



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ADMINISTRATIVE BOARD  
THURSDAY, SEPTEMBER 25, 1980  
9 a.m. — 12:30 p.m.  
INDEPENDENCE ROOM  
WASHINGTON HILTON HOTEL  
WASHINGTON, D.C.**

COUNCIL OF DEANS  
ADMINISTRATIVE BOARD  
September 25, 1980  
9:00 a.m. - 12:30 p.m.  
Independence Room  
Washington Hilton Hotel

AGENDA

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

Minutes

Thursday, June 26, 1980  
9:00 a.m. - 12:30 p.m.  
Independence Room  
Washington Hilton Hotel  
Washington, D.C.

PRESENT

(Board members)

Steven C. Beering, M.D.  
Stuart Bondurant, M.D.  
John E. Chapman, M.D.  
Neal L. Gault, Jr., M.D.  
Richard Janeway, M.D.  
William H. Luginbuhl, M.D.  
Allen W. Mathies, Jr., M.D.  
Richard H. Moy, M.D.  
Leonard M. Napolitano, Ph.D.

(Guests)

Julius R. Krevans, M.D.  
Dan Miller  
Charles B. Womer

(Staff)

Janet Bickel  
Robert Boerner  
John A. D. Cooper, M.D.  
James B. Erdmann, Ph.D.  
Charles Fentress  
Betty Greenhalgh  
Paul Jolly, Ph.D.  
Thomas J. Kennedy, Jr., M.D.  
Joseph A. Keyes  
Richard M. Knapp, Ph.D.  
James R. Schofield, M.D.  
John F. Sherman, Ph.D.  
August G. Swanson, M.D.  
Kathleen Turner  
Marjorie P. Wilson, M.D.

I. Call to Order

The meeting was called to order at 9:00 a.m.

II. Report of the Chairman

Dr. Bondurant began by adding two items to the agenda: H.R. 7036, the Health Research Act of 1980, and a proposal to amend the Social Security Act relating to the reimbursement of primary care residents. These items would be discussed when the appropriate speakers appeared before the Board.

Dr. Bondurant then described an Executive Committee action to resolve a problem which had arisen in regard to the election of emeritus members in the Association. There had existed conflicting guidelines for eligibility. One guideline specified that a candidate for emeritus membership had to have been a member of one of the Councils while

another guideline stated this was not a requisite. The Executive Committee authorized the emeritus membership guidelines to permit the election of an individual who had not been a member of a Council.

A second item brought to the Board by Dr. Bondurant which had been discussed by the Executive Committee concerned the desirability of providing a continuing role for retired Board members in the affairs of the AAMC. Because the people who had gained expertise through service on the Board represented a valuable resource it seemed wasteful not to consult them or at least keep them informed on current issues. The former members themselves appear to desire a modest level of continuing involvement. The Executive Committee, therefore, decided to provide agenda books to retired members of Boards for three years after the completion of their term so they will be able to track issues in which they are interested. This issue led to a discussion by Board members as to the possibility of continuing the involvement of the immediate past chairman of the COD into deliberations of the Board. Questions were raised regarding whether or not the Board could be restructured to include the past chairman and the budgetary considerations of such a move. Staff were requested to prepare an analysis of this subject for discussion at the next Board meeting.

The final item in the Chairman's Report regarded the meeting between the AAHC and AAMC Executive Committees. Dr. Krevans gave the report because Dr. Bondurant could not be present at that meeting which took place on April 18 in Chicago. Dr. Krevans thought the meeting was useful as a device for more effective communication and clarification of matters of mutual interest to the two groups. More meetings of this type were planned for the future. The issue of most pressing concern was how the AAHC could realize its position of developing a better relationship with teaching hospitals. One recommendation presented by John Colloton was that the chairman of COTH be invited to participate in AAHC Executive Council meetings; this recommendation was rejected as being an unsatisfactory way to accomplish AAHC objectives. The AAHC desired a more direct relationship with the directors of university hospitals and planned to invite the directors to future meetings of the AAHC.

The discussion of the meeting with the AAHC Executive Committee led to a discussion of the AAHC study on "The Organization and Governance of Academic Health Centers" and the desirability of an AAMC consideration of it. The Board was reminded that Dr. Hogness, AAHC President, had been invited to present a discussion of the report at a Joint Boards Meeting to occur in conjunction with the June meetings sequence. The discussion was deferred because of his inability to join us at this time; he had already been invited to come in September. Board members responded that, while they welcomed the opportunity to discuss the study with Dr. Hogness, they did not regard this prospect as fully meeting their desires regarding the report. They suggested that the report had several troubling features which warranted further attention by the AAMC and more intensive deliberation than would be likely on

such an occasion. They noted that the report reflected the existence of several underlying issues which should be addressed not only by the COD, but by the CAS and the COTH Boards as well.

III. Approval of Minutes

The minutes of the March 20, 1980, meeting of the Administrative Board were approved as submitted.

IV. Reimbursement of Primary Care Residents

Dr. Knapp presented a description of problems faced in the financing of residency programs which emphasized education through the provision of care in the ambulatory setting. A legislative proposal had been crafted which would permit residents in such programs to bill in their own name and be reimbursed by Medicare Part B. This provision is contained in Title V of H.R. 6802, the Health Professions Educational Assistance and Nurse Training Amendments of 1980. The AAMC, while endorsing the objective of Title V, testified that "its adoption. . . would create intolerable turbulence in graduate medical education. . . [I]t would create two different systems for compensating residents. . . This would engender enormous morale problems and other managerial difficulties."

Subsequently the Academy of Family Practice drafted an alternative approach defining an outpatient setting which can submit charges for payment under Part B without adhering to the requirements of I.L. 372. The Board was asked to review an alternative which would permit an appropriately constituted and supervised clinic to submit charges under Part B for services, if the clinic fulfills the description of primary care residencies supported under Public Law 94-484 and bills in its name rather than in the name of individual physicians. Part A reimbursement for overhead and educational costs would be allowed but costs for resident stipends and supervisory physicians would be excluded.

The Board concluded that neither option was satisfactory and urged the AAMC to oppose both while seeking some alternative to accomplish the same objective.

V. Discussion of COD Spring Meeting 1980; Plans for 1981; Time and Site for 1982

Dr. Moy shared his thoughts on the discussion of the academic preparation of candidates for medicine from the spring meeting. He had summarized the written comments of the deans and had written back to the officials of institutions he had queried before the meeting. He stated his desire that the COD, as a whole, adopt a set of resolutions directed at rectifying the problems identified at that meeting. He then sketched the outlines of four resolutions which he considered candidates for such an action:

(1) the establishment of more open and clear communications between medical school admission committees and undergraduate colleges and universities; (2) the establishment of the baccalaureate degree as a universal prerequisite for admission to medical school; (3) that "premed programs" would no longer be suitable preparation for medical school; (4) the expansion of early admission decisions such that students would be accepted upon completion of their third year, contingent upon completing undergraduate degree requirements. Dr. Moy asked that these resolutions be formulated for Board consideration in the September agenda.

Dr. Bondurant reported that two presentations from the 1980 Spring Meeting had been submitted for publication in The New England Journal. Dr. Eichna's had been accepted and Dr. Barondess was waiting to hear.

Dr. Beering spoke briefly on the 1981 Spring Meeting. Although the Program Committee had not yet met, Dr. Beering posed a couple of suggestions for meeting topics: the possibility of reinviting the AAU and health policy committee representatives and the possibility of making a mini MAP program available to new deans. He welcomed suggestions from the Board.

Dates for the 1982 Spring Meeting were selected: March 28-31. Given the alternatives presented to the Board, the members expressed a preference for South Carolina, authorizing the AAMC staff to make the final selection from the three alternatives presented. Staff has arranged for the meeting to be held at Kiawah Island, Charleston, South Carolina.

#### VI. Relationship with the NBME

Dr. Swanson explained to the Board that the NBME concerns contained in the Executive Council agenda evolved out of the Annual Meeting of the National Board. There are concerns about the National Board and its relationship to the medical school faculties. These concerns are manifested in Board proposals in the areas of its membership and governance, the review and evaluation of the comprehensive qualifying exam implementation, and the relationship of the comprehensive qualifying exam to the Federation of State Medical Boards proposed FLEX I and FLEX II licensure sequence.

#### ACTION

The Board approved the recommendation that the Executive Council appoint an ad hoc committee charged to examine these issues and recommend to the Council actions to preserve and improve the relationship between the medical schools, their faculties, and the National Board of Medical Examiners and its examination program.

VII. H.R. 7036, "The Health Research Act of 1980"

The Senate bill, S.988, had been passed by the Senate with little discussion; Dr. Sherman appeared before the Board to develop AAMC strategy for coping with the House version, H.R. 7036. Dr. Sherman explained that it was essential to convince the House leadership that H.R. 7036 is a controversial bill and would need appropriate time for it to be debated properly. Since the AAMC had been the only visible organization to oppose the bill thus far, further action would be focused on engaging other organizations in taking a more active and visible role in the opposition of H.R. 7036. There appeared to be the prospect of an elected head of another prestigious organization to send letters to each House member urging delay of the Waxman bill. Finally, Dr. Sherman discussed the preparation of a package of materials to be sent to the House members. Board members agreed that although their contacts with their Representatives regarding H.R. 7036 had resulted in negative responses, deans should be urged to continue their efforts and to provide AAMC with feedback as to the results.

VIII. Disposal of Radioactive Wastes from Biomedical Institutions

The position paper in the COD agenda was provided only for information, discussion, and comments. While no formal approval was necessary, the Board was in agreement with the recommendations contained in the paper.

IX. Possible Meeting with National Commission on Research

The Board agreed to meet with Dr. Cornelius Pings, Director of the National Commission on Research, other staff of the Commission, and the CAS Administrative Board preceding the September Board meeting.

X. A Position Paper: The Expansion and Improvement of National Health Insurance in the U.S.

No formal action was needed because the COD had endorsed the position paper at its Spring Meeting. The Board deferred discussion of this until the Executive Council meeting to be held later in the day.

XI. Distribution of Assembly Memoranda

Each year the AAMC distributes about 70 Assembly or Deans' "pink" memoranda, about half of which go to all three Councils. Occasional distribution is made to Distinguished Service Members, many of whom are Vice Presidents at medical centers. The memoranda are of two general types:



--housekeeping memoranda--concerned with internal AAMC matters like the Borden and Flexner Awards announcements, the call for resolutions for the Assembly, and questionnaires; and

--memoranda on policy matters--relating to appropriations, authorizations, and other legislative and regulatory matters. These frequently recommend contact with appropriate Members of Congress and the Administration.

The question of distributing these memoranda to all Vice Presidents of academic health centers was raised at the recent joint meeting of the AAMC and AAHC Executive Committees. Several options for meeting this interest of the Vice Presidents were presented. The Board recommended that the AAMC distribute memoranda on policy issues directly to the Vice Presidents of Academic Health Centers on the AAHC mailing list.

XII. Medical Sciences Knowledge Profile Program Ad Hoc Evaluation Committee

The Medical Sciences Knowledge Profile Program was introduced in 1980 to replace the Coordinated Transfer System which the Association had sponsored since 1970 as a service to those medical schools interested in placing U.S. citizens studying medicine abroad in positions of advanced standing. By late August, data on the characteristics of the 2,144 registrants and their scores will be available. In order to assess the first year's experience of the program and determine what, if any, modifications should be made, it is proposed that a seven to eight member Ad Hoc Committee be appointed to evaluate the program.

ACTION

On motion, seconded, and carried, the Board recommended that the Executive Council approve the appointment of this Ad Hoc Committee.

XIII. Election of Institutional Member

ACTION

On motion, seconded, and carried, the Board endorsed the election of the following institution to Full Institutional Membership in the AAMC:

University of Nevada  
School of Medical Sciences

XIV. Rumored Amendments to Senate Health Manpower Legislation

Schools of chiropractic are not currently eligible for the programs authorized by the current health manpower law. However, Congressional interest in these schools did prompt the Congress to include within that statute a mandate to the Secretary of DHEW to: determine the

national average annual per student educational cost of providing education programs which lead to a degree of doctor of chiropractics; develop methodologies for ascertaining the average annual cost of chiropractic education; and determine the current demand for chiropractic services and developing methodologies for determining if current supply of chiropractic is sufficient to meet this demand.

During the recent Subcommittee markup on the new version of the Senate health manpower bill, plans were announced to submit amendments at the full Committee level adding schools of chiropractic to the list of institutions eligible for certain health manpower programs.

ACTION

On motion, seconded, and carried, the Board recommended that the Executive Council adopt a formal position opposing these amendments.

XV. Tax Treatment of Residents' Stipend

The defeat of H.R. 2222, the publication of the AAMC Task Force Report on Graduate Medical Education, and the favorable Court of Claims decision in the New Mexico case suggest that now may be an appropriate time for the AAMC to seek a legislative clarification of the tax status of house staff stipends.

ACTION

On motion, seconded, and carried, the Board recommended that the Executive Council, being mindful of the potential hazards, carefully monitor the possibility of the AAMC seeking legislative treatment of a portion of the house staff stipend as fellowship.

XVI. Deans' Compensation Survey

The Association has conducted surveys of deans' compensation since 1965, as a service to members of the Council of Deans. The results are distributed in a confidential memorandum to the Council and are not used for any other purpose by the Association. The Board was asked to advise staff on the desirability of continuing the survey and to suggest any modification which might improve its utility.

Board members were in agreement that the survey continue to be conducted but stated that receipt of the report in the fall would prove far more useful to them. They also agreed that there needed to be a better distinction between fringe benefits and perquisites on the survey.

XVII. AAMC Annual Meeting

The Board members looked briefly at the Preliminary Schedule of the Plenary Sessions for this year's Annual Meeting. Suggestions regarding the Council of Deans and potential program topics included: a meeting with Dr. Pings, Director of the National Commission on Research; and a meeting with directors of Continuing Medical Education programs. Dr. Bondurant was requested to decide on these matters as he considered appropriate.

XVIII. New Business

Dr. Napolitano brought an article appearing in a cancer center director's newsletter to the Board's attention. The article identified medical school deans as the chief obstacle to the development of centers with the level of institutional autonomy desired by the directors. Dr. Napolitano pointed out that continued agitation by special interest groups for organizational aggrandizement was having a disruptive effect on the governance of medical schools. Board members agreed that centers created difficult governance issues for medical schools. Dr. Bondurant's presentation to the President's Panel on Biomedical Research presented in Florida in 1975 was suggested as one of the best available descriptions of the complexity of the governance issues created by the presence of centers.

XIV. Adjournment

The meeting adjourned at 12:40 p.m.

## PROPOSED COD RESOLUTIONS REGARDING MEDICAL SCHOOL ADMISSIONS

At the last meeting of the COD Administrative Board, Dr. Moy stated his desire that the Council of Deans follow up its deliberations at the spring meeting by adopting an appropriate set of resolutions relating to medical school admissions. In his view, there are a set of problems which can most appropriately be addressed by the deans acting in concert. In part he is seeking some tangible product that would tend to mitigate the skepticism that he encountered among undergraduate educators that medical school deans would really be concerned about these issues. His hope is that the resolutions would have symbolic value to stimulate better communication.

The problems the resolutions are intended to address relate to the anti-intellectual and anti-academic behavior introduced into our undergraduate institutions by the pressures to get into medical school. In response to the survey distributed to the Council members in advance of the final program session in Fort Lauderdale and collected afterwards, all 36 respondents replied to the question, "Are the apparent pre-med pressures, disruptions and behavior based more on reality or myth?" Their responses are summarized in a report prepared by Gerry Schermerhorn, Department of Medical Education, Southern Illinois University, as follows:

*All 36 respondents replied to this item, with 25 opting for "reality." One of these stated that he was "not certain, however, if it is a function of medical school imposed competition or innate competitiveness of aspirants." Another blamed "inadequate communication of actual policies and practices of admissions processes." One person felt that the reality was "evidenced by continued struggle after entrance into medical school." Another suggested that colleges must "share part of the blame." One qualified the reality response, noting the problem was "overstated numerically, but a reality because the overstatement is generally believed." One person suggested that these pressures were "real and destructive and could be avoided by appropriate channels." A few persons felt that these pressures, disruption and behaviors were actually a myth, and one suggested that they represented a "general cultural phenomenon."*

*Six persons suggested the problems cited were a combination of myth and reality. One stated: "In that the myth is perceived as reality, the question is moot. Therefore, rigorous steps must be taken to change the mythology." Two respondents felt that the problems were probably overstated, and one noted: "students are sufficiently resilient to withstand what happens." One person stated: "the situation can be improved by some of the suggestions for early (delayed) admission and criteria for medical school preparation."*

The resolutions proposed by Dr. Moy are responsive to the suggestions proposed by respondents to the first question in the survey requesting a specification of "changes" which ought to receive the Council's consideration categorized by Schermerhorn under the heading, Premedical Education and Admissions:

*Changes in admissions procedures were recommended by nine of the respondents. Among the changes noted were the following: assessment of the basic character of applicants; reduction of mandatory admission requirements to the absolute minimum; guaranteed preadmissions; flexibility to permit a one-year delay in matriculation after admission; elimination of the pre-med major. Opinion varied regarding appropriate timing for admission: one person favored early admission after two years of college; another respondent emphasized the importance of admitting only those persons who had earned at least a bachelor's degree. Another respondent suggested selection of students at the high school level. One person emphasized the importance of increased liberal arts in college.*

Dr. Moy's formulation of the resolutions (to which he invites appropriate editorial modifications) are as follows:

1. *The Council of Deans calls upon its member schools to establish by appropriate mechanisms more open and clear communications between medical school admission committees and undergraduate colleges and universities. The goal from the medical schools would be a clear definition of minimum requirements and expectations and from the colleges and universities a better definition of the quality of the course taken in addition to grades achieved.*
2. *The Council of Deans strongly endorses establishing the baccalaureate degree as a universal prerequisite for admission to medical school (with a note of exception for those medical schools whose programs are specifically designed to provide both undergraduate and professional education).*
3. *The Council of Deans resolves to advise undergraduate universities and colleges that so-called "premed programs" will no longer be considered suitable preparation for medical school. It would thus be expected that the student would enroll in and complete an established academic program, defined by the undergraduate faculty, in either the sciences or liberal arts that would also include the minimum course requirements for medical school.*
4. *The Council of Deans strongly recommends expansion of early admission decisions contingent upon completing undergraduate degree requirements. These decisions should be made sufficiently early so that selected students can choose course work in their senior year unencumbered by pressures for admission.*

Because of their direct impact on and relationship to the business of the Group on Student Affairs, Mr. Robert Boerner, Director of the AAMC Division of Student Programs and W. Albert Sullivan, Jr., M.D., Associate Dean of

the University of Minnesota Medical School and National Chairman of the GSA, were invited to review and comment upon the proposed resolutions. Their commentaries follow.

These commentaries cite previous actions of the GSA and the AAMC related to admissions decisions and describe a state of affairs that questions the appropriateness of these resolutions.

There are additional reasons for proceeding conservatively at this time:

--The AAMC has announced its intention to conduct a major review of "The General Education of the Physician." Funds are being sought and present indications are that it will get underway shortly.

Query: Will the adoption of a set of resolutions by the COD at this time preempt or undercut this effort before it begins? Would not a preferable approach be that the Council of Deans convey the explicit message that this is an area that needs explicit attention in this overall review?

--The stake of the GSA in the area of admissions is unmistakable. Should not any formal action be undertaken in collaboration with, or at least after, having sought the advice of this group? While the GSA Chairman has been informed of these deliberations, there is no possibility of a formal GSA consideration of these resolutions in advance of the COD meeting on October 27.

COMMENTARY BY ROBERT BOERNER  
DIRECTOR, DIVISION OF STUDENT PROGRAMS, AAMC

At the 1980 spring meeting of the Council of Deans the negative impact of the admission requirements and processes of the U.S. medical schools upon the students of and curricula at undergraduate colleges was discussed. It was perceived that pressure to get into medical school fosters anti-intellectual and anti-academic behavior at undergraduate institutions. Pursuant to the spring meeting discussion the following specific recommendations have been suggested for consideration by the Council of Deans Administrative Board at its September 1980 meeting.

1. The Council of Deans calls upon its member schools to establish by appropriate mechanisms more open and clear communications between medical school admission committees and undergraduate colleges and universities. The goal from the medical schools would be a clear definition of minimum requirements and expectations and from the colleges and universities a better definition of the quality of the course taken in addition to the grade achieved.

Background: In response to what was perceived as "the admission crisis" in the early 1970's the AAMC Group on Student Affairs (GSA) in cooperation with health professions advisors made a series of recommendations intended mainly to reduce the workload of medical school admission officers and committees and additionally to reduce pressures on premedical students and medical school applicants. The primary focus was on the four stage admission plan (attached). It was intended first to provide more and better information to the premedical students and their advisors about the admission criteria of the medical schools both in the schools' own publications and in the Medical School Admission

Requirements published annually by the AAMC. Schools were urged to provide detailed information about accepted students each year so that premedical students and advisors could decide for themselves the qualifications necessary for acceptance at each school.

Secondly, the four stage plan created the Early Decision Plan (EDP) which provides qualified students who apply to the one medical school they wish to attend by August 15 the opportunity to learn by October 1 whether they have been admitted. In the past several years 850 to 900 students per year have been admitted under EDP saving the processing of 6,500 to 7,000 multiple applications annually.

Stage 3 of ~~the plan provided for uniform dates for the sending out of~~ acceptance letters by the schools. December 15, January 15, February 15, March 15, April 15 and May 15 were the generally accepted dates. Use of uniform dates provided candidates a standard period each month during which to expect acceptance notices. It also helped some schools to establish a monthly routine for processing applicants and sending notices. Stage 4 proposed that beyond May 15 admission would proceed on a continuous or "rolling" basis. It was understood that rejection notices would continue to be sent as soon as decisions were made.

Concurrently, a uniform evaluation form (attached) was developed by the medical school admission officers in consultation with health professions advisors to encourage uniformity and completeness of the applicant information supplied from the undergraduate schools. These forms were distributed to advisors in packets which included both a form for the chief advisor to complete and one which could be used to summarize several separate faculty evaluations.



The Medical School Admission Requirements book published by the Association assists applicants and their advisors by providing information about the medical school admission process principally in its chapters on premedical planning, deciding whether and where to apply to medical school and the medical school application and selection process in addition to the individual school entries in the last chapter. Tables on such subjects as courses required for entrance, acceptance by undergraduate major, undergraduate grades of students accepted to medical school, distribution of acceptees by grades and MCAT scores, and first-year enrollment by residence and sex provide useful data.

2. The Council of Deans strongly endorses establishing the baccalaureate degree as a universal prerequisite for admission to medical school (with a note of exception for those medical schools whose programs are specifically designed to provide both undergraduate and profession education.)

Background: According to the Medical School Admission Requirements for the 1979 entering class 20 schools required the baccalaureate degree, 73 schools preferred the baccalaureate degree, 31 schools did not require a baccalaureate degree, and of those preceeding, 15 schools offered a baccalaureate/M.D. degree option.

3. The Council of Deans resolves to advise undergraduate universities and colleges that so-called "premed programs" will no longer be considered suitable preparation for medical school. It would thus be expected that a student would enroll in and complete an established academic program, defined by the undergraduate faculty, in either science or liberal arts that would also include the minimum courses for medical school.

Background: Medical School Admission Requirements in recent years has included

a table showing acceptance to medical school by undergraduate major. In 1978-79 1,557 applicants or 4.2 percent were premed majors. Six hundred sixty seven or 42.1 percent were accepted. In contrast 13,865 or 37.8 percent of applicants majored in biology and 5,909 or 42 percent were admitted, and of 4,344 chemistry majors or 11.9 percent of applicants 2,296 or 52.9 percent were admitted. The average acceptance percentage for all majors was 45.1.

4. The Council of Deans strongly recommends expansion of early admission decisions contingent upon completing undergraduate degree requirements. These decisions should be made sufficiently early so that selected students can choose coursework in their senior year unencumbered by pressures for admission.

Background: ~~As mentioned earlier the present Early Decision Program with an~~ application processing time of June 15 to August 15 and an admission decision deadline of October 1 matriculates approximately 850 to 900 applicants per year. Assuming that students would have to have an admission decision close to August 15 in order to change a first term, senior schedule established in the spring, on the present timetable medical schools and AMCAS would have to begin processing applications on May 1; the application deadline would be July 1; and admission committees would have until August 15 to render a decision.

## ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

#### A. Background

Unless appropriate steps are taken by medical school deans and admissions officers, approximately 45,000 applicants are expected to file some 315,000 applications for only about 15,000 places in the 1975-76 entering class. The magnitude of excessive paperwork and expensive processing in store is brought home even more forcefully when one calculates the above to equal 21 applications for each available place.

On the recommendation of the AAMC Council of Deans, an extensive study was conducted during the past year of possible ways to help alleviate the growing admissions crisis. This study included a thorough investigation of the technical feasibility of an admissions matching plan as one possible solution. The staff committee was chaired by Dr. Robert L. Thompson and included Drs. James Erdmann, Roy Jarecky, Davis Johnson and Paul Jolly. Staff consultants included Mr. Dario Prieto and Dr. James Schofield. Extensive technical assistance was provided by the Systems Research Group of Toronto, Canada.

Results of the above feasibility study plus alternative solutions were presented on March 12, 1973 to a 13-member advisory panel representing the ~~COD (1 member), CAS (1), CSA (5), CSR (2) and the AAHP (4 members).~~ Although it was apparent that a matching plan was technically feasible and relatively inexpensive, it was the consensus of the panel and of AAMC staff that an alternative four-stage plan would be more feasible at this point in time and could make a major contribution to the alleviation of the admissions crisis. The alternative plan was favorably received by the COD Administrative Board on March 15; and on March 16 the AAMC Executive Council approved the suggested procedure for discussing and acting on the proposal. (See Section C).

#### B. Description of Plan

The proposed four-stage plan consists of the following inter-related elements:

- 1) Information Dissemination
- 2) Early Decision Plan
- 3) Uniform Acceptance Date(s)
- 4) Rolling Admissions

Stage 1 of the proposed plan attempts to reduce unnecessary paperwork by means of improved communication whereas stages 2-4 seek to reduce paperwork and to make other improvements by modifying the admissions schedule. Special attention is called to the following aspects of these four stages:

- 1) Stage 1 (Information Dissemination) could conceivably reduce the potential pool from 45,000 to perhaps 40,000 and might well lower the average number of applications per applicant from the current 7 to perhaps 6. The above would result in

\*This revised explanation, prepared by AAMC staff, contains modifications suggested at the Western Regional Meetings.

W#8335-Revised

an overall reduction of 75,000 applications. The publicizing of more specific information about the characteristics of accepted students has long been urged by applicants and by premedical advisors and many schools have started doing this (see attached sample). Past research by Potthoff suggests that with adequate communication, the number of applicants tends to move towards approximately twice the number of available places.<sup>#</sup> Specific suggestions for improved information are given below:

- a) More detailed information is needed about the characteristics of applicants accepted and enrolled for inclusion in the annual Admissions Requirements Book (see Attachment No. 1 for sample).
  - b) Similar information is also requested annually for AMCAS materials. These data in the past have generally been even more specific than those in the Admissions Book.
  - c) More specific information is needed in individual school publications about the characteristics of the applicant pool and the results of the admissions process -- a matter for local initiative.
  - d) The integration of AMCAS and non-AMCAS files, together with data on enrolled students, is underway. This integrated system will facilitate the production of improved reports about applicants and students. The Association will be able to respond to requests for special studies based on these data. This system will provide the principal data to be used by the new AAMC Division of Student Studies to be activated on July 1, 1973.
  - e) A Pilot Program of Information to Preprofessional Advisors is in process. The results of the first two mailings indicate that this is a much needed service. This program reports summary data on the national pool of applicants as well as data about action taken on applicants from the specific undergraduate school.
- 2) Stage 2 (Early Decision Plan) could eliminate approximately 18,000 applications if 20% of the 15,000 places were filled via this plan. Further details concerning EDP are provided in Attachment No. 2. The rationale for more widespread use of EDP is as follows:
- a) Many entering students who are so outstanding that they have an excellent chance of admission to their first choice school could decide on this choice a full year before matriculation.
  - b) Without an expanded EDP, these students would probably apply to an average of six additional schools to assure themselves admission.

<sup>#</sup>Potthoff, E.F. The Future Supply of Medical Students in the United States. J. Med. Educ., 35:223-237, 1960.

- c) The added applications are largely a waste of time, effort and money for the six schools and for the exceptional applicant. This time, effort and money could better be spent by the schools in evaluating applicants requiring more thorough consideration.
- 3) Stage 3 (Uniform Acceptance Date[s]) would allow any rejected EDP applicant adequate time to file additional applications. A single uniform date (e.g. February 15) would also allow the advisors ample opportunity to submit their evaluations on these and on all non-EDP candidates. Even more importantly, the uniform date would enable the medical school to consider its remaining pool as a whole and would permit the applicant to receive and consider all of his offers simultaneously. It is also recommended that he have a full month (rather than the current two weeks) to compare schools on financial and other grounds and to reach a firm decision, thus greatly reducing the current problem of widespread "musical chairs." (Although the Western OSR endorsed the single uniform acceptance date, the Western GSA preferred January 15, February 15, and March 15 and all but one of the Western Schools intend to initiate this plan on a regional basis for their 1974-75 entering classes. The Western Advisors urgently desired some type of uniformity to help reduce the psychological pressures on applicants whose friends receive acceptance letters on a daily basis and to facilitate their advising and evaluation preparation.)
- 4) Stage 4 (Rolling Admissions) would enable schools to complete balancing their classes. Since only a small part of the class would be filled after the Uniform Acceptance Date(s), admissions staffs should have a much less demanding Spring work schedule than is now the case. This, in turn, should help prepare them for the slightly heavier Summer and early Fall work schedule that could result from more widespread adoption of the Early Decision Plan.
- 5) Rejection notices would continue to be mailed as promptly as possible after all of the rejectee's pertinent admissions credentials have been received and evaluated by the medical school. This will allow the rejected applicant to start making alternative plans as early as possible.

#### C. Method of Implementation

Proposed next steps are as follows:

- 1) Approval in principle of the proposed four-stage plan at the Spring, 1973 regional meetings of the GSA, OSR and AAHP.
- 2) Official approval of the four-stage plan (slightly modified if necessary) at the Fall, 1973 national meetings of the GSA, OSR and COD.
- 3) Implementation of the national plan starting in November, 1973 to help alleviate the admissions crisis for the 1975-76 entering class.
- 4) Implementation of some or all of the proposed plan on a local or regional level starting in the Spring of 1973, if desired, to help simplify the application process for the 1974-75 entering class.

D. Summary of Recommended Action

Finally, to simplify consideration of this proposal at the remaining regional meetings, the following summary of recommended action is presented:

<u>STAGE</u>	<u>RECOMMENDED ACTION BY MEDICAL SCHOOLS</u>
1 - Information Dissemination	Agreement to publicize more detailed information about the characteristics of applicants accepted and enrolled at each medical school.
2 - Early Decision Plan	Agreement to consider admitting some of each school's entrants under EDP, starting locally or regionally for 1974-75 and nationally for 1975-76.
3 - Uniform Acceptance Date(s)	a) For the 1974-75 entering class, agreement this Spring by as many schools as possible to offer no acceptances other than EDP until a specified date (e.g. 2/15) or series of dates (e.g. 1/15, 2/15 and 3/15).  b) For the 1975-76 entering class, agreement to offer no acceptances other than EDP until a specified date (e.g. 2/15) and to try to fill most of one's remaining places on that date. (No formal action on 3b is needed until the national meetings this Fall.)
4 - Rolling Admissions	Agreement to limit this method of notification to the relatively small portion of the class not filled during stages 2 and 3.

- Attachments: 1) Sample Description of Accepted Students  
2) Description of Early Decision Program

DGJ/sg 3/28/73

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Sample Statement of Characteristics of a Class of Accepted Medical Students

For the 1973 entering class, over 800 applications were received for 80 places. Only 380 were seriously considered; 340 from in-state and the rest from neighboring states without medical schools. Accepted students for the 1972 entering class had the following characteristics: GPA, mean of 3.4, 92% above 3.0; MCAT, mean 580, 95% above 500; age, mean of 22, range 18-32; sex, 15% female (acceptance rate the same for male and female); minority group members, 12%; residence, 97% from in-state, 3% from neighboring states without medical schools; undergraduate major, 61% biology or chemistry, remainder from a wide variety of fields including engineering, English, history, mathematics, music, psychology, sociology, etc.; overall acceptance rate, 33% of those seriously considered received acceptances (i.e. 92 of 281 seriously considered applicants were offered places to obtain a class of 71 freshmen). Disadvantaged students from in-state are strongly encouraged to apply.

DGJ/sg 3/28/73

W#8335 R/1

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

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

1. Permits the applicant to file a single early application prior to September 1, 1973.
2. Guarantees a prompt decision from the school, usually by October 1, 1973.
3. Allows the applicant who is not accepted by a given school as an Early Decision candidate to be reconsidered and possibly accepted by that school as a regular candidate early in the admissions season.

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

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

\* \* \* \* \*

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

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

\* Schools not participating in AMCAS

DGJ/slw 3/16/73 W#8335R/2

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Name of Student \_\_\_\_\_ Social Security Number \_\_\_\_\_

LETTER OF EVALUATION

1. In what capacity have you been associated with the student?

A. Instructing:  Lecture  Laboratory  Seminar  
Specify course(s): \_\_\_\_\_

B.  Academic Advising

C.  Socially

D.  Other (Please specify) \_\_\_\_\_

E.  Not Acquainted

How well do you know the applicant?

A.  Very Well B.  Fairly Well C.  Slightly

How long have you known the applicant? \_\_\_\_\_

2. What would be your attitude toward having this student in a responsible position under your direction?

A.  Definitely would want him/her;

B.  Would want him/her;

C.  Would be satisfied to have him/her;

D.  Would prefer not to have him/her;

E.  Definitely would not want him/her;

F.  Unable to judge.

3. To your knowledge, has there ever been any disciplinary action involving this student which might indicate unsuitability for medicine?

Yes  No

If yes, please provide full explanation in Narrative Comments Section or in a letter.

4. Please indicate with a check (✓) for each factor below your opinion of this applicant's position on that factor relative to other students at your institution.

FACTORS	OUTSTANDING Top 5%	EXCELLENT Next 10%	VERY GOOD Next 20%	GOOD Next 40%	FAIR Next 20%	POOR Bottom 5%	NO BASIS for Judgment
MOTIVATION for MEDICINE: genuineness and depth of commitment.							
MATURITY: personal development, ability to cope with life situations.							
EMOTIONAL STABILITY: performance under pressure, mood stability, constancy in ability to relate to others.							
INTERPERSONAL RELATIONS: ability to get along with others, rapport, cooperation, attitudes toward supervision.							
EMPATHY: sensitivity to needs of others, consideration, tact.							
JUDGMENT: ability to analyze a problem, common sense, decisiveness.							
RESOURCEFULNESS: originality, skillful management of available resources.							
RELIABILITY: dependability, sense of responsibility, promptness, conscientiousness.							
COMMUNICATION SKILLS: clarity of expression, articulateness.							
PERSEVERANCE: stamina, endurance							
SELF CONFIDENCE: assuredness, capacity to achieve with awareness of own strengths and weaknesses.							

Applicant's Name and Address

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The above student is applying for admission to medical school, and has given your name as a reference. The Admissions Committee would appreciate your frank opinion of this student on the form attached.

In selecting applicants to medical school, the Admissions Committee depends very much on evaluations of the applicants supplied by undergraduate faculty members. Since the number of qualified applicants to medical schools far exceeds the number of first year class positions available, we are anxious to select those individuals whose accomplishments, personal attributes, and abilities indicate that they have the greatest potential for medical training and practice. Therefore, we ask you to provide a thoughtful and completely frank appraisal of the applicant in relation to other premedical students you have known at your institution. If you do not know the applicant well enough to complete this form, please notify him/her and return the form. Your early reply is appreciated since the applicant will not be evaluated without your appraisal.

This form includes a section in which to check responses, a narrative comments portion, and a summary evaluation question. Please complete each.

GUIDELINES FOR NARRATIVE COMMENTS ON APPLICANTS

Use guidelines below for completing page 2 of the attached form.

The following has been suggested by admissions committee members as important information they would like to have included in narrative comments on each applicant. Please compare this applicant to other applicants from your institution.

1. *Personal attributes:* Please emphasize assets and liabilities, particularly those qualities which would indicate special promise or potential problems for medical education or practice. Description of the applicant's actions in particular situations would help to clarify your appraisal.
2. *Academic achievement:* Since transcripts are available, comments should amplify the information on the applicant's academic record including the following:
  - A. Academic achievement relative to others from your college or university, e.g., class standing.
  - B. Consistency of performance.
  - C. Extenuating circumstance which might account for atypical grade(s) or course load(s).
  - D. Degree of strenuousness of class(es)--honor section(s), etc.
3. *Employment, extra-curricular or avocational activities:* Since this is given on the application, mention only if you can elaborate meaningful on them. Any activities which indicate motivation for medicine or concern for others are of special interest. If involvement was extensive, what was the effect on academic achievement?
4. *Honors received, academic or nonacademic:* Specify the competition or degree of selectivity of such awards, e.g., how many were awarded in what student population?

NARRATIVE COMMENTS (Please see accompanying sheet for suggested guidelines. Include extra pages if you wish.)

Please check your overall evaluation of the applicant for medical school.

- A.  Outstanding Candidate
- B.  Excellent Candidate
- C.  Very Good Candidate
- D.  Good Candidate
- E.  Fair Candidate
- F.  Poor Candidate
- G.  No Basis for Judgment

Name (print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Department \_\_\_\_\_

Date \_\_\_\_\_ School \_\_\_\_\_

City/State/Zip \_\_\_\_\_

COMPOSITE LETTER OF EVALUATION FOR PREMEDICAL COMMITTEE OR ADVISOR

This form may be used by the chief advisor or the premedical committee to summarize individual evaluations of an applicant that have been presented by three or more faculty members. Names of faculty members submitting individual appraisals of the applicant should be entered in the spaces provided across from the name of the appropriate department listed below.

Symbols from the key given below (A, B1, B2, etc.) should be entered in the appropriate boxes to indicate the information obtained from the individuals evaluating the applicant. For example, if a biology and an English professor had been associated with the student through lectures then both symbols "B1" and "E1" would be placed in the box under question 1A, Instructing: in front of Lecture. If a physics professor has known the student socially, then the appropriate symbol "P1" is entered in the box at 1C Socially.

Please compare the applicant to other premedical students at your institution.

Key:

- A. Preprofessional Advisor
- B1. Biology Department
- B2. Biology Department
- C1. Chemistry Department
- C2. Chemistry Department
- E1. English Department
- E2. English Department
- P1. Physics Department
- P2. Physics Department
- O1. Other (Specify Department)
- O2. Other (Specify Department)

Name:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. In what capacity have you been associated with the student?

A. Instructing:

Lecture       Laboratory       Seminar

B.  Academic Advising

C.  Socially

D.  Other (Please Specify)

E.  Not Acquainted

How well do you know the applicant?

A.  Very Well      B.  Fairly Well      C.  Slightly

How long have you known the applicant? \_\_\_\_\_

\_\_\_\_\_

2. What would be your attitude toward having this student in a responsible position under your direction?

- |   |  |
|---|--|
| <p>A. <input type="text"/> Definitely would want him/her</p> <p>C. <input type="text"/> Would be satisfied to have him/her</p> <p>E. <input type="text"/> Definitely would not want him/her</p> | <p>B. <input type="text"/> Would want him/her</p> <p>D. <input type="text"/> Would prefer not to have him/her</p> <p>F. <input type="text"/> Unable to judge</p> |
|---|--|

3. To your knowledge, has there ever been any disciplinary action involving this student, which might indicate unsuitability for medicine?

Yes       No      If yes, please provide full explanation in Narrative Comments Section or in a letter.

4. Please indicate with identification codes below the opinions of this applicant's position on that factor relative to other premedical students at your institution.

FACTORS	OUTSTANDING Top 5%	EXCELLENT Next 10%	VERY GOOD Next 20%	GOOD Next 40%	FAIR Next 20%	POOR Bottom 5%	NO BASIS for Judgment
MOTIVATION for MEDICINE: genuineness, and depth of commitment							
MATURITY: personal development, ability to cope with life situations.							
EMOTIONAL STABILITY: performance under pressure, mood stability, constancy in ability to relate to others.							
INTERPERSONAL RELATIONS: ability to get along with others, rapport, cooperation, attitudes toward supervision.							
EMPATHY: sensitivity to needs of others, consideration, tact.							
JUDGMENT: ability to analyze a problem, common sense, decisiveness.							
RESOURCEFULNESS: originality, skillful management of available resources.							
RELIABILITY: dependability, sense of responsibility, promptness, conscientiousness.							
COMMUNICATION SKILLS: clarity of expression, articulateness.							
PERSEVERANCE: stamina, endurance.							
SELF CONFIDENCE: assuredness, capacity to achieve with awareness of own strengths and weaknesses.							

Please indicate the overall evaluation(s) of the applicant:

Number and Percent of premedical students in each category of premedical advisor's ratings

	<u>Number</u>	<u>Percent</u>
_____ Outstanding Candidate	_____	_____
_____ Excellent Candidate	_____	_____
_____ Very Good Candidate	_____	_____
_____ Good Candidate	_____	_____
_____ Fair Candidate	_____	_____
_____ Poor Candidate	_____	_____
_____ No Basis for Judgment	_____	_____

Name (Print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Department \_\_\_\_\_

Date \_\_\_\_\_ School \_\_\_\_\_

City/State/Zip \_\_\_\_\_



UNIVERSITY OF MINNESOTA  
TWIN CITIES

Office of Admissions and Student Affairs  
Medical School  
Box 293 Mayo Memorial Building  
420 Delaware Street S.E.  
Minneapolis, Minnesota 55455  
(612) 373-8091  
Offices at 139 Owre Hall

August 8, 1980

Dr. Richard Moy  
Dean and Provost  
Southern Illinois University  
School of Medicine  
P.O. Box 3926  
Springfield, IL 62708

Dear Dr. Moy:

In my role as National Chairman of the Group on Student Affairs (GSA) the recent motions which you have recommended to the Council of Deans have been brought to my attention. I refer specifically to your letter of July 2, 1980 to Mr. Joseph Keyes and would like to discuss the items individually because of their relationship with the Admissions Officers of all the U.S. Medical Schools.

1. Each Medical School has listed in the Medical School Admissions Requirements 1981-82 (MSAR) its individual requirements so that there should be no question as to the minimum requirements of each school. Basically there seem to include approximately two years of Chemistry, which would include Organic Chemistry; one year of Physics; and one year of Biology. Most of the schools also require an understanding of higher Mathematics and fortunately, nearly every school has non-science requirements that are spelled out but for which there is a fair degree of option on the part of an individual applicant.
2. Although personally agreeing with you about the requirements of a Baccalaureate degree, and we rigidly adhere to it at the University of Minnesota Medical School with which I am presently associated, I think there are possible situations in which the requirement of a degree might not be a necessity - particularly so in the case of some of the older students who had made a career change and for whom getting a degree might indeed be onerous or financially difficult.
3. If you will look at Table 2B on page nine in the 1981-82 booklet "Medical School Admissions Requirements" you will note that although Biology and Chemistry are the majors of approximately 49% of the applicants, there are over 34 separate majors listed with only 4%

Re: Dr. Richard Moy

of the applicants listing "pre-medicine" as a major. Our own undergraduate University of Minnesota no longer offers "pre-medicine" as a major and I think you will find this true of many Universities. For undergraduate colleges, though, who have such a program it might be considered intrusive and presumptuous were we to tell them that they could no longer have this specific major. Certainly, I agree with you in this concept and if I personally could select an undergraduate major for a freshman in college I would suggest History, Anthropology, or Greek. Any one of these three would give the broadly based education that I think appropriate, and the applicant could indeed get the required science courses along with the best of a Liberal Arts education. Regrettably, though, in dealing with over 35,000 applicants, 128 Medical Schools, and multiple undergraduate colleges, I am not certain that we could achieve this unanimity of thought - as laudable as it might be.

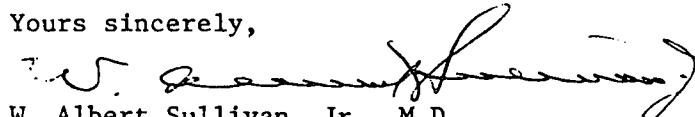
4. The majority of Medical Schools do participate in the Early Decision Program and rather routinely all Medical Schools indicate that students are required to finish the coursework in which they indicated they would be enrolled. In our own school, here, we consider no grades after the summer session one year prior to the date of matriculation. This means, therefore, that most applicants will have had to have taken the required science courses by the end of their third year in college and thus have the fourth year to complete their degree, hopefully taking many of the Liberal Arts courses which most of us would like to have. The New MCAT presupposes, by the way, that the examinee will have had the basic pre-medical science courses prior to taking the examination.

In summary, Dr. Moy, I think we can have unity amongst the Medical Schools without having uniformity. Moreover, we must recognize that a certain amount of diversity is not only acceptable but quite necessary for the intellectual health of the 128 Medical Schools in the country. The vigor and strength of medical education - certainly since the Flexner report - attests to the fact that although certain minimal criteria should be met, a rigidity of thought requiring all schools to be exactly the same would be a real restriction of the academic freedom which those of us in higher education praise so highly.

In view of the fact that I will be out of the country at the time of the next meeting of the Council of Deans, I am taking the opportunity of expressing these sentiments to you with a copy to Dr. Bondurant for this to be available to those Deans attending the September meeting.

Be assured, Dean Moy, that the GSA members welcome discussion such as this and I hope that you will recognize the degree with which all GSA members are interested in Medical Education and their desire to turn out the best possible product, namely, the well-educated and competent physician.

Yours sincerely,

  
W. Albert Sullivan, Jr., M.D.  
Associate Dean

WAS:ey





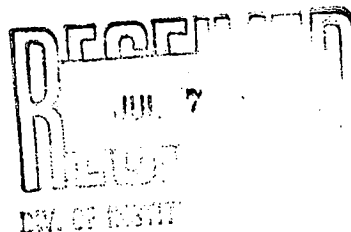
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area code 904 • 392-2761

WILLIAM B. DEAL, M.D.  
Vice President for Health Affairs  
KENNETH F. FINGER, PH.D.  
Associate Vice President for Health Affairs

July 1, 1980

Stuart Bondurant, M.D., Dean  
University of North Carolina  
School of Medicine  
Chapel Hill, NC 27514



Dear Stu:

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 2:00 PM EDT on June 24, 1980 by telephone conference call. At that time 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  
William H. Luginbuhl, M.D.  
Dean  
University of Vermont College of Medicine

Member-at-Large of the Council of Deans  
David R. Challoner, M.D.  
Dean  
St. Louis 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:

Council of Deans Representatives to the Executive Council  
Edward J. Stemmler, M.D.  
Dean  
University of Pennsylvania School of Medicine

Richard H. Moy, M.D.  
Dean and Provost  
Southern Illinois University School of Medicine

College of Medicine • College of Nursing • College of Pharmacy • College of Health Related Professions • College of Dentistry  
College of Veterinary Medicine • Shands Teaching Hospital and Clinics • Veterans Administration Hospital

EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Stuart Bondurant, M.D.  
July 1, 1980  
Page 2

Richard Janeway, M.D.  
Dean  
Bowman Gray School of Medicine  
Wake Forest University

Chairman-Elect of the Assembly

The nominating committee has authorized me, as chairman, to exercise my discretion in the deliberations of the AAMC nominating committee with the understanding that, all else being equal, I will support the nominee of the Council of Academic Societies.

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 to the work of the Association.

Thank you for the opportunity to serve in this capacity.

Sincerely,

*Will*

William B. Deal, M.D.  
Vice President for Health Affairs  
and Dean, College of Medicine

WBD/hb

cc: William F. Kellow, M.D.  
M. Roy Schwarz, M.D.  
Robert B. Uretz, Ph.D.  
W. Donald Weston, M.D.  
✓ Joseph A. Keyes

THE COMMITTEE MET AGAIN ON THURSDAY, SEPTEMBER 11, TO RECOMMEND A PERSON TO FILL THE VACANCY CREATED BY THE RESIGNATION OF THEODORE COOPER, M.D. FROM THE BOARD AND THE EXECUTIVE COUNCIL. THE COMMITTEE SELECTED:

John W. Eckstein, M.D.  
Dean  
University of Iowa  
College of Medicine