association of american medical colleges

AGENDA FOR COUNCIL OF DEANS

ADMINISTRATIVE BOARD
THURSDAY, JUNE 23, 1977
9:00 AM—1:00 PM

INDEPENDENCE ROOM
WASHINGTON HILTON HOTEL
WASHINGTON, D.C.

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

Future Meeting Dates

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

AAMC ANNUAL MEETING
November 5-10, 1977
Washington Hilton Hotel
Washington, D.C.

COUNCIL OF DEANS
ADMINISTRATIVE BOARD
June 23, 1977
9 a.m. - 1 p.m.
Independence Room
Washington Hilton Hotel

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

March 31, 1977
9 a.m. - 1 p.m.
Hamilton Room
Washington Hilton Hotel

PRESENT

(Board Members)

Stuart A. Bondurant, M.D.
Neal L. Gault, 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.

(Guests)

Ivan L. Bennett, Jr., M.D.
Thomas A. Rado, Ph.D.
Paul Scoles

(Staff)

Robert J. Boerner
Judith B. Braslow
John A. D. Cooper, M.D.
Joseph A. Keyes
Diane Newman
Jaimee S. Parks
James R. Schofield, M.D.
Emanuel Suter, M.D.
Bart Waldman
Marjorie P. Wilson, M.D.

ABSENT

Steven C. Beering, M.D.
Christopher C. Fordham III, M.D.
John A. Gronvall, M.D.

I. Call to Order

The meeting was called to order at 9 a.m. by Julius R. Krevans, M.D., who chaired the meeting in the absence of Dr. Gronvall.

II. Chairman's Report

Dr. Krevans reported on the steps taken to follow up on his plan to meet with members of the Council in small groups during this academic year. Two such meetings had been held; the first in Minneapolis on February 12 with 9 deans of the Midwest-Great Plains

region was hosted by Dr. Neal Gault, the second in Boston on March 30 with 9 New England Deans was hosted by Dr. Strickler. Each meeting provided for several hours of wide ranging and unstructured discussion about the role of the AAMC in serving the needs of medical schools. These meetings offered an opportunity for the deans to communicate directly with the COD leadership to make known their problems and concerns as well as their aspirations for the Association. Dr. Krevans thought it was an extremely valuable method for him to acquaint himself with the deans and their needs and for him to help them develop a more detailed understanding of the way the Association is organized and how it functions. He noted that he had received a number of letters from the participants expressing their appreciation for the meeting.

Dr. Krevans noted that one of the major topics of discussion at the Minneapolis meeting was medical school/VA hospital affiliations and the problems currently being encountered. Dr. Gault was asked to review with the Board some of the highlights of that discussion. Dr. Gault pointed out that there was a wide range of issues and a wide spectrum of satisfaction among the deans present. At one extreme the relationship appeared quite satisfactory, while at the other, there were serious indications of a deteriorating relationship. There was no single problem which dominated the discussion or which was shared by each of the institutions present, but it was clear that there was a general level of concern. The problems included: a niggling and destructively restrictive approach to accounting for the time of VA residents, a failure to fully realize the potential of the adverse impact on the medical centers of the VA's approach to the regionalization program, and the effect on faculty morale of the VA's current method of operating its research program, which treats VA employed basic scientists as principal investigators on grants permitting them to develop their own laboratories and support staff without reference to the activities of the medical school faculty.

Drs. Van Citters and Bondurant responded from their perspective as members of the VA Special Medical Advisory Group (SMAG). Dr. Van Citters pointed out that there is substantial consideration being given to revising Memorandum #2 and expanding the deans committee to include representatives of all the health sciences rather than just the medical school. This might further attenuate the ties between the medical school and hospital. Dr. Bondurant reminded the Board that the VA must be responsive to its constituents, the Veterans organizations, and to Congress. The current tensions between the medical school and the affiliated hospitals is to some degree a reflection of dissatisfaction on the part of these groups.

Dr. Krevans summarized the discussion by indicating that since the problems seemed to be very diffused and not focused on a single set of issues, the AAMC would need to continue to develop its relationships with the VA central office as a means of working on these issues. In particular, the new AAMC-VA Liaison Committee was identified as an important instrument for addressing these issues. The chief concern of the New England schools was the perception that the AAMC was not responsive to private schools and particularly to their very serious financial problems. It was pointed out, for example, that the Administrative Board of the Council of Deans included only two deans from private schools. In a brief discussion, the Board considered the suggestion that the AAMC conduct a study to develop strategies for improving the financial status of private schools. It was concluded that this would be an appropriate topic for general discussion at the Spring Meeting.

Dr. Krevans summed up his review of the small group meetings by relating that both groups were very interested in finding ways to increase and broaden the participation of the deans in the Association's activities. A number of suggestions were made to accomplish this. There was a great deal of interest in being informed of the time and agenda of the Executive Council meetings in advance of the meetings. Dr. Krevans planned to continue the series by meeting with the Southern Deans on April 17.

III. Minutes of the Previous Meeting

The minutes of the January 13, 1977 meeting of the Administrative Board were approved as submitted.

IV. Executive Council Actions

A. Approval of Subscribers

The Board endorsed Executive Council approval of the following Subscribers:

University of Alaska
Fairbanks, Alaska
Dr. Wayne Myers, WAMI Coordinator

University of Wyoming
College of Human Medicine
Laramie, Wyoming
Robert M. Daugherty, M.D., Dean

B. Kountz v. State University of New York

Background

The University counsel of the State University of New York system has asked the Association to join as amicus curiae in the school's appeal of a Kings County Supreme Court decision invalidating the faculty practice plan at SUNY-Downstate. This case involved a faculty member's challenge to a New York State statute authorizing the University to establish a clinical practice income management corporation to collect clinical practice income generated by the full-time faculty at the school. The Court utterly failed to acknowledge or understand that the responsibilities of the clinical faculty involved patient care as well as classroom instruction. The Court expressed "shock" at any interpretation of the law which would allow the University to "take away from doctors the fees they earn in private practice." Furthermore, the court suggested that if the law did sanction a confiscation of this type, it would most likely violate constitutional due process protections.

The Association staff feels that the court's failure to understand the integral nature of teaching and patient care sets a dangerous precedent which must be clarified on appeal. The SUNY counsel has asked that the AAMC become involved in the case to inform the appellate court of the wide-spread phenomenon of faculty practice plans and to establish for the record the integral nature of teaching and patient care responsibilities.

Discussion

Dr. Bondurant pointed out that the law is viewed by many legal commentators in New York as being a flawed instrument in its reference to income associated with education. The Board agreed that the Association's role in this matter, if it should decide to involve itself, should be limited to pointing out the wide-spread use of faculty practice plans in the United States and their significance in the financing of medical education. The Association should not concern itself with the technical legal matters involved in interpreting the statute. Dr. Bondurant pointed out that his institution was engaged in litigation involving somewhat similar issues and suggested that the AAMC might wish to seek the assistance of his counsel in this matter because he is well-informed and cognizant of the issues. The Board tentatively endorsed the Association's involvement in this case, but felt that it was particularly important to have the concurrence of the Council of Academic Societies Administrative Board.

Action:

The Board tentatively endorsed AAMC involvement as amicus curiae in the Kountz case, but urged that any decision to do so take into account the judgments of the CAS Administrative Board.

C. Coordination of the Application Cycles for GME Programs Recruiting Medical Students for GME-II Positions

Medical schools are concerned with the frequency of too-early requests for letters of student evaluation from graduate medical education program directors recruiting residents into their program. This is particularly common in the case of graduate medical education programs which admit students at the second graduate year level.

A report from the GSA Ad Hoc Committee on Professional Development and Advising details the problems. There are substantially two:

1) The application cycle for GME programs which admit students after their first graduate year is highly variable from specialty to specialty and from program to program within specialties.

2) This variability leads to a significant number of programs pressing students to apply in their third year and results in students seeking supporting letters of evaluation from Deans for Student Affairs or faculty before they have completed their basic clerkships.

It was recommended that the Executive Council approve the following statement which would be forwarded to the LCGME, the American Board of Medical Specialties, the Council of Medical Specialty Societies, and organizations of program directors:

> The AAMC is concerned that uncoordinated efforts to fill positions in graduate programs which normally begin after one year of graduate medical education are resulting in inappropriate and premature requests for student evaluations, often before medical students have completed their basic clinical clerkships. The Association requests that program directors for specialties which predominantly admit students after completion of a first graduate year of education coordinate their application cycle so that students and medical schools are not imposed upon to provide letters of evaluation prematurely. A cycle which does not permit acceptance of applications prior to the late fall of the students' senior year is recommended.

Deans' offices and faculty are urged to respond to requests for premature evaluation by pointing out that the information being supplied is not based upon adequate observation of the student and that students are being denied an opportunity to explore the full range of options for their professional career development.

In the case of programs admitting students directly after graduation from medical school, the application rules and guidelines of the NIRMP should be followed.

The Board agreed that the problem identified was an important one for some students. The members were not confident that the adoption of the recommended statement would be effective in changing the situation. An effective response would require that the associate deans and the department heads in the specialties concerned, uniformly refuse to accommodate to requests for premature evaluations of students. This approach was viewed as having an extremely low likelihood of being implemented because of the reluctance of both department heads and associate deans to in any way damage the affected students career opportunities. Even if it were possible to achieve the complete cooperation of the associate deans, the problem would remain because the most significant recommendations are those of the department heads in the specialty involved, the very people, who as program directors are creating the problem in the first instance.

Action:

The Board endorsed Executive Council adoption of the recommended statement to be forwarded to the LCGME, the American Board of Medical Specialties, the Council of Medical Specialty Societies and organizations of program directors.

D. CCME Committee on Physician Distribution Report: The Specialty and Geographic Distribution of Physicians

The Coordinating Council on Medical Education appointed a Committee on Physician Distribution on March 19, 1973. Its Chairman is Dr. William D. Holden and members include Drs. John C. Beck, C. Rollins Hanlon, Bernard J. Pisani, August G. Swanson and David D. Thompson. Dr. Thomas Dublin was appointed as consultant. This committee produced two reports, now published, respectively on "The Primary Care Physician" and "The Role of the Foreign Medical Graduate." A third, "The Specialty and Geographic Distribution of Physicians", was distributed to members of each of the Boards in draft form for review.

It has been obvious for sometime that the latest effort of the Committee on Physician Distribution is controversial. The AAMC staff expressed concerns with the September draft, and became even more disturbed when both its substantive and procedural recommendations received less than adequate attention.

The CCME considered this report in a special meeting in October and again on December 13, 1976. A lengthy discussion culminated in an action to refer the working document, "Physician Manpower and Distribution: The Specialty and Geographic Distribution of Physicians," back to the parent organizations for their review and recommendations. The members of the Executive Council as well as those of the four Administrative Baords, were sent copies of the draft report together with a short staff evaluation in late January 1977. Based on the responses received from six of the ten members of the COD Board, three of the thirteen members of the COTH Board, four of the twelve members of the CAS Board, and none of the eleven members of the OSR Board, a position paper was developed and circulated to the members of the Committee on Physician Distribution at a special meeting on March 5, 1977. The Committee decided to revise the report, shortening it to a version of no more than 20 pages (compared to the current 156-page document). However, the CCME met in mid-March and again asked the parent organizations to comment formally.

Action:

The Board recommended:

1) That the AAMC not approve the committee report;
2) That the AAMC endorse, instead, the committee recommendation that a new report be drafted which a) is short, b) lays out the existing data and its limitations very briefly, c) emphasizes the rapidly changing situation, d) identifies new information which is likely to become available in the near future, and e) defers major policy recommendations until the data is available and the situation is somewhat clarified.

The Board also recommended that the AAMC correspondence relating its decision be more moderate in tone than the analysis in the agenda book.

E. Problems Regarding Foreign Medical Graduates

The statutory provisions of Title VI of P.L. 94-484 governing the admission to the U.S. of alien graduates of foreign medical schools creates special problems for certain classes of physicians seeking to come to this country as either immigrants or visitors. The Administrative Board considered two of these problems.

1) Distinguished Visitors

The regulations to implement the present law limit the functions that can be undertaken by distinguished physician visitors solely to teaching and research if admitted under the usual H-1 visa. It is not certain that patient care is recognized to be an integral and inseparable part of the teaching and research activities of many clinicians, nor is it clear how best to resolve the uncertainty. If one assumes that the H-visa distinguished visiting physicians are not permitted to assume patient care responsibilities, only absurd alternatives are available -- having them engage in patient contact under the nominal supervision of an American physician; asking them to seek a J-visa, with the requirement to pass the NBME examinations; limiting their patient contact while in the U.S. Since few would tolerate such indignities, since the law is intended to protect U.S. citizens from incompetent -- not superbly competent -- physicians, and since the U.S. stands to profit far more than the visitor from that individual's visit, the existing situation calls for a change.

Action:

The Administrative Board urged the staff to pursue any or all of the following approaches in a way that seems best calculated to achieve the desired results:

1) Again request the Department of Justice to amend the regulation, striking the word solely.

2) Request the chairpersons of the appropriate Congressional Committees to inform the Department of Justice that the present regulations fail to reflect Congresstional intent.

3) Seek an appropriate technical amendment to the statute to clarify this issue.

4) Seek new legislation to authorize the Secretary DHEW to waive upon application and on the advice of an appropriately constituted advisory body, the examination requirement and thus enable the continuation of a highly desirable distinguished physician visitor program.

2) Immigrants

Title VI of P.L. 94-484 makes it quite difficult for alien FMGs to obtain immigrant visas to come to the U.S. Candidates must demonstrate academic and intellectual competence by, inter alia, passing a specified examination and must receive labor certification.

There is a broad consensus in the country that the new requirements are appropriate and, in principle, the AAMC and other organizations such as the CCME are fully supportive of the statutory provisions as legitimately protective of the American public. There is one class of alien FMGs that might be considered for exemption from the present requirements.

Historically, the faculties of U.S. medical schools have been enormously enriched by the recruitment of scholars from foreign institutions. The fact that such aliens are sought by U.S. schools attest to their high level of competence. They have varied in calibre from junior faculty members -- who have completed their graduate medical education, possess the equivalent of "Board certification", have published a (modest) number of papers in well recognized referred journals and have been elected to membership in competitive scholarly societies -- to highly distinguished scholars of international renown. Their immigration promises to benefit the U.S. to a far greater extent than themselves. To require such alien FMGs to take the required NBME (or equivalent) examination is obviously highly inappropriate and actually self-defeating, since few if any will submit to such an indignity.

Recommendation. A technical amendment to P.L. 94-484 or new legislation should be formulated and enacted, under which the Secretary, DHEW, upon application, could, on the advice of an appropriately constituted body determine whether the candidate has competences equivalent to those embodied in U.S. faculty members. If the Secretary makes such a determination, he should be empowered to waive the examination requirement for issuance of a visa.

Discussion

The discussion of this matter focused on the question of the advisability of seeking a revision of this act at this early date. The concern was that by opening up consideration of the provision for what would appear to be self-serving purpose we would be inviting others to present their own self-serving claims on matters contrary to our interests. The contrary argument was that the Act effected its purpose by means of a blunt instrument and that now was the time to refine its precision. As to appearing self-serving, that should not be an overriding concern since our chief objective as an Association should always be to represent the interests of our member institutions. If the AAMC did not undertake that task, no one would and the AAMC

would have failed in its responsibilities. There could, of course, be no guarantee that opening the matter for consideration would result in no in appropriate Congressional action. But we would be proposing a means for accomplishing the essential purpose of the Act by suggesting a mechanism for reviewing the qualifications of the physician. The key question ought to be whether the existing provision might preclude the recruitment of superior faculty members to U.S. schools.

Action:

The Administrative Board endorsed the staff recommendation.

3) Implementation of Title VI Provisions for Foreign Graduate Exchange Visitors

Among the requirements for alien physicians to come as exchange visitors with J-visas to the United States for graduate medical education and training are included (1) a written agreement by a medical school and its affiliated hospitals to provide the training, (2) assurance that the alien has passed Parts I and II of the NBME examination or an equivalent examination as determined by the Secretary, HEW, (3) a commitment by the alien to return to his/her home country upon completion of the training period and assurance of employment, and (4) a limitation of stay for two years with the possible extension for a third year upon specific request.

These requirements may be waived by the Secretary of HEW on a program by program basis between January 10, 1977 and December 31, 1980 provided the failure of an alien to join a graduate program in the United States because of the provisions listed above would create a substantial disruption in the health services provided by such a program.

Due to the unavailability of an acceptable examination, the Secretary of HEW declared a blanket waiver of the new requirements listed above (except duration of stay), thus permitting aliens to be admitted with J-visas between January 1977 and June 30, 1978 if they are to fill a vacant position which was held on January 10, 1977 by an exchange visitor. Under this blanket waiver, no consideration can be given to potential disruption in individual programs not qualifying for the blanket waiver, because they either had no foreign exchange visitors at the time of the census (January 10, 1977) or none will be leaving the program in June 1977). Unfortunately, the blanket waiver has the effect of perverting the intent of the law by transforming into a numerical limit what is basically a quality limit - the availability of qualified physicians interested in training.

Since an "equivalent examination", the Visa Qualifying Examination, will be available by September 1977, it is recommended that the AAMC urge the Secretary of HEW to develop in the immediate future regulations for the implementation of the J-visa and waiver provisions as prescribed by the law. These regulations will permit individual programs to appoint foreign exchange visitors and to apply for a waiver on the basis of specific merit. A failure to have these regulations will result in enormous pressures by many large municipal hospitals to extend the blanket waiver which has the effect of condoning the continued corruption of the Exchange Visitor Program, a situation which AAMC policy as well as the Congress intended to correct.

Action:

The Administrative Board urged that the Executive Council authorize staff to press for speedy implementation of the provisions contained in Title VI of P.L. 94-484 regarding J-visas and waivers.

F. Admission of Foreign Medical Graduates as Exchange Visitors

Background

The provisions regulating the entry of graduates of foreign medical schools to the United States contained in PL94-484 require reexamination of the present administrative process for admitting FMGs to the United States in order to pursue graduate medical education.

According to Title VI of this law, all foreign physicians seeking visas to enter the United States with the intention of rendering patient care services (usually in connection with graduate medical education programs) must have passed Parts I and II of the NBME examination or an examination declared equivalent by the Secretary of Health, Education and Welfare. A new examination, the Visa Qualifying Examination (VQE), is being developed by NBME to be given abroad at 10 or 15 selected centers. Prior to being admitted to this examination, the candidate will be required to provide proof of his/her command of the English language and of an ability to adapt to the United States environment.

These provisions apply equally to applicants for immigration and for exchange visitor visas. Exemptions from these provisions are relatively insignificant and address themselves only to close relatives of U.S. citizens and to refugees.

The statutes describe additional conditions to be met for a foreign physician to be admitted under the J-visa program. They include the following:

- the program must be under the control of a LCME accredited medical school with its affiliated hospital,

- the applicant must be sponsored by the home institution or government with which the U.S. institution enters into an agreement for offering a specified training program,

- the applicant must give assurance that he/she will return after completing the training period and that the training obtained in the United States will be required and applicable to his/her employment or professional activities, and

- the training period is limited to two years with the possibility of a one year extension under specified conditions.

Administration of Program

The entry of physicians as exchange visitors into the United States and their admission to training programs should be carried out in two steps. The first step would include the examination of educational records, determination of professional competency and mastery of English; the second step would deal with the procedures for being admitted into a training program. Each step would be carried out separately since it is unlikely that a U.S. institution will enter into negotiations with a foreign institution or government unless the proposed trainee has qualified for the J-visa. For administration of these two steps the following is suggested:

1. Visa Qualification Certificate

   The Visa Qualification Certificate should be issued by the ECFMG upon fulfillment of the following requirements:

   - documentation of competency in the English language as demonstrated through passage of either an examination offered by ECFMG or TOEFL administered by U.S. embassies,

   - documentation of having received an M.D. degree or its equivalent from a medical school recognized in the physician's home country or country of last residence, and

   - documentation of a passing score on Parts I and II of the NBME examination or on an examination declared equivalent by the Secretary of Health, Education and Welfare.

2. Program Admission

   For admission of exchange visitors into accredited graduate medical education and/or fellowship programs, the AAMC should seek from the Department of State delegation of P-II sponsorship on behalf of all U.S. accredited medical schools and their affiliated hospitals. As the designated sponsor, AAMC would issue the DSP-66 under the following conditions:

- the physician has received a Visa Qualification Certificate from ECFMG,

- a satisfactory agreement in writing has been reached between the physician's home institution and/or government and the U.S. institution offering the program. Such an agreement would include assurance that:

* all programs offered for exchange visitor physicians are under the direct control of an accredited medical school and its affiliated hospital(s),

* assurance in writing has been given by the prospective visitor that he/she will return to his/her country and that the training obtained is required for and applicable to his/her expected professional activities,

* extension by one year beyond the prescribed two year period will be granted only upon specific requests by the trainee's home institution and/or government.

RECOMMENDATION

It is recommended that the Executive Council approve the following policy statement setting forth the roles of the AAMC and the ECFMG to take effect at the termination of the blanket waiver issued by the HEW Secretary and upon the availability of the Visa Qualifying Examination abroad.

1. The AAMC, on behalf of the medical schools and their affiliated hospitals, should seek sponsorship of the P-II Programs of the Exchange Visitor Program. In this capacity, the AAMC would facilitate the initiation of contacts and the negotiation of agreements between foreign governments or institutions and U.S. institutions for specified clinical training programs for exchange visitor physicians. The AAMC would issue the DSP-66 to alien physicians for whom programs have been arranged. Support for this program would be obtained through charges to foreign institutions and/or governmental agencies. Such charges would serve to emphasize their commitment to the individual for whom these agencies seek training.

2. The ECFMG should retain the certifying function for all graduates of foreign medical schools not accredited by the LCME after the requirements listed under B/1 above have been fulfilled. It should further maintain records on all candidates for the examination, on those who passed and failed and on recipients of the ECFMG certificate as well as those who subsequently enter U.S. graduate programs.

Discussion

The staff feels that the AAMC can better serve the needs of the member schools involved in this new program than any other agency which might perform the brokering function. The primary concern was whether this would be a small program within the stated objectives of the statute and thus involve a modest expansion of the AAMC role, or whether it would be used as the means for continuing to do business in the same old way with only a different set of labels, which would be a major and inappropriate expansion of the AAMC role. In response, it was pointed out that a major responsibility for living up to the statutory intent rests with the medical schools since a condition for granting the J-visa is that there be an agreement between the U.S. institution and the home institution or government. It was recognized that there will be considerable pressure from hospitals on schools to engage in such programs.

The question of the receptivity of the state department to having the AAMC take on this function was raised. All indications are that they would be pleased to have the AAMC do it, since a year ago, we were asked and declined, and there appears to be continuing dissatisfaction with the performance of the ECFMG.

Action:

The Administrative Board endorsed the staff recommendation.

G. Eligibility Requirements for Entry into Graduate Medical Education

Graduates of foreign medical schools seeking to enter the U.S. as immigrants or exchange visitors to provide services as members of the medical profession will, in the future, be required by law to demonstrate their professional preparation by passing Parts I and II of the NBME exam, or an exam determined as equivalent by the Secretary of HEW. In imposing this requirement, the Congress clearly intended to upgrade the standards of eligibility for foreign educated physicians entering the medical profession in the U.S.

The Liaison Committee on Graduate Medical Education should, therefore, also set its eligibility requirements for entry into graduate medical education at a comparable level.

At present, the LCGME requirements for entry into graduate medical education for graduates of foreign medical schools are those established by the AMA's Council on Medical Education prior to the formation of the LCGME. They are that foreign medical graduates must either:

1) have a full and unrestricted license, or
2) have secured a standard certification from the Educational Commission for Foreign Medical Graduates.

In the case of U.S. citizen graduates of foreign medical schools, they may in lieu of (1) and (2) above:

3) either have successfully completed the licensure exam in a U.S. jurisdiction which will grant a full and unrestricted license without further examination upon completion of internship or residency, or
4) have completed an academic year of clinical clerkship in a "fifth pathway" program sponsored by an accredited U.S. medical school.

Discussions with officials of the ECFMG reveal that they plan to base all future ECFMG certifications for non-resident alien physicians on their passing a new examination now being developed by the NBME as equivalent to Parts I and II of the Board exams. It is anticipated that the Secretary of HEW will determine this exam as the standard for foreign educated physicians seeking visas to enter the U.S. to provide services as members of the medical profession.

However, the ECFMG intends to continue to use the present ECFMG exam for purposes of certifying U.S. citizens educated in foreign medical schools and for certifying alien physicians at present resident in the U.S. It is estimated that this group may exceed 10,000. The purpose of ECFMG certification in the case of these two groups would be to make them eligible for entry into graduate programs accredited by the LCGME. Thus, the new exam being developed by NBME will be an additional standard imposed only on alien foreign medical graduates who enter the U.S. in the future. If passing this exam were simply added to the present LCGME eligibility requirements, it would be an additional "sixth pathway" into graduate medical education.

Considering the intent of Congress, the position taken by the AAMC in its position statement on foreign medical graduates, and the Coordinating Council on Medical Education's directives to the LCGME in that body's position paper on the "Role of the Foreign Medical Graduate," continuing to use the ECFMG exam for the purpose of certifying any foreign educated physician as eligible for entry into graduate medical education in the U.S. is unsupportable.

Recommendation

It is recommended that the Executive Council request that the LCGME withdraw recognition of ECFMG certification based upon passing the ECFMG examination, and require that after July 1, 1978 al physicians educated in medical schools not accredited by the LCME be required to have ECFMG certification based either on passing Parts I and II of the NBME exam or the exam determined as equivalent by the Secretary of HEW.

Discussion

It was emphasized that this recommendation would effect a change for those who do not need a visa -- aliens already in the U.S. as permanent residents who had never qualified for graduate medical education and U.S. graduates of foreign medical schools.

Action:

The Board endorsed the staff recommendation.

H. AAMC Involvement in the USFMS Transfer Program

The capitation requirement that medical schools reserve a number of positions for USFMS is going to be a difficult provision to administer. There is no real base of knowledge to estimate the number of U.S. citizens who will apply to the Secretary. The time schedule for getting application materials out to students and getting back their applications, plus their transcripts and a statement of successful completion of two years from multiple foreign schools, is very short.

The Division of Medicine desires to encourage schools voluntarily to enroll USFMS from the eligible cohort for the 1977-78 academic year and have those students count toward the quota of positions schools will have to reserve for the 1978-79 academic year, but whether this thrust will be approved at higher levels in HEW is conjectural. The earliest date when a partial list of individuals deemed eligible by the Secretary can be published is August 15. Schools acting to admit USFMS transfers prior to publication of the eligibility list and approval of the voluntary credit system will be speculating.

The Division of Medicine has approached AAMC regarding our undertaking the task of verifying the documents submitted by the applicants. They will approach NIRMP to operate a matching process for the students who will apply to enter in 1978.

The question is whether the AAMC should accept such an undertaking.

On the positive side:

1) The Division of Medicine is understaffed and is seeking AAMC assistance. Our relations with the Division have been excellent and our assistance now could further cement these relationships.

2) Considering the tight schedule and likely confusion, the AAMC's being involved might reduce the noise and ease the burden on the schools.

3) By handling the verification, we would develop a data base useful in future policy debate, vis-a-vis USFMS.

On the negative side:

1) The provision is unpopular with the schools and faculty and AAMC's participation might be misconstrued as facilitating their having to take USFMS. This could create a negative situation.

2) The overt zealousness and hostility of many USFMS and their families will predictably result in challenges to verification decisions. Although we could arrange our contract to place the Division of Medicine in the front line in responding to such challenges, there will be much time consumed in communicating with the Division over individual cases. The AAMC could bear the brunt of logistic problems arising from a foreign school's refusal to provide verifiable documents, e.g. dean's letter, transcript, etc. This could result in a public relations problem, if not a legal entanglement.

3) The personnel normally assigned to COTRANS will not be available because the USFMS certification season is superimposed on the AMCAS season. Therefore, a cadre of temporary employees will have to be recruited and trained, and space found for them.

4) The amount of money recoverable from a contract will be a pittance compared to the time demands placed on the professional staff of AAMC to develop and manage a program.

Discussion

The Board felt strongly that the negative side strongly outweighed the positive. It appeared to be a no win proposition. Since the administrative problems appeared so great that the likelihood of failure was fairly high. If we were a party to the administration, we would be subject to the charge of sabotaging the program. If we successfully implemented the program, we would be faced with the Congressional perception that the program washed well and should be continued. In either event, we would defeat our own interests and our credibility would be hard to retrieve.

Action:

The Board urged that the AAMC not accept any responsibility for administering the USFMS transfer provisions, but rather offer whatever advice to the BHM as might be helpful. We should refer the Bureau to other agencies such as the ECFMG, with the skills for validating foreign credentials, or preferably, an agency linked with academic enterprises but unlinked from medicine.

I. Letter from the American College of Surgeons

The Board of Regents of the American College of Surgeons has sent a letter (a copy of which appears as an appendix to these minutes) to each of the parent organizations of the Coordinating Council on Medical Education. The ACS letter calls for a response which would embody fundamental AAMC policy in viewing the accreditation of graduate medical education and the role of the Liaison Committee on Graduate Medical Education.

RECOMMENDATION

It is recommended that the Executive Council endorse responding to the American College of Surgeons by supporting the following principles (each of which represents previously expressed Executive Council recommendations concerning the accreditation of graduate medical education):

1. The Association supports the ACS recommendation that there be a free-standing, independent staff for the LCGME and the Residency Review Committees, not related in any particular way to a single parent organization.

2. The LCGME serves and should continue to serve as the private sector accrediting agency for programs of graduate medical education. The RRC's should continue to review the on-site evaluations of each particular program and to initiate modifications in the recognized "essentials" for each particular specialty. However, it is the ultimate responsibility of the LCGME to approve these essentials and to review the accreditation recommendations of the RRC's.

3. The LCGME should have the authority to appoint one member to each RRC in place of the member currently appointed by the AMA Council on Medical Education. This member would be appointed from a roster of specialist educators developed by the AMA, the AAMC, and the AHA. The other two members of the LCGME (American Board of Medical Specialties and the Council on Medical Specialty Societies) are responsible for appointing the remaining members of the Residency Review Committees.

Action:

The Administrative Board adopted the staff recommendation.

J. Uniformed Services University of the Health Sciences

BACKGROUND

President Carter's revised budget request for FY 1978 contains no funds for the continued operation of the Uniformed Services University of the Health Sciences. After a short but controversial existence, it now appears that the future of the "military medical school" rests with the Appropriations Committees of the Congress. The Association has been asked by Congressional staff members to take a position on the continuation of the school.

The USUHS currently has 32 first-year students enrolled and holds provisional accreditation from the Liaison Committee on Medical Education. The school is continuing with its plans to admit its second class next fall.

When the Congress considered the legislation sponsored by Representative Hebert which ultimately led to the establishment of the USUHS, the AAMC testified in oppostion to the creation of the new school. Two years ago, when the Defense Manpower Commission recommended to President Ford that the development of the school be discontinued, the Association declined to take a position on what was then seen as a purely political matter. Since the Association was involved in the accreditation process at that

point, it was felt that the AAMC should only comment on the quality of the educational program and not on the need or desirability of establishing the school. A copy of Dr. Cooper's letter spelling out this position follows as an appendix to these minutes.

Recommendation

It is recommended that the Executive Council reaffirm its position as represented in Dr. Cooper's letter of June 25, 1975. It is also recommended that the Executive Council agree that the Association members and staff work to help place the currently enrolled USUHS students in other U.S. medical schools and assist displaced faculty in finding new positions in the event that the Congress decides to close the school.

Action:

The Board adopted the recommendation stated above.

K. Report of the Ad Hoc Committee to Review the Talmadge Bill

The Board discussed the Committee's analysis and recommendations very briefly with Dr. Bondurant who served as a member of the Committee, deferring a detailed discussion to the Executive Council meeting at which time the reactions of the COTH Board would be available.

Note: The AAMC position as recommended by the Committee and revised by the Executive Council was mailed to the Assembly with Memorandum #77-24, dated May 19, 1977.

V. Administrative Board Actions

A. Proposed AAMC Medical Librarians Group

The Assistant Director of Libraries for the Health Sciences at the University of Washington proposed to Dr. Van Citters that the AAMC create a section on medical school libraries within the AAMC. Dr. Van Citters requested that the Board consider this proposal.

The Board was concerned that the AAMC could not afford to support the proliferation of special interest groups within its organizational structure. It suggested, however, that the medical school librarians might wish to organize themselves as a society with the objective of seeking membership in the Council of Academic Societies. This appeared particularly appropriate in view of the librarians' stated

interest in having themselves classified, regarded and treated as faculty. A second suggestion was that the group schedule its meetings in conjunction with the AAMC Annual Meeting to facilitate closer contact with the deans and others within the Association.

Action:

The Board declined to forward to the Executive Council a proposal that a Medical Librarians' Group be formed. Instead, it recommended that the appropriate response be to suggest that the group consider organizing to become a constituent member of the CAS and to meet in conjunction with the AAMC Annual Meeting.

B. AMA Section on Medical Schools

Dr. Krevans reviewed the response of the New England Deans to the AMA proposal. The almost unanimous reaction of that group was that: 1) finding the time, energy and money to send four more people to another meeting was more than the schools were interested in and 2) if there were someone from the schools attending the meeting anyway, the deans would ask that they sit in on this meeting. There was no indication of any overt negative reaction to the invitation.

Since the letter was directed to deans individually, the Board concluded that the AAMC need not take any position on this matter.

C. AAMC Legislative Alert Network

Periodically the AAMC alerts deans of the need for contacting their Congressional delegation in support of or in opposition to contemplated legislation. The response has often been disappointing. We have been informed on several occasions by Congressional staff members that the absence of communications from our members has substantially weakened our prospects on important legislative and appropriations issues

We are able to keep the deans informed of routine legislation through Deans' Memos, articles in the Weekly Activities Reports and sometimes mailgrams. If a crisis arises during subcommittee action, staff can telephone selected deans who have members of their state serving on the subcommittee in order to provide input to the Congress. Our problem lies in the fact that we have no effective and economical method of alerting all of the deans of an urgen and immediate problem, such as a veto override attempt, which quite often occurs within 24 hours of the veto.

For several years there has existed a loosely structured telephone network involving members of the Group on Public Relations. The Association staff will call the national officers of the Group with legislative information and a request for possible action by the schools. In turn each officer would place five calls and each person would then place another five calls until, in theory, the message has been spread over the country. This has not worked well. The Council of Academic Societies has a similar network called a "Cascade". It is difficult to determine how well this system works.

If the GPR Network is to continue there is a need to refine it so it becomes more effective and that it includes a mechanism for reporting back to AAMC the results of the efforts, so a head count of Congressional members can be kept. It is suggested the following be done:

1. A mechanism for the GPR member to consult with the Dean to determine appropriate action.

2. Identification with the Dean of the appropriate individuals such as board members, administrators, faculty, alumni, to assist in contacting the congressional delegation.

3. Selection of the communication method -- telegram, telephone, or personal contact -- depending on the time constraints.

4. Develop a means for documenting the number and content of the communiques sent by the institution's representatives.

5. Report the action taken by the academic medical center and the nature of the Congressional reaction to the AAMC so a master count can be kept to evaluate the effectiveness of the effort.

The Board's advice was sought as to whether 1) the network should be abolished or kept and strengthened and 2) whether the GPR is an appropriate mechanism for such an activity, or if there is a better way of quickly communicating with the deans.

Action:

The Board concluded that this should be made a discussion item at the Spring Meeting. Three aspects of the topic should be emphasized:

1. The need for persuading the deans of the importance of making their views on major issues known by personal contact, letter or telegram.

2. The need for the AAMC to be informed of the contacts made.

3. The need for an appropriate structure for the alerting and feedback processes.

D. Proposed OSR Newsletter

At the AAMC Officers' Retreat, several approaches for strengthening the OSR were discussed. One assumption upon which this discussion was based was that many medical students are unaware of OSR's existence and are uninformed about its activities and accomplishments. In this context, the suggestion was made that issuing an OSR newsletter to all medical students might significantly enhance the image of the OSR newsletter as a viable and important medical student group. It was decided that if such a newsletter were to be published, it should be similar in content to the Bulletin Board and should be bulk-mailed in sufficient quantity to either the OSR representative or the student affairs officer at each medical school for local distribution. The obvious logistical problems involved in mailing and distribution raise the question of whether the newsletters would actually reach and be read by enough students to have an impact on OSR's visibility. Dr. Gronvall concluded the Retreat discussion by expressing the willingness of the COD Board to pursue this suggestion further with the OSR Board during the year.

Questions considered by the OSR and COD Boards included:

1. Do the anticipated benefits to the OSR of increased publicity and visibility justify the increased expenditure involved in printing and mailing a publication to all medical students?

2. If the OSR and COD Administrative Boards decide that such a newsletter should be published, what format would be most appropriate and how should we recommend that distribution be handled at the local school level.

Dr. Rado, OSR Chairperson, reported that the OSR Board recommended that a four page publication be distributed quarterly, through the student affairs deans of the medical schools. The material should be primarily student generated and each issue would contain a mechanism calling for a personal response from the student recipients to test their reaction to the publication.

The first issue to be published this academic year would be viewed as a pilot issue and estimated to cost $1500, compared to the $250 cost of the OSR Bulletin Board.

The Board concluded that it was positively inclined toward supporting the measure and would discuss the proposal in further detail at the Executive Council meeting.

Action:

The Administrative Board endorsed the expenditure of a modest amount of funds to develop and test a pilot newsletter for the OSR.

VI. Report of the OSR Chairperson

Dr. Rado reported that the OSR Board had reviewed the items on the Executive Council Agenda and was in concurrence with the recommendations therein; it appointed a student to work on the uniform application working group; it submitted the vitae of four house officers for service on the Task Force on Graduate Medical Education; it declined to change its position on H.R. 2222 (the Thompson Amendment). The Board was distressed that the AAMC adopted an intransigent position on the Amendment which might preclude our effectiveness in negotiations to make the Act more acceptable. Other business included the planning of the Annual Meeting.

The Board expressed the hope that the labor relations activities could be settled soon so that the COD and the OSR could get on with the matters of medical education.

VII. Information Items

A. Emergency Medicine.

The Board was alerted that the recognition of emergency medicine as a specialty would be considered at the Executive Council meeting.

B. Spring Meeting

The program was reported to be in shape for mailing to the COD the following Tuesday; 157 hotel reservations had been received and all systems were go for the 1977 meeting in Arizona. Dr. Rado reiterated the request that the OSR Chairperson be invited to the meeting. Dr. Krevans responded that it would be appropriate for all the deans to discuss the matter prior to extending such an invitation.

C. FTC Challenge

The Federal Trade Commission challenge to the Commissioner of Education's recognition of LCME and the proceedings of the advisory

committee were reported on by Dr. James Schofield. The advisory committee recommended a two year continued approval with a one year progress report.

D. AAMC Finance Committee Deliberations

Dr. Bennett reported that the Finance Committee had concluded from the extrapolations of projected revenue and expenditures over the next few years concluded that a dues increase would likely be required by 1979 or 1980 unless there were cutbacks in current programs. The committee was considering recommending a moderate increase per year rather than calling for more major increases every four years or so. Dr. Bennett requested that this matter be discussed at the COD Spring Meeting.

E. USFMS Transfers

The matter of voluntary acceptance of USFMS on transfer in 1977 was a topic suggested for the discussion at the Spring Meeting.

F. NIRMP

Dr. Gault reported on his experience with people jumping the gun for seeking positions for those unmatched by the NIRMP. He recommended that the NIRMP announcements be held up until the designated hour. The problems associated with various approaches were discussed.

VIII. Adjournment

The meeting was adjourned at 12:40 p.m.

American College of Surgeons

55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611 AREA CODE 312 — 664-4050 CABLE: AMERCOLSUR

4 March 1977

Ivan L. Bennett, M.D.
Chairman, Executive Council
Association of American Medical Colleges
New York University School of Medicine
550 First Avenue
New York, New York 10016

Dear Dr. Bennett:

The Board of Regents of the American College of Surgeons has received and unanimously approved a report from the American College of Surgeons Graduate Education Committee. This report expressed concern over present developments in U.S. medical education, and requested the Board of Regents to express formally the concern of the American College of Surgeons to various governing bodies in medical education. These include the Coordinating Council on Medical Education, with its parent organizations, the Liaison Committee on Graduate Medical Education, each of the American "surgical" specialty boards, and the parent organizations of these specialty boards.

The Graduate Education Committee is concerned with inappropriate activities and assumptions of the LCGME in its relations with the Residency Review Committees, with their parent organizations and with the CCME. These concerns are detailed below.

First, the LCGME has designated itself as the "accrediting agency" for all residency programs, a role that is actually served by the Residency Review Committees in their recommendation for approval or disapproval of residency training programs. There is not provided a direct appeals process at the interface between the LCGME and the Residency Review Committees. Moreover, the Residency Review Committees are incorrectly presumed to be capable of speaking to policy matters affecting their composition and function, when such matters are within the authority of the Residency Review Committees' sponsoring organizations. For example, the parents of the Residency Review Committees are being bypassed in the development of a new "Structure and Functions" document for the Residency Review Committees. Nor have they been consulted in proposed and recently enacted changes in financing of the Residency Review Committees. There has not been any formal contact with (at least one of) the previous sponsors of the Residency Review Committees before abandoning preexisting agreements for function of the Residency Review Committees.

Thus, the LCGME in matters of policy ignores the ultimate power base for the Residency Review Committees.

Clarification is urgently needed on the relation between the LCGME and the CCME, the overall policy making body in U.S. medical education, speaking for its five parent organizations. It would be highly irregular if the LCGME should attempt to function as a body divorced from relation with the overall policy concerns of medical education addressed by the CCME, while paying inadequate attention to the practical questions properly raised by the Residency Review Committees, acting in accord with policies long established by their parent organizations.

The inadequacies of the LCGME as noted above are compounded by staffing that is not only insufficient and inefficient, but is formally related to one of the LCGME sponsoring organizations, introducing a bias in staff activity that would not exist with an independent staff.

The Board of Regents unanimously approved the following recommendations:

1. The Residency Review Committees should be designated as the approval bodies for graduate education "residency" programs -- in the surgical specialties.

2. All policy matters of the Residency Review Committees relating to the "Structure and Functions", approval of "Special Requirements" ("Essentials"), and the "Guide", should be approved by the active sponsoring organizations (parents) of the Residency Review Committees.

3. Active members of the Residency Review Committees should be selected and appointed to perform one function -- the evaluation of the quality of residency training programs in their specialty. Surgeons would thereby review and accredit the surgical training programs.

4. The LCGME should be designated as the appeals body for graduate education "residency" training programs in the surgical specialties, establishing policy questions in concert with input from the Residency Review Committees.

5. The CCME should define the relation between the CCME and the LCGME, and should review the relation of the LCGME to the Residency Review Committees, including the appeals process.

6. There should be a free-standing, independent staff for the LCGME and the Residency Review Committees. This staff should not be related in any way (i.e., housing, payment, accounting, or other) to any sponsoring organiza-

tion of the LCGME, the CCME, or the "parents" of the Residency Review Committees.

7. Organizations sponsoring the LCGME, such as the Council of Medical Specialty Societies and the American Board of Medical Specialties (multi-disciplinary in their organization) should not be responsible for policy questions regarding graduate education in surgery "residency" programs. This should continue as it was prior to January 1975, when the responsibility was held by the individual specialty groups as sponsors of the Residency Review Committees.

The Board of Regents is requesting the Board of Trustees of the AMA to reevaluate the process by which the AMA approves policy matters relating to the Residency Review Committees, such as revision of the "Special Requirements". Their current procedure has resulted in excessive delays regarding some policy matters relating to the Residency Review Committees.

Sincerely,

William H. Muller, Jr., M.D., F.A.C.S.
Chairman
Board of Regents

WHMJr/lk

association of american medical colleges

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

June 25, 1975

202: 466-5175

Anthony Curreri, M.D.
President
Uniformed Services University
of the Health Sciences
6917 Arlington Road
Bethesda, Maryland 20014

Dear Tony:

The Interim Report of the Defense Manpower Commission, as submitted to the President and the Congress on May 16, has raised new questions about the desirability of establishing a Uniformed Services University of the Health Sciences. The AAMC has received inquiries from several sources asking our position on this issue. The Executive Committee carefully considered this question at its most recent meeting, reviewing both our initial opposition to the legislative proposal and our subsequent support of your diligent efforts to develop a high-quality medical school.

In testimony before the House Armed Services Committee in 1971, the AAMC opposed the establishment of the proposed military medical school. One of our major concerns at that time was the degree of commitment of the Congress to provide adequate funding for the establishment of a high-quality academic institution. As you well know, the education and training of medical students is a costly process, and the quality of that process cannot be left dependent on waivering political support.

The AAMC is now convinced that a high-quality medical school can be established as part of the Uniformed Services University of the Health Sciences. Your success in recruiting a dean and faculty members of high caliber and in generating support for the school in the scientific community has alleviated our earlier concerns and demonstrated that a good school can be created.

The broader issue of whether it is economically or politically wise to continue the establishment of the Uniformed Services University of the Health Sciences is a Federal policy question which ultimately must be settled by the Congress and the President. This Association, as an organization which is now involved in the evaluation of the quality of the educational programs of the USUHS, cannot take a position on this political issue. However, we see no reason why any party would oppose establishment of the school on the basis of the quality of the program.

Sincerely,

Original signed by
J. A. D. COOPER, M.D.

John A. D. Cooper, M.D.

COUNCIL OF DEANS SPRING MEETINGS

I. Evaluation of the Meetings

Forty-five responses were received to the memorandum distributed at the Scottsdale meeting requesting the deans' evaluation of the Spring Meeting program design, format and content; in addition, several letters containing amplifying comments were received. In general, the evaluations were highly favorable: 42 respondents considered the time allotted about right (2 concluded it was too long; 1 thought that an additional day might be warranted.); 40 considered the present design an adequate vehicle for accomplishing the multiple purposes, although many of these offered suggestions for improvement as did the three who thought there should be a redesign; 41 urged the continuation of the meetings at resort-type locations.

The comments on the meeting design and handling the subject matter struck one consistent theme: the program, this year, was overloaded with speakers which limited participation by the individual deans. Nearly one quarter of the respondents suggested that this deficiency be corrected by scheduling small group discussions. A variety of grouping schemes were suggested: size, region, public v. private, urban v. rural, established v. developing, etc.

II. Dates and Location

There were several recommendations that the meeting continue to be held in the sunbelt (Arizona favored over Florida) but scheduled earlier in the year to offer a respite to those suffering from the rigors of a hard winter.

On the basis of the deans' identification of meetings to avoid conflicting with and the AAMC's schedule of events, we have prepared the following list:

Conflicting Dates

FEBRUARY

2/15-16/78 -- LCME Meeting

2/6-9/78 -- LCME Site Visit to Oral Roberts University
-- LCME Site Visit to Bowman Gray

2/21-24/78 -- LCME Site Visit to Univ. of Iowa

2/27-3/2/78-- LCME Site Visit to LSU Shreveport
LCME Site Visit to Medical Univ. of South Carolina

MARCH

3/6-9/78 -- LCME Site Visit to Univ. of Connecticut

3/18-22/78 -- MAP Phase II (tentative)

3/21-22/78 -- LCME Site Visit to Univ. of South Dakota

3/26/78 -- Easter Sunday

-- Executive Council (dates as yet undetermined)

APRIL

4/2/78 -- Society for Pediatric Research

4/5-6/78 -- LCME Meeting

4/9-14/78 -- FASEB

4/10-13/78 -- LCME Site Visit to Harvard

4/17-20/78 -- American College of Physicians
LCME Site Visit to Michigan State

4/22/78 -- Passover

4/24-29/78 -- American Association of Neurology

4/26-28/78 -- American Pediatrics Society

4/29-5/1/78-- AFCR; ASCI; AAP

The preferences of the deans were reported as follows:

1. last week in March -- 10 listed as only preference; 3 as first preference; 1 as 2nd preference

2. first week in April -- 6 listed as only preference; 2 as first preference; 4 as 2nd preference

3. second week in April -- 6 listed as only preference; 3 as first preference; 1 as 2nd preference; 4 as 3rd preference.

4. third week in April -- 12 listed as only preference; 0 as first preference; 3 as 2nd preference; 1 as third preference; 2 as 4th preference

5. fourth week in April -- 2 listed as only preference; 1 as first preference; 2 as 5th preference

Dr. Krevans suggested that we consider scheduling the meeting at a site where skiing might be available as an optional activity. We asked Dr. Ward and Dr. Davern to suggest appropriate sites in Colorado and Utah. New Mexico was also suggested as a possible location and we have asked Dr. Napolitano to evaluate two facilities in Albuquerque. On the basis of these considerations, we have contacted a large number of hotels.

Comparing dates, rates, accommodations and transportation, the following options appear to be preferable:

1. Meet on schedule similar to past but at a new type of facility, where skiing may be possible.

   a. Snowbird (Utah) -- April 23-26; $38/day single, European Plan; ½ hr. from Salt Lake City Airport. Swimming (3 heated pools) and tennis (5 courts, covered) available. Golf available with ½ hr. drive. Skiing through May 1.

2. Meet on same schedule in Arizona

   a. Scottsdale Hilton -- April 23-26; $48/day single, European Plan

   b. Doubletree Inn (Scottsdale) -- April 23-26; $46/day single, European Plan

3. Meet earlier in the year in Arizona

   a. Doubletree Inn -- February 7-11; March 9-12; $52/day single, European Plan

   b. Scottsdale Conference Center -- March 19-22; $90/day single, Full American Plan

4. Meet in Albuquerque

   a. Sheraton Old Town -- April 2-5; April 23-26 (2nd option); $30/day, single, European Plan

   b. Hilton Inn -- April 2-5; April 23-26 $24-30; single, European Plan

Florida does not appear to be a preferred location and the facilities offer non-competitive rates. The Broadmoor (Colorado Springs) is somewhat difficult to get to, although it is available in both February (9-12, at $26-32/day single EP) and April (2-5, at $36-43/day single EP).

Recommendation: Select option #1.

III. Program Content

The returns contained no clear consensus on the preferred program topic. The following subject matter areas each had the support of more than one dean.

a. Political effectiveness at state and local levels.

b. The medical education continuum.

c. The pre-medical -- pre-clinical interface.

d. Continuing medical education.

e. Faculty practice plans.

f. Cost containment

g. Medical school-university relations

h. School reports on innovative programs and/or successful approaches to solving problems.

i. Primary care, ambulatory care, health service issues.

j. Humanities//Humanism

k. Geriatrics

l. Medicine and the Environment

Comment

On the basis of the discussion at the Spring Meeting and past interest displayed by groups of deans, state and local politics may be ripe for consideration. One dean who proposed this topic did so in a fashion which bears repeating:

"AAMC has an extraordinary effectiveness and capacity to influence policy and legislation at the national level but cannot feasibly work at the state and local levels. However, actions at these levels are becoming increasingly critical and various schools are developing coping mechanisms. Others should.

Presentations could include:

--examples of steps taken and several approaches by different schools both public and private;
--consortia have been developed by some schools on a regional basis. The Director of such an organization (not his dean) could have useful insights;
--The National Association of County Governments (Washington, D.C.) and the Association of Mayors could describe their programs;
--A governor's view of state and private Universities and Medical Schools (or a state senator's view) could be interesting;
--An update on HSA's and their interaction with schools, etc."

Cost containment and its implications for medical education and medical center management will likely continue to be a hot issue at the time of the meeting. There are some interesting studies now underway and some medical center activities in this field that may be worthy of reporting.

Continuing medical education. The work of the AAMC Ad Hoc Committee on Continuing Medical Education may well provide a useful basis for a program or a portion of a program on this subject. (See the committee's interim report in the Executive Council agenda)

Faculty practice plans are the subject of a BHM contract-supported AAMC study, are the subject of some litigation now (e.g. the Kountz case) and have been the subject of a very successful workshop conducted by the Group on Business Affairs. It is highly likely that we could address this subject in a productive fashion, but probably only as a piece of the program rather than the entire program.

The pre-clinical -- pre-medicine interface is a subject of grant-supported (Commonwealth Fund) activity in several medical schools. It bears heavily on the medical school-university relations, the continuum of medical education, and would involve an exploration of the teaching of basic sciences, a topic not recently considered by the Council of Deans. There may be little new in the way of ideas, but discussions of recent experiences may be productive.

Alternatives:

a. Pick one or two topics and structure the meeting along the lines of the past meetings. Encourage discussion and participation by limiting the number of speakers to one per hour, with possible addition of an assigned dean reactor.

b. Select a limited number of topics (e.g. 5) conduct five general sessions devoted to these topics followed by 5 simultaneous discussion groups -- one devoted to each topic -- dean selects discussion group of choice.

c. Conduct small group sessions on five or more topics for a substantial part of the meeting with time reserved for reports back to a plenary session with general discussion on each topic.

d. Conduct small group discussions as work sessions. Organize groups of deans with common interests or problems with the task of working on problem identification and prioritization for AAMC-COD.

Comment (d)

This approach seemed very attractive to some deans. However, this alternative may be the most difficult to manage and the most risky in terms of developing a satisfying and productive meeting. A similar objective might be achieved by providing a substantial period for general discussion as part of a business session.

e. Develop program around a show and tell format. Solicit success stories for program committee evaluation.

Comment (e)

This technique was used for last year's "Current and Choice" program at the Annual Meeting. There is some risk of limited applicability of the presentations. A similar objective might be accomplished by calling for a series of short vignettes on a central theme or as complementary to the speaker's presentations -- this begins to merge with our traditional presenter/reactor model.

f. Survey entire COD for:

1) Choice of format from above;
2) Choice of one or several themes from a menu
3) Problem identification, either open-ended (not recommended) or as a means of identifying specific subissues or questions to be addressed on predetermined theme or topic.

Recommendation:

That the Administrative Board select the site and date of the meeting; that it discuss the content and format alternatives presented above for the guidance of Dr. Krevans and the program committee he will appoint.

ANNUAL MEETING PLANNING

The 88th Annual Meeting will be held:

November 6-10, 1977
Washington Hilton Hotel
Washington, D.C.

The theme of the meeting will be "Graduate Medical Education: Critical Issues for the Eighties".

The Council of Deans Program Activities have been planned as follows:

Sunday, November 6

7:30 - 9:30 p.m.	A program with the COD and VA hospital directors on the subject of VA-medical school relations. Various program proposals are under consideration.

Monday, November 7

7:30 - 8:45 a.m.	New Deans' Breakfast This function is sponsored by the Executive Council to welcome new deans into the AAMC.
9:00 a.m.	PLENARY SESSION
	"Historical Development of Specialization and Graduate Medical Education"-- Rosemary Stevens, Ph.D. Tulane University School of Public Health and Tropical Medicine
	"The Hospital/Medical School Partnership"-- Robert A. Derzon, M.D.
	"Options for Financing Graduate Medical Education"-- James Kelly, Ph.D. Executive Vice Chancellor SUNY
	Alan Gregg Memorial Lecture: "From Residency Training to Graduate Medical Education" -- Donald W. Seldin, M.D. Chmn, Dept. of Internal Medicine Univ. of Texas, Dallas

Monday, November 7 (continued)

12 Noon - 1:45 pm.	Council of Deans Administrative Board Luncheon
2:00 - 5:00 pm	Council of Deans Business Meeting
6:30 - 8:00 pm	Deans Reception This function is hosted by the Group on Public Relations and is sponsored by Merck and Co.

Tuesday, November 8

7:30 - 8:45 am	Midwest-Great Plains Breakfast (tentative -- This group frequently requests a breakfast function and the time is reserved for this purpose.)
9:00 am	PLENARY SESSION/ASSEMBLY Chairman's Address; President Carter or Secretary Califano
2:00 pm	Joint Council Program The tentative program developed by the staffs of the three Councils appears on the following pages. Only the Northwestern program participants have been contacted to date.

Wednesday, November 9

7:30 - 8:45 an	Deans of New and Developing Schools (tentative - This group frequently requests a breakfast function and the time is reserved for this purpose.)
9:00 am	Joint Council Program

AAMC ANNUAL MEETING
JOINT COUNCIL MEETING PLANS

Tuesday, November 8

1:30 p.m.	Session I	Transition Between Undergraduate and Graduate Medical Education
2:45 p.m.	Session II	Quality of Graduate Medical Education
4:00 p.m.		Adjourn
4:30 p.m.		Minority Session

Wednesday, November 9

9:00 a.m.	Session III	Influencing Specialty Distribution Through Graduate Medical Education
10:30 a.m.		Coffee Break
11:00 a.m.	Session IV	Institutional Responsibility for Graduate Medical Education
12:30 p.m.		Adjourn

AAMC ANNUAL MEETING
JOINT COUNCIL PROGRAM PLANS

Session I - Moderator: *Julius R. Krevans, M.D., Dean, U.C. San Francisco*

"Transition Between Undergraduate and Graduate Medical Education"

1. The Readiness of New M.D. Graduates to Enter Their GME-1 Year
   - *Dr. Barbara Korsch, USC/Children's Hospital of L.A.*

2. The Search for a Broad First Year
   - *William Hamilton, M.D., U.C. San Francisco*

Session II - Moderator: *A. Jay Bollet, M.D., SUNY Downstate*

"Quality of Graduate Medical Education"

1. The Evaluation of Residents' Performance
   - *John Benson, M.D., American Board of Internal Medicine*

2. Supervisory Relationships in Graduate Medical Education
   - *A House Officer*

3. The Program Director's Responsibility
   - *To be selected*

Session III - Moderator: *David D. Thompson, M.D., New York Hospital*

"Influencing Specialty Distribution Through Graduate Medical Education"

1. The Coordinating Council on Medical Education Should Participate with the Federal Government to Regulate Opportunities for Specialty Training
   - *John Beck, M.D.*

2. The Private Sector Should Avoid Participating with the Federal Government
   - *Theodore Cooper, M.D., Cornell University*

Session IV - Moderator: *Robert L. Van Citters, M.D., U. of Washington*

"Institutional Responsibility for Graduate Medical Education"

1. A Deanship That Has It Operating
   - *James E. Eckenhoff, M.D., Northwestern University*
   - *Jacob R. Suker, M.D., Northwestern University*

2. A Hospital Director Who is in the Operation
   - *David L. Everhart, Northwestern Memorial Hospital*

AAMC POSITION ON THE MODIFICATION OF THE CAPITATION CONDITIONS IN P.L. 94-484

By Memorandum #77-30, June 3, 1977, the members of the Council of Deans were asked to respond to the following question:

> "Should the Association take formal steps to modify P.L. 94-484, by eliminating the capitation condition which requires schools to reserve positions for USFMS' and if necessary substitute for it a one time increase in 1st or 3rd year class size of 5% or 10 students whichever is greater?"

As of June 13, the responses totalled--Yes - 30; No - 12. Those who commented expressed the following reservations, concerns or rationales for no votes.

--No additional enrollment increases are justified.

--The school is currently at peak enrollment and thus the availability of an effective waiver is essential.

--Opening up the bill might, because of the substantial sentiment against capitation, result in its complete loss.

--The provisions may ultimately prove illegal and thus more would be lost by its substitution.

--The local situation will require the school to take FMS and the modification will result in double jeopardy.

Since the returns are far from unanimously in favor of the proposed compromise, the Administrative Board is asked to consider the matter and advise the Executive Council on what the AAMC position ought to be under these circumstances.