fellows shall be left to local option.

IV. Financing and reimbursement policies should provide support for modification of programs in clinical postdoctoral medical education through the appropriate expansion of existing programs and the development and addition of needed new programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.

The discussion focused on Recommendation I, which seemed to suggest that the only legitimate mechanism for financing graduate medical education is to include it as a cost of providing medical services in teaching institutions. Other mechanisms now exist or are in proposal stage. These are also legitimate and should not be discredited by the action of the CCME and/or LCGME.

Action:

The Board recommended that the Executive Council approve the recommendations of the Joint CCME/LCGME Committee but urged, in addition, that the cover letter forwarding the AAMC response note that there are alternative forms of financing graduate medical education directly as an acknowledged educational expense, presently in existence in some cases and proposed in others. Inasmuch as these are also valid approaches, they should not be undercut by any position taken by the CCME and/or LCGME.

C. Committee on Governance and Structure Report to the Executive Council

The Committee on Goverance and Structure was created by the Executive Council in January 1976 and charged with providing a "coordinated review of how the Association might best be structured to serve the long-range interests and needs of the medical schools and teaching hospitals." The Committee was also asked to respond to all proposed modifications in the governing structure and group structure of the Association.

The Committee membership consists of the five immediate past chairmen of the AAMC:

Daniel C. Tosteson, Chairman
Sherman M. Mellinkoff
Charles C. Sprague
Russell A. Nelson
William G. Anlyan

The Committee held its first meeting in Washington on June 1 - 2. Drs. Tosteson, Sprague, Nelson, and Anlyan were present. Before the Committee were two specific proposals which had been referred by the Executive Council--one to establish a Group on Continuing Medical Education and one to establish either an Organization or a Group on Minority Affairs. The Committee's deliberations were divided into two parts which form the basis of this report: a response to the specific proposals referred by the Executive Council and an exploration of the role of the Committee and the appropriate direction and level of its future activity.

I. Response to Specific Proposals

A. Minority Affairs

RECOMMENDATION: *The Committee recommends that a formal Minority Affairs Section be established within the Group on Student Affairs. The Association should encourage each medical school dean to appoint one individual to this GSA Minority Affairs Section. The GSA should incorporate into its rules and regulations a mechanism which would assure appropriate representation on the GSA Steering Committee from the Minority Affairs Section, as well as from the functional areas of admissions and financial aid. The GSA may wish to consider the formation of additional sections in these areas. However, it is acknowledged that the present structure of the GSA incorporates regional organization, and formation of the sections should complement and not substitute for regional organization. The Committee recognizes that, although the directors of minority affairs share principal interests with the Group on Student Affairs, they also have special interests closely aligned with the instructional programs; therefore, the Committee also recommends that a mechanism be developed to allow one representative of the GSA Minority Affairs Section to sit on the Steering Committee of the Group on Medical Education. The GSA-MAS may also wish to establish other less formal programmatic liaison with the GME, similar to the effective liaison which currently exists between GSA and GME. The continued role of the GSA Committee on the Medical Education of Minority Group Students as an ad hoc advisory body should be determined by the GSA Chairman and/or Steering Committee. The financial commitment of the Association to GSA activities is currently at an appropriate level and should remain unchanged. Any additional financing should be developed through outside sources.*

Finally, the Committee asks that the Executive Council take notice of the need for representation of minorities and women on the governing councils and urges that appropriate attention be given to achieving this.

B. Continuing Medical Education

RECOMMENDATION: *The Committee recommends that continuing medical education remain a component of the GME. The Committee supports the current activity within the GME to formalize its component organization by recognizing five distinct Sections in the five functional areas of interest, and believes that these Sections should be recognized as soon as*

feasible. Each Section should have appropriate representation on the GME Steering Committee, which should also retain regional representation. The Committee further recommends that membership requirements in GME (and its Sections) be modified to permit the designation of one individual to each of the five Sections from each medical school, academic society, and teaching hospital holding membership in the AAMC. Designation of these GME members would be at the discretion of the dean, the society president, and the hospital director.

II. The Role and Future Activity of the Committee on Governance & Structure

The Committee devoted a considerable portion of its meeting to an exploration of its charge and how it might best serve the Association in the coming months and years. Although it seemed apparent that the Executive Council had intended the Committee to take a broader role than just reacting to referred proposals, it was not clear whether the Council had intended that the Committee undertake a thorough re-evaluation of the Association's present governance and structure. It was agreed that such an analysis would require the Committee to assess and define the Association's goals and missions, since governance and structure must be designed to facilitate achievement of those goals and missions. Such an undertaking would build upon the Coggeshall Committee study conducted in the early 1960's.

Three specific issues were identified by the Committee as appropriate for future discussion if the Executive Council agreed with this direction:

1) How can the AAMC better represent the chief executive of the academic medical center who is often not the dean?

2) How far beyond the granting of the M.D. degree should the AAMC seek to play a role in the education and training of the physician?

3) Should the AAMC encourage either formal or informal regionalization of its member organizations?

Request to the Executive Council: *The Committee senses some urgency in addressing the broad concerns indicated above. The Committee recognizes that a comprehensive re-evaluation of AAMC governance and structure must necessarily begin with an assessment and definition of goals and missions.*

The Committee stands willing to participate in this review process in any way which the Executive Council feels appropriate. Therefore, the Committee requests that the Executive Council consider whether such a study is desirable and timely and define the role of the Committee on Governance & Structure in participating in this activity.

Action:

The Board endorsed the two recommendations of the Committee concerned with the appropriate organizational locus of the minority affairs membership and the directors of continuing medical education within the AAMC structure. The Board advised that it did not appear timely to formally address the specific issues on which the committee sought guidance, nor did the committee, as currently constituted, appear appropriate to the task.

D. AAMC Response to the Report of the President's Biomedical Research Panel

The President's Biomedical Research Panel issued its Congressionally-mandated report on the nation's biomedical and behavioral research enterprise on April 30, 1976. Both the Council of Deans and the Council of Academic Societies held formal discussions with Panel members during 1975. The staff of the Association conducted a study of the impact of federal research funding on academic medical centers under contract with the Panel.

Stimulated by these and many other considerations of mutual interest in the problem, the Association has undertaken a study and critique of the Panel Report and its major recommendations. On June 8, 1976, a committee composed of Drs. Robert Berliner, Chandler Stetson, Daniel Freedman, Leslie Webster and Thomas Kennedy met with AAMC staff to study the Panel Report.

The group developed a summary of the Panel Report and a commentary on it which included recommendations for biomedical and behavioral research. The Administrative Boards and the Executive Council were asked to review and adopt the recommendations.

The Council of Deans Administrative Board reviewed the report and endorsed the proposed response with four changes recommended.

1. Delete second sentence of proposed recommendation #5: "The Director (or his Deputy) of OSTP should be a biological scientist."

The Board judged that this recommendation delved too deeply into the organization of the OSTP. The previous sentence satisfied the policy objective that the OSTP be the focus for biomedical and behavioral science advice to the President.

2. Specify an appropriate interval (such as 3 to 5 years) for the regular review of the state of service and projections for the future recommended in recommendation #8.

The characterization "at regular but not frequent intervals" was judged to be too vague to be instructive of the intent.

3. Rephrase the last paragraph prior to recommendation #15 to emphasize the importance of research to the development of more effective clinical practice.

The impression might be left by the paragraph as written that clinical practice and research were more distinctly separate than is in fact the case.

4. Recast recommendation #15 to provide NIH with a positive leadership responsibility in a) identifying research results ripe for exploitation, developmental or demonstration work, b) identifying competent agencies to undertake the effort, and c) in collaborating in the design of effective protocols for demonstration and/or evaluation of the potential technology.

While the Board concurred with the basic thrust of the recommendation that the NIH should not be called upon to divert its energies from research to "widespread dissemination through demonstration projects" it did judge that it would be reasonable to call on NIH to bring its expertise to bear on the matter of identifying research results ripe for further exploitation and the agencies competent to undertake such efforts. The image is one of NIH assuming an active, "torch passing" role rather than the passive, "its not any longer our concern" stance.

V. Administrative Board Actions

A. OSR Representation on Executive Council

At its January meeting, the OSR Administrative Board requested that the OSR be granted a second voting seat on the Executive Council. The board members felt that increasing representation on the Council would enhance OSR's credibility both within and outside the Association. They pointed out that their constituency frequently questioned whether their single vote on the Executive Council was indicative of the Association's level of receptivity to medical student views. The OSR Administrative Board brought their request to the COD Administrative Board and stressed that increasing the number of student votes on the Executive Council would be a gesture viewed very positively as reflective of the AAMC's commitment to medical students.

The COD Administrative Board discussed the OSR request at its January and March meetings. During those discussions, COD members expressed concern about the proliferation of requests from various groups within and outside the Association for changes in the governing structure of AAMC and composition of the Executive Council. On the other hand, it was generally agreed that the addition of a second seat on the Executive Council would augment the efficiency of the Council's deliberations if a mechanism could be worked out that would guarantee a greater degree of continuity in OSR participation on the Executive Council.

In March, a joint committee of COD and OSR board members (Dr. Gronvall, Dr. Krevans, Mr. Seigle, and Dr. Rado) met with AAMC staff to discuss ways by which both goals--increasing OSR Executive Council representation and ensuring continuity of that representation--could be met. The joint committee agreed that any system which would ensure continuity would require that at least one of the two Executive Council representatives had served in that capacity the previous year. It was acknowledged that while such a system would guarantee continuity, it would, by definition, limit the infusion of new people with new ideas into leadership positions and might foster the self-perpetuation of leadership which was not the most representative of the membership. It was also acknowledged that it is often difficult for medical students to commit themselves for a two or three year period of service although such a commitment would be necessary in a system designed to ensure continuity.

It was agreed that the system that would work best for the OSR and for the Executive Council would strike a balance between the need for continuity within the Executive Council on the one hand and the negative effect within the OSR if their leadership structure were inflexible to such an extent as to make it virtually impossible for new people to become involved in the Organization. The committee developed several options for consideration by the OSR and COD Administrative Boards, and these are outlined below. It was understood that any recommendations regarding a change in the composition of the Executive Council would require a Bylaws change and would thus require review by the Committee on Governance and Structure and approval by the Assembly. The options for OSR and COD consideration are:

I. *The OSR would elect a Chairperson-Elect who would automatically assume the office of Chairperson in the second year. Both the Chairperson and Chairperson-Elect would be voting members of the Executive Council.* With this option, the OSR would return to a system it once had and which the three councils currently have. It would require that the Chairperson-Elect be a 1st, 2nd, or 3rd-year student so that he or she would be an institutional representative when serving as Chairperson.

While this option would provide optimum continuity, it could cause problems for the OSR if the Chairperson-Elect were not functioning well. In order to prevent an individual who had not functioned adequately in the first year to automatically assume the office of Chairperson and to continue as an Executive Council member, it would be advisalbe to include a mechanism which would allow for the removal of the Chairperson-Elect (e.g., the Administrative Board be empowered to prohibit the Chairperson-Elect from serving a second year by a two-thirds vote).

II. *The OSR would continue to elect both a Chairperson and Vice-Chairperson for one year terms, but neither would sit on the Executive Council. Two representatives would be elected specifically to serve on the Executive Council, and each would be elected in alternate years for two-year terms. The two Executive Council representatives would be members of the OSR Administrative Board in the same capacity as the Representatives-at-Large currently serve; no further expansion of the OSR board would be required.*

With this system, one Executive Council representative each year would have had a year's experience of serving on the Council. The potential problems associated with an individual who is not functioning well to automatically continue into a second year of office are not as great with this option as with the first option since the individual would not be continuing in both capacities of Chairperson and of Executive Council representative. The potential drawback of this system would be the decentralization of OSR leadership since neither of the traditionally highest-ranking officers of the OSR would be members of the Executive Council. This system might also cause communication problems since it would not always be clear who should be consulted on matters relating to the Organization between meetings.

III. *The Chairperson and the Immediate-Past-Chairperson would serve on the Executive Council.* In order for AAMC to maintain its tax-exempt status, this option would have to include the provision that the Chairperson be a 1st, 2nd, or 3rd-year student when elected so that he or she would be an institutional representative when serving on the Executive Council as Immediate-Past-Chairperson. It is likely that the Chairperson would be a third-year student in order to have the background and experience to assume this office. This could present a problem in that the time commitments during the third year are usually such that it would be difficult for a third-year student to also serve as OSR Chairperson.

IV. *The Chairperson and two Representatives-at-Large would sit on the Executive Council, but only the Chairperson and one Representative-at-Large would vote. Each Representative-at-Large would be elected, in alternate years, to two-year terms, and the Representative-at-Large in the second year of office would vote on the Council.*

This option would provide continuity without eliminating the possibility for new people to become involved in leadership roles within the Organization. It would also permit the Chairperson to be an Executive Council representative, and would therefore not cause the potential problems mentioned under Option II. The potential drawback with this system involves the financial and operational considerations related to the further expansion of Exeuctive Council composition.

V. One alternative in addition to the ones outlined above would be to retain the status quo. Each of the other options is based upon modification of the present system, and before modifications are recommended, consideration should be given to the advantages and disadvantages of the current system. At present, the OSR has two members on the Executive Council. Although only one member votes, both are given the privilege of the floor and both are included in Executive Sessions. While it may be advantageous in terms of OSR's credibility as viewed by the student constituency to increase their voting representation on the Executive Council, it is very unlikely that an Executive Council decision would ever be altered by one vote.

The OSR Chairperson reported the OSR Board's deliberations which concluded that the most desirable alternative would be to assign the second vote on the Executive Council to the OSR Immediate-Past-Chairperson without, however, stipulating that this person be an undergraduate medical student at the time he served in this capacity. Several technical difficulties relating to the question of who such a person represented were discussed. These related to the requirements of the tax status of the AAMC and the concomitant requirement that the governance structure consist of those serving in a capacity of representing a constituent institutional, society or hospital member. There was some sentiment, particularly on the part of the students that this was a technical problem which could be overcome if there were the will to do so. Other objections related to the appropriateness of having undergraduate students represented by a member of a house staff and the propriety of the AAMC becoming engaged with house staff representation by such an indirect means.

Action:

The Board defeated a motion to endorse the OSR preferred alternative for providing for a second voting member of the Executive Council--that the immediate-past-chairperson be seated ex officio with vote.

The Board recommended that the Executive Council approve the following plan to increase by one, OSR representation on the Executive Council:

> The OSR would elect a Chairperson-Elect who would automatically (unless recalled by a vote of the OSR membership or Board) assume the office of Chairperson in the second year. Both the Chairperson and Chairperson-Elect would be voting members of the Executive Council.

B. Institutional Governmental Liaison Officers

Now and for the forseeable future both state and federal governments appear to have an increasingly intimate and influential role in the activities and institutional health of academic medical centers. While

we have been aware of this situation, we do not appear either to be as keenly aware or as effective in our response as those with whom we are in a competitive position in the resource allocation process. Compare, for example, the relative success of the higher education community the most recent appropriations bill with our own measure of success. This recognition suggests that it is appropriate for us to begin thinking collectively regarding approaches which would enhance our prospects for success in this arena.

A first step might be to specify the roles and responsibilities of 1) the staff and officers of the AAMC, and 2) the roles of the constituent institutions themselves.

It seems important to recognize that the AAMC as an organization has several important, but on the whole limited, functions. These may be tentatively listed as:

1) Monitoring national developments;

2) Communicating important developments to the membership;

3) Facilitating the development of strategies and positions on issues by the community;

4) Representing the academic medical community in hearings and other such forums.

This is to be contrasted to the matter of contacting individual legislators and persuading them that it is in the public interest and that of their own constituents to support or oppose measures impacting upon medical centers. This function can be done far better by the schools themselves. In this regard, the response of the schools to dean's memoranda suggesting the importance of contacting legislators on various issues has been quite spotty. Occasionally, a school's response has been excellent. Generally, however, the result is either no response, or a poorly prepared one. We are informed that this is putting us at a substantial disadvantage with competing interests.

One approach for enhancing the effectiveness of the institutions in this arena has been the appointment of institutional governmental liaison officers. Such a person, generally a faculty member or a ranking administrative staff member has the responsibility for monitoring relevant governmental activity, communicating with the appropriate institutional officials or faculty and orchestrating the institution's response. There are various models of this which are essentially multi-institutional arrangements of groups with a defined community of interest, e.g., the New York deans, the Pennsylvania deans.

We have been particularly impressed with the Pennsylvania deans' model. The deans meet periodically, a staff member of one school serving as executive secretary over an extended period while the chair of the group rotates. On national legislative issues, the deans meet as a group, agree upon strategy, precede their visit to the Hill with one to AAMC, meet with the entire delegation at once (the interchange among the legislators is an effective tool of persuasion) and debrief the AAMC staff upon their return.

The role of institutional governmental liaison may be even more significant at the state level than at the national, since at present the AAMC has little capability to assist in this area.

Staff suggested that it might be timely for the AAMC to conduct a survey to learn the names and identities of such officials.

Action:

The Board advised that Association inquiry into this matter, while potentially worthwhile, deserved further and careful consideration. Staff was asked to develop a draft questionnaire for review by the Board.

VI. Adjournment

The Board adjourned its meeting at 11:30 a.m. to begin a joint session with the CAS Board.

JOINT COD/CAS DISCUSSION
11:30 a.m. - 1 p.m.
Hamilton Room
Washington Hilton Hotel

The two boards were joined by Thomas Kinney, Chairman of the Liaison Committee on Medical Education, Steven Beering, member of the LCME representing the AAMC and Edward Petersen of the AMA staff, newly designated alternate LCME secretary. Both Boards had for their reference a copy of the paper "Accreditation: The Public Policy Nexus" prepared by Marjorie P. Wilson. In addition, each Board had the current draft of two LCME "Guidelines" documents which were undergoing review prior to dissemination: a) "LCME Guidelines for Functions and Structure of a Medical School" prepared by a committee chaired by Dr. Kinney and b) "Supplemental Guidelines for Medical Schools with Branch or Multiple Campuses", prepared by a committee chaired by Dr. Beering.

The first document was printed with the comments of the Board members and suggested language changes. These comments and suggestions were discussed. Several of the items dealt with matters of tone and phrasing and there appeared to be consensus on the appropriateness of finding a way to accommodate the criticisms of the document in this regard.

One matter stimulated considerable discussion; the propriety of including family medicine in a list of clerkships "normally" included in those experiences provided students in the major disciplines of medicine. Eventually the following formulation achieved consensus:

> "In addition to the traditional clerkships in medicine, pediatrics, surgery, obstetrics and gynecology, psychiatry, many institutions offer interdisciplinary clerkship and/or clerkships in family medicine."

The two Boards urged that the Executive Council refer back the document to the LCME for revisions which take account of the comments provided.

The Boards next considered the document "Supplemental Guidelines for Medical Schools with Branch or Multiple Campuses." Discussion centered around the statement "Faculty, regardless of geographic assignment, should be subject to the same process and meet the same institutional standards for appointment, promotion, tenure, privileges and benefits." There was a broad consensus that requiring uniform procedures and standards throughout the geographically diverse settings was unduly restrictive of institutional prerogatives and unrealistic. The Boards agreed to recommend that the statement be reformulated to read, "Faculty, regardless of geographic assignment, should meet appropriate institutional standards for appointment, promotion, tenure, privileges and benefits." Additional discussion dealt with an objection to the requirement that "transfer students with advanced standing be assigned for at least half of their first academic year to that component of the school which offers the most complete program and broadest variety of resources and experiences." The group concluded that this was a sound requirement.

With the single change identified above, the group indicated its preparedness to recommend the endorsement of the document by the Executive Council.

The meeting adjourned at 1:00 p.m.

APPENDIX A

TOWARD A MEDICAL MANPOWER MODEL

FOR THE

ASSESSMENT OF CRITICAL POLICY ISSUES

by

Gary B. Hirsch

Edward B. Roberts

Introduction

The factors causing physicians to locate or not locate in a state are many in number, are interrelated in a complex manner, and are likely to have different effects on physician location decisions over time as conditions within the state change. Policies designed to affect the distribution of physicians must be based on an understanding of these factors if they are to be effective in achieving a better distribution of physicians among states and within states. A System Dynamics model can serve as a useful tool for making explicit the set of forces that impinge on physician location decisions and assessing the impact of various policies and programs for improving distribution. The following pages present a tentative set of causal relationships that would be part of a System Dynamics model of physician manpower at the state level. The model focuses on physicians' decisions to practice in a state and within particular areas in that state.

Detailed Illustration of the Proposed Model's Relationships

The medical manpower model would be developed at the state level. It would have at least two modules, one representing urban areas in a state and the other representing a state's rural areas. Additional modules could be used for further disaggregation. Medical manpower would flow between the modules as well as between each module and areas outside the state. Figure 1 indicates how the modules relate to each other in representing a given state. Figure 2 provides an aggregate overview of the module's basic structure as it applies to both urban and rural areas. The remaining diagrams begin in Figure 3, by focusing on the factors affecting the numbers of physicians (disaggregated into four specialty clusters) that locate in each area of the state. The next two diagrams (Figures 4 and 5) contain sets of causal relationships (called positive feedback loops) that cause concentrations of physicians to develop and be perpetuated in certain areas. Figures 6 and 7 display sets of relationships that would work against further concentration of physicians in a given area (negative feedback loops). Figure 8 combines feedback relationships from several of the earlier diagrams to provide a more detailed overview of the complete set of factors affecting each specialty cluster in a given area within a state.

Though many of the model's relationships are shown in separate diagrams for ease of presentation, all of them relate to a single specialty cluster and are interdependent. The presence of certain factors on more than one diagram indicates some of these interdependencies as does Figure 8. Because the relationships shown in Figures 3-8 relate only to a single specialty cluster within a given area of a state, the complete model for

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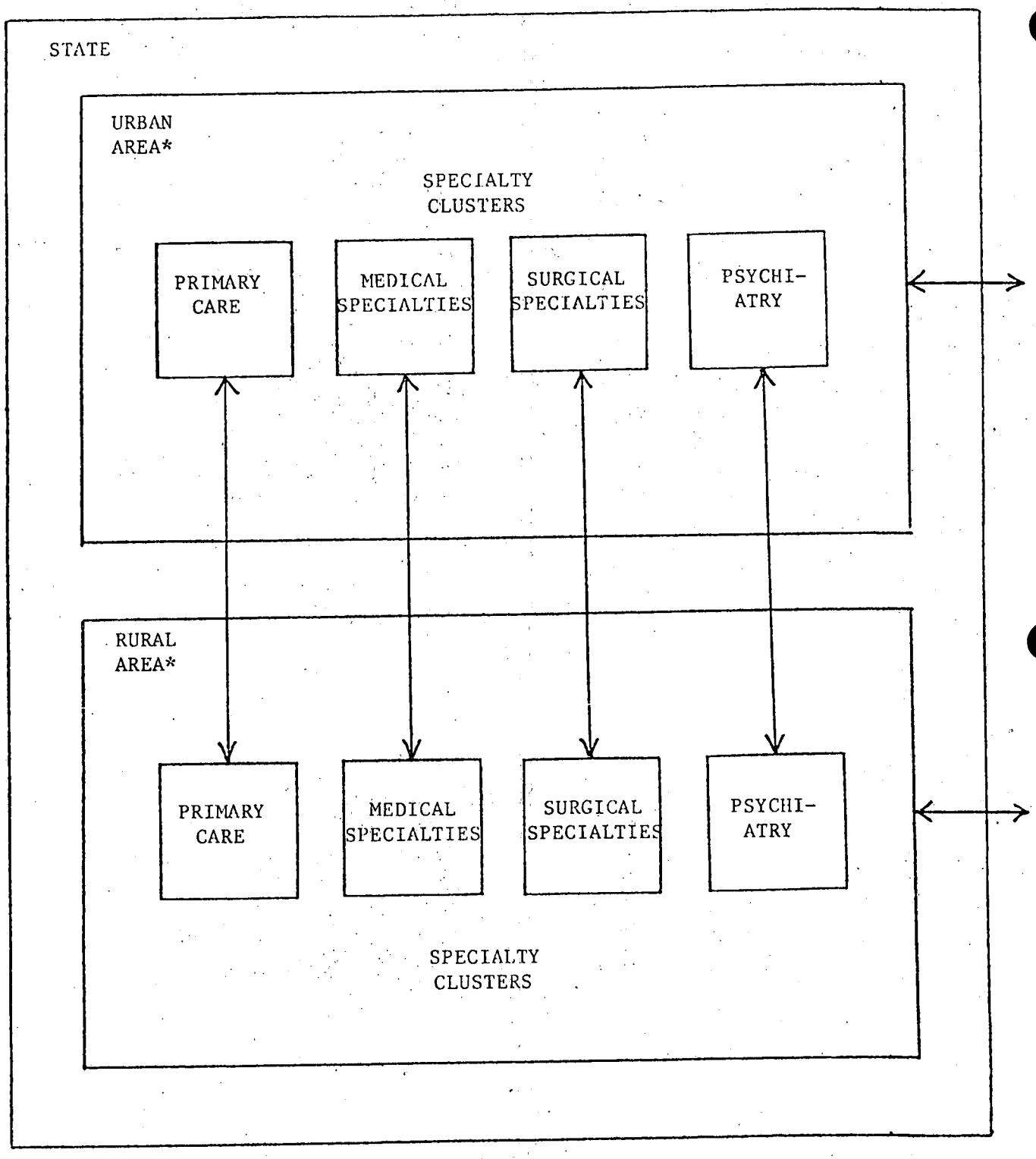
simulating the dynamics of physician manpower within a state would be created by replicating the relationships shown in Figures 3-8 four times to represent the specialty clusters within each area and then replicating that full set (at least) twice to represent the two (or more) areas within a state. Figure 1 provides an overview of the complete model's structure.



*or some other set of geographical categories

Figure 1: Overview of the Geographic/Specialty Cluster Structure of the State-Level Physician Manpower Model

The state level model is composed of at least an Urban Area Module and a Rural Area Module which provide the basis for further disaggregation to multiple urban and rural areas within the state. Modules are interconnected to form a model for a given state as shown in the previous figure. Figure 2 provides an overview of the module's principal components.

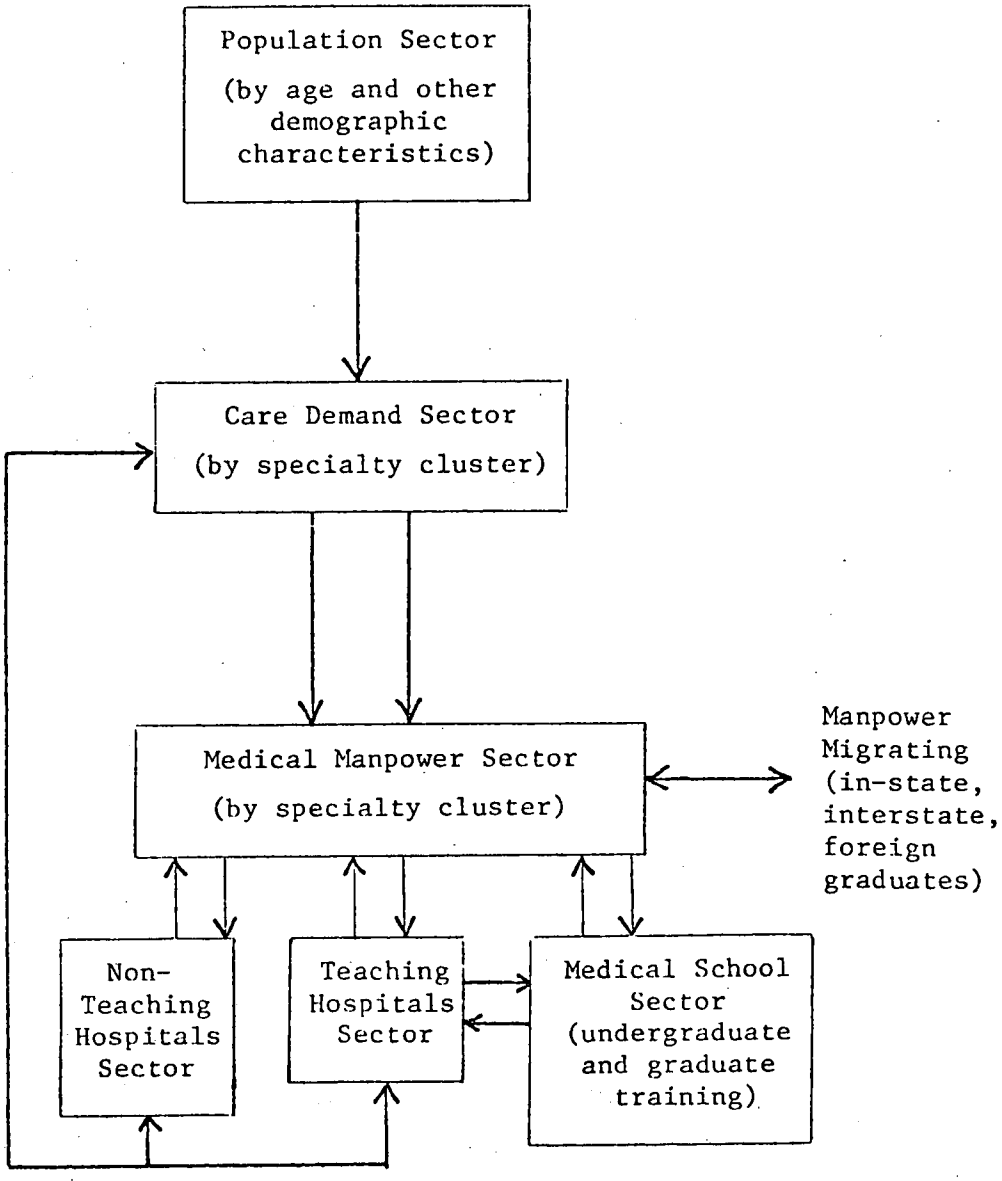


Figure 2: Overview of the Module Representing an Area Within a State

The following set of diagrams is intended to illustrate the detailed model structure that needs to be developed for each physician cluster.

The factors shown in Figure 3 are those principally identified in the literature as determinants of physician location.

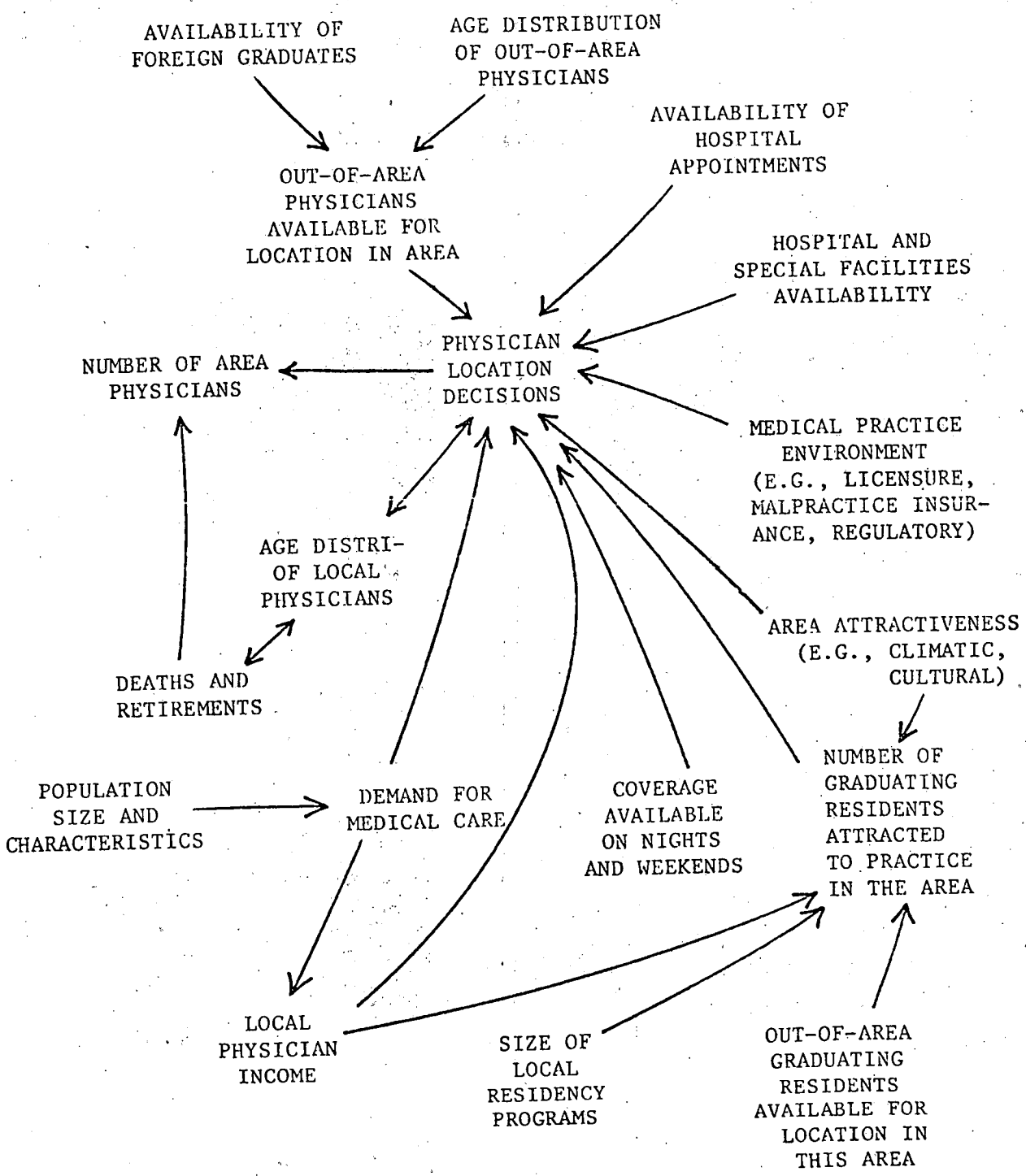


Figure 3: Primary Determinants of Physician Location Decisions

The number of physicians deciding to locate in an area, as shown in Figure 3, is dependent on the number of physicians that may potentially locate there and the area's attractiveness to physicians. Physicians potentially locating in an area include physicians practicing in another area within the state or outside the state, residents who have just completed their training in programs outside the area, and residents completing their training in a local program. The rate at which physicians move out of the area is governed by the age distribution of area physicians as it affects deaths and retirements and by various aspects of the area's attractiveness.

Attractiveness of the area is a composite of many factors such as those shown in Figure 3. Some of the factors are of special concern to physicians such as the availability of hospital appointments, availability of night and weekend coverage by other physicians and/or residents, perceived potential income, and characteristics of the "medical environment" such as regulatory mechanisms within the state and the level of malpractice insurance premiums. Overall area attractiveness determined by the availability of cultural activities, good schools, and desirable climate and geography, and other area attributes will also have an important impact on physician location decisions.

The following several diagrams illustrate sets of causal relationships that may cause physicians to concentrate in a given area or that may prevent further concentration from occurring.

Certain sets of factors promote increased concentrations of physicians in an area. A number of these factors are shown in Figure 4.

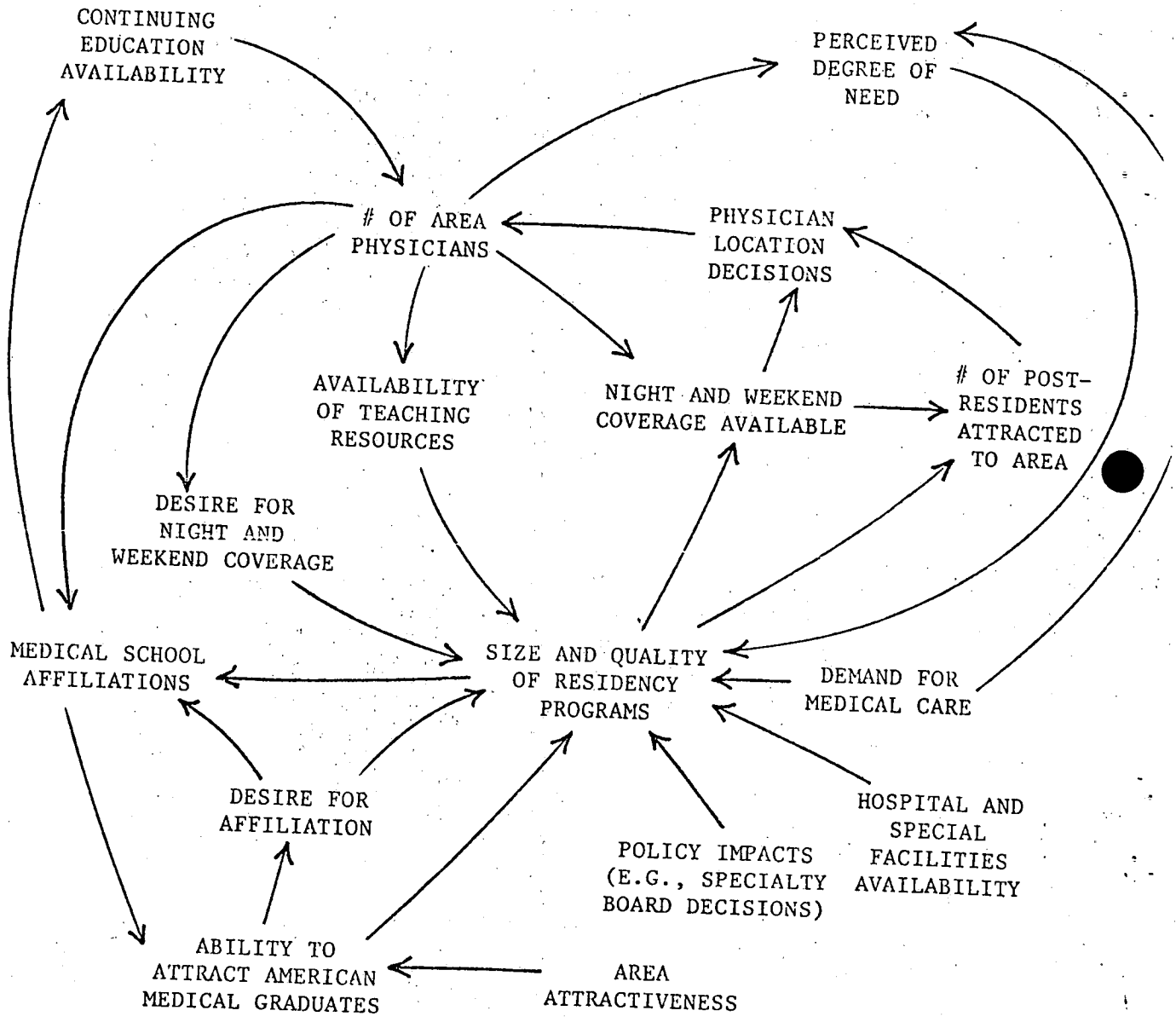


Figure 4: Interrelationships between Physician Location Decisions and Residency Programs

Concentrations of physicians in an area generally lead to the establishment of residency programs and expansion of existing ones because of the need by physicians for better coverage and their availability as a teaching resource. Concentrations of physicians also permit levels of after-hours coverage that make an area more attractive. Growth in residency programs (whose residents are likely to locate in the area) and increased coverage by both residents and physicians lead to increased concentration of physicians in an area.

As residency programs grow, a concern about their quality and ability to attract American graduates often develops. This usually leads to the development of affiliations with medical schools as a means of increasing quality and attractiveness. A by-product of these affiliations is often the increased availability and quality of continuing education programs and other educational opportunities that also improve the area's attractiveness to physicians.

There is, of course, a limit to the extent to which concentrations of physicians can build up as a result of local residency programs. A perception by local physicians that an area is "saturated" relative to the demand for care is likely to result in the curtailment of local residency programs that would otherwise cause additional physicians (the graduating residents) to settle in the area. This would be especially likely if the concentration of physicians is sufficient to provide adequate after-hours coverage without relying on residents. Specialty board decisions made on a national level may also cause a curtailment of local residency programs in specialties that are perceived to have an "oversupply."

As the number of physicians in an area increase and, as the proportion of those physicians who are specialists grows, care patterns (e.g., fractions of cases referred, fractions of cases hospitalized) can be redefined to increase the volume of care demanded by the population and allow physicians to continue concentrating in an area without saturating. An increased supply of medical care, by itself, is also likely to lead to greater demand (up to a point, of course). Development of hospitals and special facilities will result from a concentration of physicians and help to produce increased concentration as more physicians are attracted.

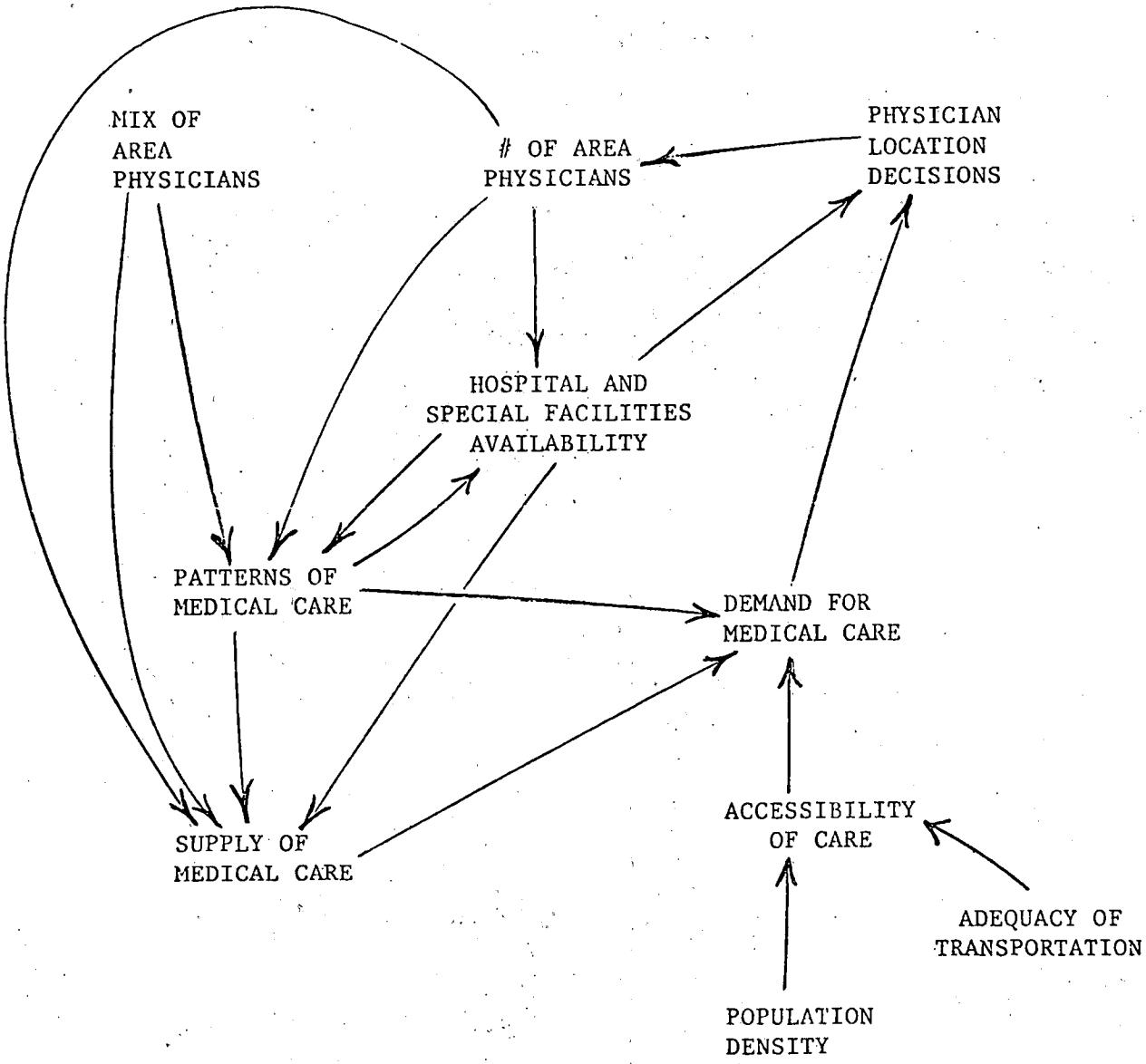


Figure 5: Patterns of Care Influences

As hospitals in an area acquire specialized facilities and expand their residency programs in response to the needs of physicians concentrated in the area, hospital costs increase. Blue Cross and other third-party payers are likely to resist cost increases beyond a certain point and, thereby, constrain further growth in special facilities and residency programs or even cause reductions in both. Limitations and reductions in levels of specialized facilities and residency training will then constrain the further concentration of physicians in the area by reducing its attractiveness to physicians.

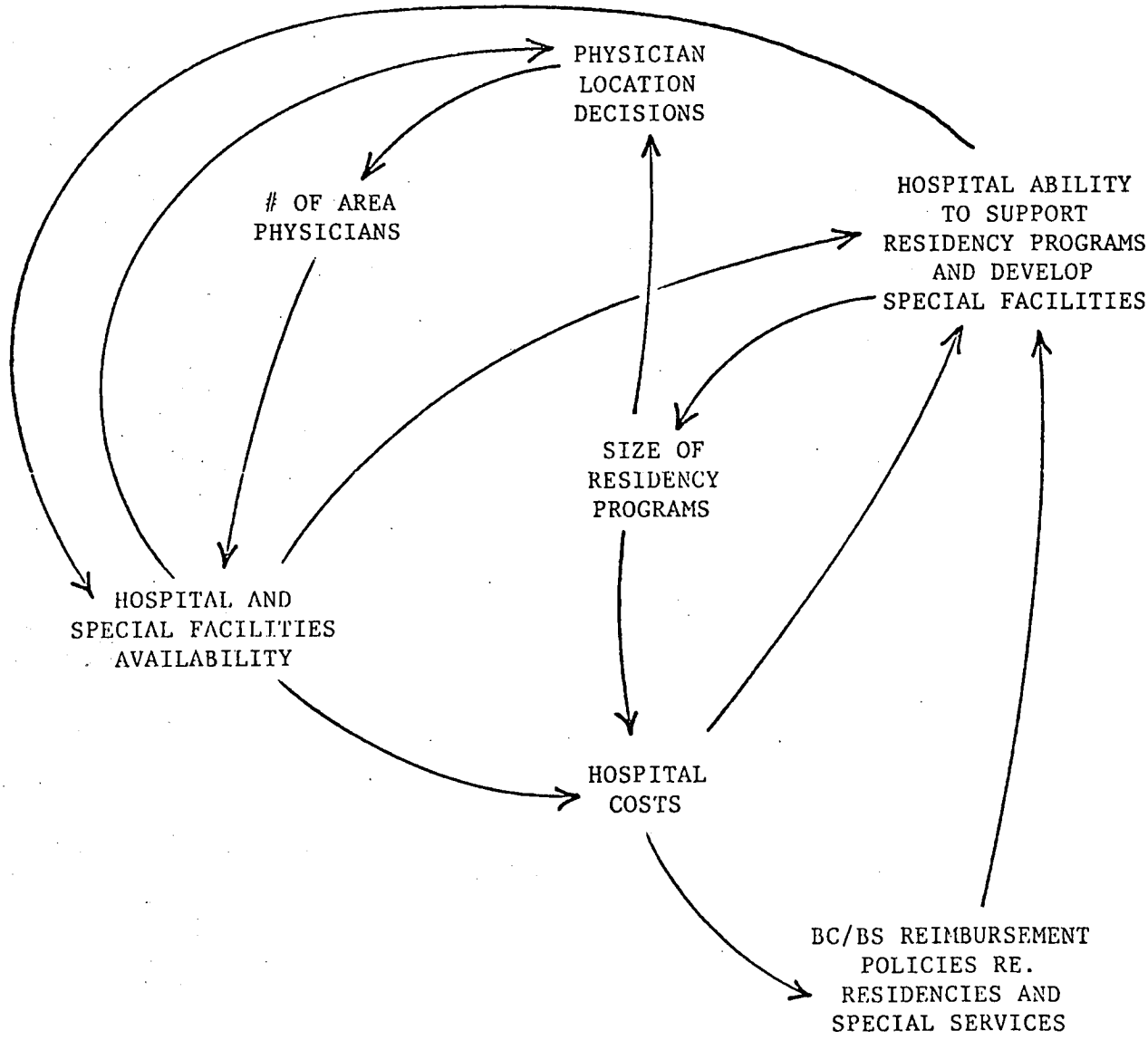


Figure 6: Cost Limitations on Size of Residency Programs and Special Facilities

As more physicians concentrate in an area, the additional supply of medical care creates additional demand and physician incomes may grow even as the number of physicians increases. While their incomes are increasing, an area's physicians are likely to be encouraging the establishment of additional residencies (or at least accepting the existing number as necessary) because of the coverage of hospitalized patients provided by residents. They may also be amenable to the receipt of admitting privileges at local hospitals by new physicians moving into the area to practice. Creation of additional residencies in the area and the continued availability of hospital privileges will cause more physicians to locate in the area. At some point however, if concentrations of physicians in an area exceed the potential demand, physician incomes will reach a plateau. To prevent their incomes from actually falling, the area's physicians will seek to curtail growth in or reduce the size of the area's residency programs and prevent additional physicians from receiving hospital privileges. By that point, graduating residents and practicing physicians are likely to view the area as unattractive anyway because the existing concentration of physicians implies a less-than-adequate income for new ones locating there.

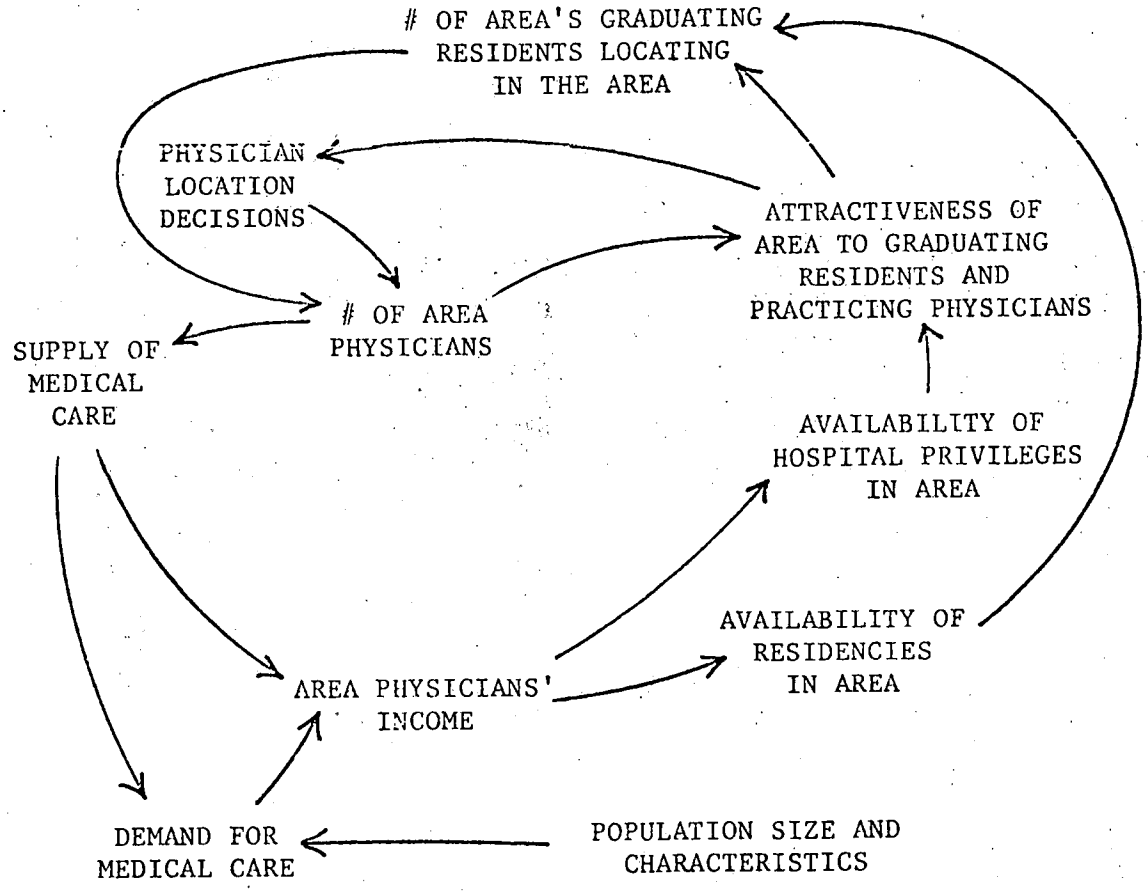


Figure 7: Effects of Area Physician Income on Physician Location Decisions

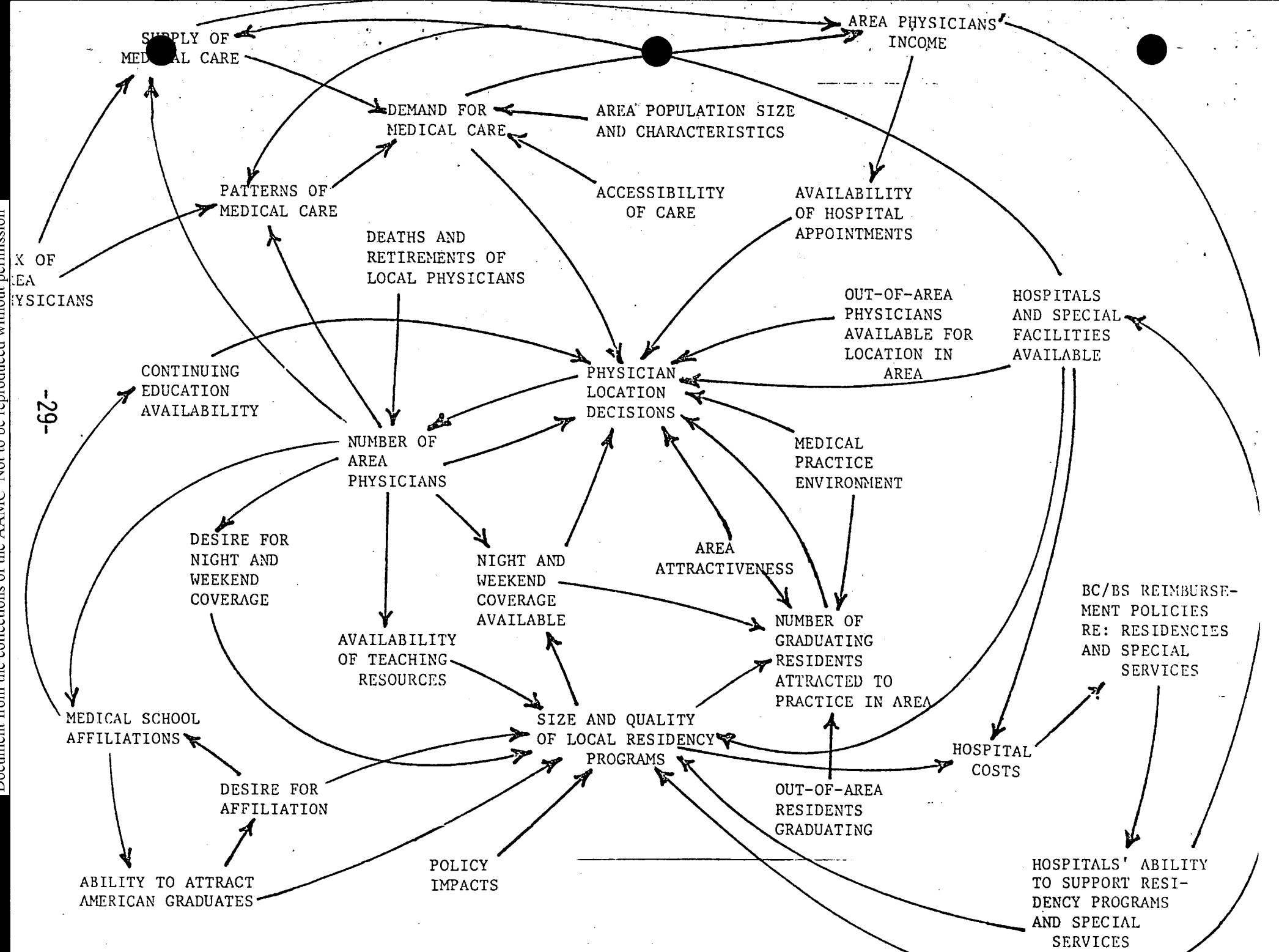


FIGURE 8: Overview of Causal Relationships Affecting

A state-level medical manpower model would involve at least two modules made up of the relationships in Figures 3-8 combined and replicated four times to represent the four specialty clusters. Once the model's relationships were quantified and represented in a computer simulation language, the model could be used to simulate the effects on a state's medical manpower levels and medical care of a variety of different policies and programs. The causal diagrams themselves would also serve as a useful basis for discussions about policies affecting the distribution of medical manpower.

The state-level model would be designed to be as flexible as possible. Each state would be represented by inserting a set of numbers (e.g., physicians in each specialty cluster, residencies in each specialty cluster, measures of attractiveness along different dimensions) characteristic of each area within that state into the model. As indicated earlier, some states could be represented as segmented into two areas while others might require additional segmentation. Once a state was adequately represented, simulations with the model would indicate the impacts of various policies and programs on that particular state. This would make the model a useful tool for state-level policymakers (as well as those concerned with sub-state areas such as the staffs of Health Systems Agencies) and for national policymakers concerned with the impact of national manpower, health insurance, and other programs on different types of states.

OSR EXECUTIVE COUNCIL REPRESENTATION

At its June meeting, the Council of Deans Administrative Board discussed the OSR's request that the number of OSR voting seats on the Executive Council be increased from one to two. During that discussion, Richard Seigle and Tom Rado pointed out that the OSR's preference would be to grant ex officio voting status on the Executive Council to the OSR Immediate-Past-Chairperson. The COD board considered this proposal at length and reached the consensus that it would be neither appropriate nor desirable to have an individual who would in many cases be a house officer represent undergraduate medical students on the Executive Council. On the following pages appear a letter from Dr. Gronvall summarizing the outcome of the COD board's deliberations on this issue and a letter from AAMC's legal counsel describing the legal implications of OSR's preferred alternative. At its June 25 meeting, the Executive Council approved the addition of the OSR Chairperson-Elect as an ex officio voting member and requested that staff draft the necessary AAMC Bylaws and OSR Rules and Regulations amendments.

The following pages in this section include:

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 Chairman-Elect 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.

Title VI. Section 2

The Executive Council shall consist of fifteen members elected by the Assembly and ex officio, the Chairman, Chairman-Elect, President, the Chairman of each of the three councils created by these Bylaws, and the Chairman and Chairman-Elect of the Organization of Student Representatives, all of whom shall be voting members. Of the fifteen members of the Executive Council

elected by the Assembly, three shall be members of the Council of Academic Societies, three shall be members of the Council of Teachings Hospitals; eight shall be members of the Council of Deans, and one shall be a Distinguished Service Member. The elected members of the Executive Council shall be elected by the Assembly at its annual meeting, each to serve for three years or until the election and installation of his successor. Each shall be eligible for reelection for one additional consecutive term of three years. Each shall be elected by majority vote and may be removed by a vote of two-thirds of the members of the Assembly present and voting.

PROPOSED AMENDMENTS TO OSR RULES & REGULATIONS

Section 4. A.2.

The Chairperson-Elect, whose duties it shall be to preside or otherwise serve in the absence of the Chairperson.

Section 4. B.

Officers other than the Chairperson shall be elected at each annual meeting of the Organization and shall assume office at the conclusion of the annual meeting of the Association. The Chairperson shall assume office as provided in Section 6. Regional Chairpersons shall be elected by regional caucus. The term of office of all officers shall be one year. Each officer must be a member of the Organization of Student Representatives throughout his/her entire term of office, and no two officers may be representatives of the same institutional member. Any officer who ceases to be a member of the Organization must resign from the Administrative Board at that time. Vacant positions on the Administrative Board shall remain unfilled until the annual meeting, except as provided for in Section 6.

3)

Section 4. D.

Presence at the Annual Meeting shall be a requisite for eligibility for election to office. At the time of election, each candidate for office must be a member of the Organization of Student Representatives or must have been designated to become a member of the OSR at the conclusion of the annual meeting. In addition, each officer must be an undergraduate medical student at the time of assuming office. If it becomes necessary to elect a Chairperson, candidates for the office of Chairperson shall in addition have attended a previous meeting of the Organization, except in the event that no one satisfying this condition seeks the office of Chairperson, in which case this additional criterion shall be waived.

Section 4. F.

There shall be an Administrative Board composed of the Chairperson, the Chairperson-Elect, the Regional Chairpersons, the Representatives-at-Large, and as a non-voting member the immediate past Chairperson of the Organization.

Section 5. 2)

The Chairperson-Elect of the Organization of Student Representatives;

Section 6.

A. The Chairperson-Elect shall assume the office of Chairperson at the conclusion of the annual meeting of the Association, dependent upon receipt of a vote of confidence from the Administrative Board prior to the annual business meeting of the OSR. If the Chairperson-Elect fails to receive this vote of confidence or otherwise resigns from office, the next Chairperson shall be elected in accordance with the procedures established in Section 4. A Chairperson-Elect who does not succeed to office as provided by this section may not subsequently become a candidate for the office of Chairperson.

4)

B. If the Chairperson of the Organization is for any reason unable to complete the term of office, the Chairperson-Elect shall assume the position of Chairperson for the remainder of the term. Further succession to the office of Chairperson, if necessary, shall be determined by a vote of the remaining members of the Administrative Board.

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

July 19, 1976

Richard S. Seigle
Chairperson
Organization of Student Representatives
969½ Farnum
Los Angeles, California 90024

Dear Rich:

I am writing in follow-up to our conversations on June 24 regarding the actions of the Council of Deans Administrative Board in response to the OSR recommendation on the proposals for providing a second OSR vote on the Executive Council. While you were present at those discussions and thus can provide a full report on the deliberations to the OSR, we agreed that it would be useful for me to report on the matter in writing from my perspective.

When you and the OSR Vice Chairperson, Dr. Tom Rado, appeared before the COD Administrative Board and presented the OSR position, you made it very clear that the strong preference of OSR would be to exchange the non-voting ex officio seat of the Vice Chairperson for a voting ex officio seat for the immediate-past-chairperson. You reported that when the OSR Board was informed of potential legal and policy problems related to that option, it discussed the possibility of stipulating that the chairperson, when elected, have at least two years remaining as an undergraduate medical student. You indicated that the OSR rejected that stipulation since the educational demands on third-year students appear to be so great as to make the position unattractive and unlikely to be filled as responsibly as desired. You also reported to the COD that the OSR recommended an alternative which it considered far less desirable than the immediate-past-chairperson option. The

alternative would provide for the second OSR vote on the Executive Council to be held by a chairperson-elect who would in the subsequent year assume the office of chairperson unless recalled by a vote of the OSR Board or membership for inadequate performance during his/her first year.

The Council of Deans Administrative Board considered your preferred option first and in some detail. You and Tom pointed out that your knowledge of unsatisfactory experiences of student organizations with the chairperson-elect structure was the primary reason for selecting the immediate-past-chairperson option. The tax status considerations appeared to the OSR Board to be technicalities which could be overcome if approached creatively. The COD Board considered the mechanisms by which a student who had graduated could be designated an OSR representative. These mechanisms included: 1) appointment for two years by the M.D. granting school initially designating the student; 2) appointment by that school of the person as its representative in the second year even though the student is no longer in residence; 3) appointment by the medical school affiliated with the house officer program that the student is currently enrolled in; and 4) appointment, by the hospital in which the student is a house officer, as a COTH representative.

The reaction of the COD Board to these proposals was that they appeared to be contrived, difficult in their administration, and inconsistent with the objectives of the AAMC Bylaws specifying the various classes of membership. The OSR representative is required to be elected from the student body of an institutional member and serves as a second institutional representative to the AAMC. If a student were no longer a part of the undergraduate student body, this fundamental concept would be violated.

The COD Administrative Board in its discussion further pointed out that house officers and students frequently have conflicting points of view and that it would in many cases be inappropriate to have a house officer as a spokesman for medical students. In any event, it seemed unwise for the AAMC to establish a house officer as a voting institutional representative to the Association by such an indirect means. The COD Administrative Board then voted to defeat a motion in support of the OSR proposal.

After additional discussion, which focused primarily on the desirability of including a specific recall provision in any scheme involving the establishment of a chairperson-elect position, the Council of Deans endorsed the OSR alternative proposal. This alternative proposal was subsequently adopted by the Executive Council.

I understand that you continue to have some skepticism regarding the validity of the tax consequences problem identified by the staff regarding the first alternative. Although it is not my perception that the COD Board rejected your preferred option on those grounds, I have asked that Dr. Cooper seek a written opinion of the AAMC counsel regarding this matter and the approaches you have suggested. He has assured me that he will do so.

I hope this adequately sets out the issues and the stance of the Council of Deans. I trust that the matter is well on the way toward resolution and that staff will present the necessary bylaw amendments to consider in September.

Sincerely,

John A. Gronvall, M.D.
Chairman
Council of Deans

/jsp

cc: Robert J. Boerner
John A. D. Cooper, M.D.
Joseph A. Keyes

June 30, 1976

Joe L. Oppenheimer
Williams, Myers and Quiggle
888 17th Street, N.W.
Suite 900
Washington, D. C. 20006

Dear Joe:

The Administrative Board of our Organization of Student Representatives last week considered several means of attaining a second vote on the AAMC Executive Council. The mechanism favored by the OSR would be to modify the AAMC Bylaws to allow both the chairman and immediate past chairman of the OSR to sit on the Executive Council ex officio with vote. (Currently, only the OSR chairman has that status.)

In most years the OSR chairman will be a 4th-year medical student, graduating halfway through the November to November term of office. As you may remember, last year we modified the OSR rules and regulations to allow a medical school to designate its representative "from the student body of each..." so that elected officers of the OSR could be designated as institutional representatives beyond graduation until the completion of their term of office the following fall. Providing a vote on the Executive Council to the immediate past chairman would mean that this individual might retain voting status one and one-half years beyond graduation from medical school.

This raises several questions in our minds as to the consistency of this arrangement with applicable provisions of the tax code and with the Association's articles of incorporation. The OSR exists as part of the AAMC "Institutional Membership," which is defined as medical schools and colleges of the United States. Can the immediate past chairman vote on the Executive Council as an OSR representative:

a) when he/she is no longer the institutional representative to the OSR?

b) when he/she is no longer a medical student, even though the institution which he/she represented might be willing to continue his/her designation as one of the two representatives to the OSR?

The OSR has suggested several ways by which the past chairman might be designated as an institutional representative. One method would be to have his/her school appoint that person to the OSR for two years, beginning in November of the senior year. Another method would be for the medical school affiliated with the residency program in which the past chairman enrolls after graduation to designate that person as an OSR representative. In either case, the school would be permitted to designate another representative who would be an undergraduate medical student and not an intern or resident, but this second representative would not have the privilege to vote in any meeting at which the past chairman voted. And in either case, the OSR, which was established to represent medical students in the AAMC, would be represented on the Executive Council by an individual who is not a medical student in the general sense of what the OSR was established to represent in 1971. (The Association views interns and residents as graduate medical students while the OSR was created to represent undergraduate medical students.)

I would appreciate your general impressions, considered legal opinion, and any other advice which you would like to offer. If I can explain or clarify any of this, please let me know. For your background information, I am enclosing copies of the current AAMC Bylaws and OSR Rules and Regulations.

Sincerely,

Bart Waldman
Special Assistant to the
President

Enclosures

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ROBERT H. MYERS, JR.
THOMAS ARDEN ROHA
DONALD LEWIS WRIGHT

WILLIAM M. WILLIAMS
(1921-1932)
EDMUND B. QUIGGLE
(1921-1935)
PAUL FORREST MYERS
(1921-1965)

July 28, 1976

Mr. Bart Waldman
Special Assistant to the President
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Re: Organization of Student Representatives

Dear Bart:

I refer to your recent correspondence addressed to me and our conversations regarding the proposal that the immediate past chairman of the Organization of Student Representatives become a member of AAMC's Executive Council ex officio with vote. Such a change in the structure of AAMC would of course require amendment to its by-laws which presently limit the Executive Council to fifteen members elected by the Assembly and certain officers of the Association including the Chairman of the OSR (Article VI, Section 2 of the by-laws). As a matter of procedure, an amendment to affect this change could be adopted as long as the requirements of Article VIII, Section 8 of the by-laws are met.

I understand, however, that in most situations, the chairman of the OSR is a fourth year medical student who, in the normal course of events, graduates before completion of his term as an officer of OSR. I recall that the Association's by-laws and OSR's Rules and Regulations were amended last year to permit the OSR chairman to complete his term of office, even though doing so would confer upon him the authority and responsibilities of the position during the period subsequent to his graduation, after which he would no longer be an undergraduate medical school student. If the same individual as Past Chairman were to continue to participate in the affairs of the Association as a voting member of its Executive Council for an additional twelve month period, he would in fact continue to serve as a representative of undergraduate students for as long as 18 months subsequent to his graduation. For the reasons set forth below, I do not believe that such an arrangement is in the best interest of the Association or OSR.

First, I believe it is most important to recognize that the OSR was created and is intended to function as a means of participation in AAMC policy and activities by the undergraduate medical school student community. It is inconsistent with this purpose to permit an individual who is not a member of that community to continue to represent it for a substantial period of time in the important role of a voting member of the Executive Council. I would expect that medical school students and the members of OSR themselves would justly criticize such representation by an individual not chosen from the constituency being represented. Further, I think that this possible situation is significantly different from that presently existing, namely where the chairman of OSR may complete his term of office and continue to serve as a voting member of the Executive Council, even though he may graduate from medical school during that period. Completion of a role once begun is, in my opinion, not comparable to assumption of further authority and different responsibilities by virtue of occupying a different office (past chairman) not held until subsequent to graduation.

Moreover, I do not believe it would be a satisfactory solution to these objections to have the institution at which the past chairman may become affiliated as a resident to designate him or her as one of its representatives to the OSR. This would reverse the procedure inherent in any representative organization which is, specifically, that the constituents determine collectively through whatever procedures they may choose who shall represent them. To require that an individual first named by another institution must necessarily become the representative of an organization with which he becomes associated in a different capacity at a later time is contrary to the basic concept of representation inherent in OSR and AAMC. Furthermore, as noted above, such an individual would not be a member of the undergraduate medical school student body he is purportedly representing.

Finally, as you know, this matter presents a question concerning the tax-exempt status of the Association under the Internal Revenue Code. AAMC is a charitable and educational organization exempt from payment of federal income tax under Internal Revenue Code Section 501(c)(3). A requirement of that section is that such an organization not be organized or operated for the benefit of any "private individual". It is arguable that including among voting members of the Association's governing board individuals who do not represent in a bonafide capacity any part of the community involved in medical education is inconsistent with this restriction in that such an individual would be participating for his personal gain or "private benefit" and that of other individuals - not institutions. I believe the Association is best advised not to adopt a procedure or policy which could generate such issues with the Internal Revenue Service. (As you know, all amendments to the Association's by-laws must be submitted to the Service as a matter of routine.)

41a

I hope the foregoing is fully responsive to your questions. I shall, of course, be pleased to discuss this matter with you or others if it will be helpful to do so.

With best regards, I am,

Sincerely,

41 fr.

MEDICAL SCHOOL ADMISSIONS -- A PROPOSED POLICY STATEMENT

Within the past year, press reports have alleged that the admissions process at a number of the Association's member institutions is vulnerable to financial and political pressures. Substantial financial contributions were a hidden prerequisite for admissions at one institution. The continuing favor of appropriations committee chairmen and institutional benefactors appear to be operative considerations in admissions decisions at other institutions. The public perception that political influence is effective in gaining admission has made credible charges of extortion that appear in the attached clipping.

It is not unreasonable to suggest that these revelations contribute to public cynicism, undermine public esteem for the medical profession, and weaken public support for medical education.

Would it strengthen the hand of member institutions to resist such pressures, if the Association were to adopt a strong policy statement opposing these practices and specifying them as grounds for expulsion from membership along the following lines?

> "Applicants selected for medical school should be those whose personal merit and academic achievement pull them to the top in fair competition, according to publically stated, published criteria. The use of any unpublished fiscal or political consideration in the final selection of students is grounds for expulsion from membership in the AAMC."

'Dan Flood's Man'

Political Pull Puts Him in Med School

The Philadelphia Sunday Bulletin July 25, 1976

By JEFF NESMITH
Of The Bulletin Staff

Dan Flood's man is now a physician.

He is in the middle of a year of internship at a Philadelphia hospital.

But four years ago he was just one of 36,135 students who were clamoring for admission to medical schools in the United States. Throughout the country, only 13,726 places were available. Each student's chances were little better than one in three.

Among the several schools to which he applied was Hahnemann Medical College, 235 N. Broad st., Philadelphia. His chances of getting in were not good, according to a memorandum written in January 1972 by an assistant dean at Hahnemann.

But he was accepted by the medical school anyhow. As the president of the school put it, "This is Dan Flood's man."

Dan Flood is U. S. Rep. Daniel J. Flood, who represents east-central Pennsylvania's 11th Congressional district.

The young doctor said last week he did not know how he came to be "Dan Flood's man" or what role the congressman played in his being admitted to Hahnemann four years ago.

He said college officials told him they didn't know either. And his parents refused to talk to him about the matter.

Flood's man grew up in Pittsburgh, where his father is an optometrist. His home is 200 miles from Flood's district and, he said, he has never been a constituent of the Democratic congressman.

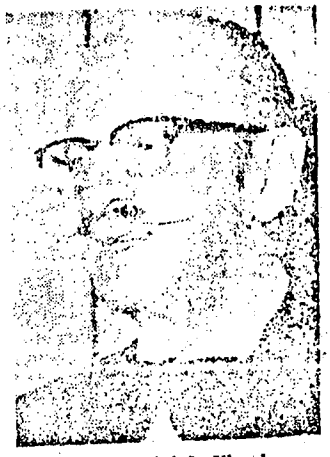
"I don't know what it's all about," he said. "I just applied to medical school and was accepted."

When the student's application was pending, Robert J. Boerner, an assistant dean at Hahnemann, wrote to college president Wharton Shober:

"I have again reviewed the application. . .and I feel that while he probably has the ability to complete our program, it is doubtful that he will ultimately be accepted."

Boerner pointed out that the student's scores on the Medical College Admissions Test, a national test given to prospective medical students, were low. Considering this and "the 40 percent increase in our application vol-

Please Turn to Page 4



Rep. Daniel J. Flood
...letter of recommendation

AAMC DATA DEVELOPMENT ACTIVITIES

At its September 1975 meeting, the Administrative Board reviewed the recommendations of the Association's Data Development Liaison Committee (DDLC) regarding the classification of a large number of data items maintained by the AAMC on its member institutions. While in most instances the Board agreed with the Committee's recommendations, it disagreed on several categories of information. The DDLC will have met twice in the intervening period to consider the classification of new data items and to consider the Administrative Board's disagreement with its previous recommendation. Dr. Richard Janeway, Chairman of the DDLC, has agreed to meet with the Board in order to describe the activities of his committee and to discuss its recommendations with the Board.

At the conclusion of the Board's discussions of this subject last year, the Board expressed an interest in being briefed on the internal procedures used by the staff to respond to requests for information from various sources. Dr. Paul Jolly, Director of the Division of Operational Studies has subsequently formalized the procedures and has prepared a presentation of them for the Board. His presentation will describe the operational implications of the application of the Data Release Policy and the assignment of a release category ("unrestricted", "restricted", and "confidential") to the items of information.

As background for these presentations, three documents are included in this section of the agenda book: Scope of AAMC Data Activities; Role of the Data Development Liaison Committee; AAMC Data Release Policy.

SCOPE OF AAMC DATA ACTIVITIES

Data on Students

Sources

- MCAT questionnaire and scores
- AMCAS application
- Admission actions and Matriculation Blanks
- Change of Status Form
- Graduation Report
- COTRANS Application

Nature of Information

- Biographical data
- College record and MCAT scores
- Application, acceptance and matriculation
- Graduation or withdrawal

Systems

- MCAT files for each test administration
- AMCAS record system for each entering year
- Student Record System
- Graduate Record System

Reports and Analyses

- MCAT score reports
- Applicant Lists and Acceptance Lists, Labels and Cards
- Summaries of Application Activity
- COTRANS eligibility summary
- Class Rosters
- Annual Applicant Study
- Study of Enrolled Students
- Study of Minority Applicants
- Study of Career Choice
- Study of How Medical Students Finance Their Education

Data on Individual Faculty

Sources

Faculty Roster New Accession Form
Faculty Roster Update Form

Nature of Information

Biographical Data
Educational History
Employment History
Nature of Employment
Major Areas/Responsibility
Predoctoral and Postdoctoral
Current Participation on Federal Programs

System

Faculty Roster System

Reports and Analyses

Annual Report on Medical School Faculty
Rosters by department for each school
Statistical Summaries for each school
A Preliminary Analyses of Differential Characteristics Between High and Low Mobile Medical School Faculty
Postdoctorals vs. non-Postdoctorals: Career Performance Differentials within Academic Medicine
Institutional Variables Related to High Faculty Attrition
Mobility Characteristics of U.S. Medical School Faculty
Participation of Women and Minorities on U.S. Medical School Faculties

Data on Medical Schools

Sources

- Annual (LCME) Medical School Questionnaire, Part I
- Annual (LCME) Medical School Questionnaire, Part II
- Fall Enrollment Survey
- Primary Care Programs Survey
- Directory of American Medical Education Questionnaire
- Curriculum Directory Questionnaire
- Medical School Admissions Requirements Questionnaire
- Annual Faculty Salary Survey

Nature of Information

- Revenues and Expenditures
- Enrollments
- Curriculum
- Administrative Officers
- Statistics on Minorities and Women
- Facilities
- Financial Aid Data
- Primary Care Programs

Systems

- Institutional Profile System

Reports and Analyses

- Directory of American Medical Education
- Curriculum Directory
- Medical School Admission Requirements
- Annual Report on Medical School Faculty Salaries
- Annual Report on Medical School Financing
- Variables Related to Increases in Medical School Class Size
- Classification of Medical Education Institutions
- Medical Education Interrelationships between Component Variables
- Annual Description Report on U.S. Medical Schools

Data on Teaching Hospitals

Sources

Survey of House Staff Policy
Survey of University Owned and/or Operated Teaching Hospitals
Income and Expense Data Extracted from the files of the American Hospital Association

Nature of Information

Stipends and Fringe Benefits of Residents
Income and Expenditures

Systems

American Hospital Association file
House Staff Policy File

Reports and Analyses

COTH Survey/House Staff Policy
COTH Directory
Datagrams and Journal Articles

Data on Compensation

Sources

Deans Compensation Survey/Compensation for Administrative Positions in Medical Schools
Executive (Hospital Administrators) Salary Survey
Faculty Salary Survey

Nature of Information

Salaries, fringe benefits, and perquisites of deans
Titles and reporting lines of deans
Previous experience of deans
Salaries, titles and academic rank of medical school administrative staff
Activities of medical school administrative staff
Salaries and benefits of hospital administrators
Salaries of medical school faculty

Systems

Institutional Profile System
Hospital Administrators salary file
Salary Survey System

Reports and Analyses

Annual Deans' Compensation Report
Annual Executive (Hospital Administrators) Salary Report
Study of Organization of the Dean's Staff
Medical School Administrative Salary Survey
Annual Report on Medical School Faculty Salaries

Role of the Data Development Liaison Committee

The function of the Data Development Liaison Committee will be to provide guidance to the Association in its continuing substantive role as the principal repository for data on American Medical Education. These data are collected, organized and stored, analyzed and reported by the staff of the Association on behalf of its member institutions. This effort provides information for planning, for comparative and self study, and for the development of local, regional and national policy.

It is important that this effort be responsive to the needs of the constituency, not only because it is conducted for their benefit and in their name, but also because substantial burdens are imposed on the staff of the institutions by the data collection itself. This effort should not be more burdensome than necessary, and it should be designed where possible to be useful in itself to the institutions. The Committee is asked to help us achieve these ends.

The Association is now embarking on a major program of data development, with the aim of integrating and rationalizing its currently distinct data collection activities, and with the aim also of providing more analysis of the data base already extant. This new effort has received a major impetus from the contract concluded last October with the Bureau of Health Manpower Education, which consolidated in one contract support for data collection activities previously received from the Bureau, and also provided additional

funds for the Association's analytical studies which are of interest to the Bureau. The contract includes a statement that the AAMC is not required to provide information on individual institutions, where confidentiality has been pledged.

In the light of substantial and generally increasing governmental support for medical education and its institutions, there is pressure for greater public accountability, and many of the senior officials of our institutions see it as a legitimate and inevitable development. This committee is asked to advise the Association on just what data ought to be made public, and on what restrictions should be placed on data that should not be made public.

From time to time there are pressures on the Association from without or initiatives from within for the collection of additional elements of data. Some of these are very sensible and even necessary, and some are not worth the burden of collection. This kind of judgment is a difficult one to make, and the Committee will be asked to advise here as well.

The development of comparative data on institutions requires an agreement on terminations and terminology, and this committee is also asked to identify and propose resolutions for problems of ambiguity and ill definition.

Finally, the staff of the Association would appreciate advice regarding their analytical effort. What information can be and needs to be developed from the data, and what priorities should be placed on these analyses?

POLICY FOR RELEASE OF AAMC INFORMATION

It is the responsibility of the AAMC to make information on American medical education available to the public to the greatest extent possible, subject to limitations imposed by the sources of the data collected and by law.

Data collected by the Association will be owned and maintained by the Association for the benefit of medical education.

Data in the possession of the Association will be classified according to permitted access using the following categories:

I. Unrestricted - may be made available to the general public.

II. Restricted - Association confidential -- may be made available to member institutions and other qualified institutions, organizations and individuals subject to the discretion of the President.

III. Confidential - A) Institutional - Sensitive data collected concerning individual institutions generally available only to staff of the Association. It may be released with permission from the institution; and B) Personal - Sensitive data collected from individual persons generally available only to staff of the Association. It may be released with permission from the individual person.

Classification will be guided by a group of individuals broadly representative of the Association's constituency. No information will be released which could be identified with an institution unless reported or confirmed by that institution.

The Association will always be willing to disclose to the individual institution or individual person any data supplied by that institution or person.

In those cases where, as a result of collection by another organization, data is owned wholly or in part by the other organization, the data would be classified in one of the above categories so far as the AAMC is concerned, but additional restrictions imposed by the other organization may also be necessary.

INTERPRETATIONS AND COMMENTS

Data made public by the individual person or individual institution (as in the case of school catalogues, Who's Who, and news released to the press), will be classified as unrestricted.

When confidential or restricted data is aggregated, it generally becomes less sensitive. Thus, data related to groups of individuals or groups of institutions might be less restricted than the same data elements related to individuals.

In accordance with the above policy, restricted data concerning individual institutions or individual persons can be provided to scholars or institutions at the discretion of the President. The staff would try to verify the worthiness of the purpose and bona fides of the organization or individual scholar in such cases, and would insist upon assurances that any result in publication would adhere to Association policies restricting individual identification.

The intended classification of each element of data will be identified on the data collection instrument itself, so that the respondent will know what will be done with the information provided.

It is recognized that a general decision to identify an item as public or restricted, even though it represents a consensus of the constituency, may still lead some individuals to refuse to supply the data.

Women Liaison Officers

In February, 1976, Mrs. Judith Braslow joined the Association Staff as Special Assistant to the President for Women in Medicine. In Mrs. Braslow's six months with the Association she has made contact with a number of selected women in medical schools as well as both formal and ad hoc groups related to the status of women in medical school. Meetings have been held with staff from the Harvard Joint Committee on the Status of Women, Center for Women in Medicine at Pennsylvania Medical College, the Radcliffe Institute Programs in Health Care, and Women Administrators in Medical Education. Almost routinely discussion has centered on certain issues. These issues, which appear to be national in scope are as follows:

I. Preparing Institutional Settings for the Influx of Women
   1. Increasing the pool of qualified women applicants to medical school
   2. Development and identification of reduced schedule and flexible time training options for both men and women
   3. Increasing primary care residency positions to accomodate interests of women medical students
   4. Adapting facilities for the special needs of women (i.e. on call rooms, changing areas, uniforms, safe parking areas, and child care facilities)
   5. Assisting women physicians in setting up practice by dealing with the problems of credit, child care, domestic help, and income inequities
   6. Identification of part-time job opportunities for women physicians
   7. Acceptance of women in decision making positions in academic medicine and throughout the health care system

II. Non-Cognitive or Support Services for Women
   1. Lack of sufficient female role models for women medical students
   2. Problem of "role isolation" of women physicians
   3. Super-human aspects of women physicians

Although Mrs. Braslow has had productive dialogue with some of the leading women's groups in academic medicine, she has found her contact with individual medical schools quite limited. In an effort to rectify that situation and open up communications lines with women in all medical schools we are proposing that each Dean appoint a liaison officer for Women in Medicine to the Association. This individual may either be a female in the administration or the head of a recognized women's group if there is one in the medical school. By the appointment of these individuals, both the AAMC and the individual medical schools will be formally recognizing that there are problems unique to women in medical school and drawing on talented individuals to collectively work together on solving those problems.

While it is not expected that the liaison officers will meet on any regular basis or that they will become a formal AAMC group, there will be occasions

throughout the year where selected individuals will be called upon to assist Mrs. Braslow in some capacity. Some examples of uses of these individuals are listed below:

1. Responding to a report on Women in Medicine
2. Assisting with the writing of a proposal for funding
3. Identification of women to serve on AAMC Committees

Because of the limited number of women on the AAMC Senior Staff and on the administrative boards of the Councils, input from women in the medical schools needs to be sought in other ways. It is hopeful that with the appointment by the Deans of these women liaison officers, that the concerns of women in the medical schools can become more visible through this low key approach.

Judith Braslow
September 2, 1976

RECOMMENDATION:

That the Administrative Board review this proposed course of action and provide its comments for the guidance of staff.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Annual Meeting
November 11-15, 1976
San Francisco Hilton Hotel
San Francisco, California

Council of Deans' Activities

Thursday, November 11

2:00 p.m. -- 5:00 p.m.
Ballroom 4

COD Program Session
"CURRENT & CHOICE: Developments in Medical Education"

7:30 p.m. -- 10:00 p.m.
Ballroom 4

COD/OSR Joint Program
"Educational Stress: The Psychological Journey of the Medical Student"

Friday, November 12

7:30 a.m. -- 8:45 a.m.
Embarcadero Room

New Deans' Breakfast

9:30 a.m. -- 11:30 a.m.
Ballroom 6

COD/COTH Joint Program

The Commission on Public-General Hospitals

"Activities of the Commission"
Russell A. Nelson, M.D.
Chairman

"Issues for State University-Owned Hospitals"
John R. Hogness, M.D.
President
University of Washington

"Issues for Big City Public Teaching Hospitals"
Joseph V. Terrenzio
President
United Hospital Fund of New York

12:00 Noon -- 1:30 p.m.
Whitney Room

Administrative Board Luncheon

2:00 p.m. -- 5:00 p.m.
Ballroom 4

COD Business Meeting

Saturday, November 13

7:30 a.m. -- 8:45 a.m.
Embarcadero Room

Midwest-Great Plains Region Breakfast

PLENARY & ASSEMBLY SESSIONS

Sunday, November 14

7:30 a.m. -- 8:45 a.m.
Walnut B

Deans of New & Developing Schools Breakfast

PLENARY SESSION

	THURSDAY 11/11	FRIDAY 11/12	SATURDAY 11/13	SUNDAY 11/14	MONDAY 11/15
a.m.		New Deans' Breakfast COD/COTH Joint Prog. Ad. Bd. Lunch	Midwest-Great Plains Bkfst. PLENARY SESSION	New & Dev. Schools Bkfst PLENARY SESSION	
p.m.	COD Program Session COD/OSR Joint Program	Business Mtg.	ASSEMBLY/PROGRAM		

THE UNIVERSITY OF NEW MEXICO ☐ ALBUQUERQUE, NEW MEXICO 87131
OFFICE OF THE DEAN ☐ SCHOOL OF MEDICINE
HEALTH SCIENCES CENTER, NORTH CAMPUS, TELEPHONE 505: 277-2321

July 12, 1976

John A. Gronvall, M.D.
Dean
University of Michigan
Medical School
1335 Catherine Street
Ann Arbor, Michigan 48104

Dear John:

This letter constitutes my report as Chairman of the Council of Deans Nominating Committee to you as the Chairman of the Council of Deans. The Committee met at 3:30 p.m. EDT on June 30, 1976, by telephone conference call. As you know the Committee consisted of John E. Chapman, M.D., Dean, Vanderbilt University, John E. Dennis, M.D., Dean, University of Maryland, Joseph M. Holthaus, M.D., Dean, Creighton University and Robert S. Stone, M.D., Dean, University of Oregon. At the time of the conference call we had available to us the tallies of the advisory ballots submitted by the Council of Deans.

The following offices will be filled by vote of the Council of Deans. The slate proposed by your Nominating Committee is as follows:

Chairman-Elect of the Council of Deans: Julius R. Krevans, M.D., Dean, University of California-San Francisco School of Medicine

Member-at-large, Council of Deans Administrative Board: Steven C. Beering, M.D., Dean, Indiana University School of Medicine.

The following offices are filled by election of the Assembly. Consequently, the slate proposed for the Assembly's consideration will be developed by the AAMC Nominating Committee of which I am a member. Thus, these names will be submitted in the form of a recommendation from our Nominating Committee to that Nominating Committee:

Chairman-Elect of the Assembly: Robert G. Petersdorf, M.D., Chairman, Department of Medicine, University of Washington School of Medicine

Council of Deans Representatives to the Executive Council:

John A. Gronvall, M.D., Dean, University of Michigan Medical School (MW)

Julius R. Krevans, M.D., Dean, University of California-San Francisco School of Medicine (West)

Christopher C. Fordham III, M.D., Dean, University of North Carolina School of Medicine (South)

These nominations, I believe accurately reflect the wishes of the members of the Council of Deans. I am confident that we have a slate which will contribute substantially to the work of the Association.

Thank you for the opportunity to serve in this capacity.

Sincerely,

Leonard Napolitano

Leonard Napolitano, Ph.D.
Dean, School of Medicine
Interim Vice President for Health Sciences

LN/bc

xc: John E. Chapman, M.D.
John M. Dennis, M.D.
Joseph M. Holthaus, M.D.
Joseph A. Keyes
Robert S. Stone, M.D.