

COUNCIL OF DEANS
ADMINISTRATIVE BOARD

Wednesday, June 29, 1983
5:30 pm - 7:00 pm
Map Room

AGENDA

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- I. Presentation: "Health Care Cost Containment"
-- William H. Luginbuhl, M.D.

Thursday, June 30, 1983
9:00 am - 1:00 pm
Dupont Room

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- II. Report of the Chairman
- III. Approval of Minutes 1
- IV. Action Items
- A. Plan of Action for Dealing with PGY-2 Match Issues
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- B. ECFMG Constitutional Issues
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- C. Loan Forgiveness for Physicians in Research Careers
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

Thursday, April 21, 1983
9:00 am - 1:00 pm
Dupont Room
Washington Hilton Hotel
Washington, D.C.

PRESENT

(Board Members)

Arnold L. Brown, M.D.
D. Kay Clawson, M.D.
William B. Deal, M.D.
Richard Janeway, M.D.
Louis J. Kettel, M.D.
William H. Luginbuhl, M.D.
Richard H. Moy, M.D.
M. Roy Schwarz, M.D.
Edward J. Stemmler, M.D.

(Staff)

Robert Beran, Ph.D.
John A. D. Cooper, M.D.
Debra Day
John Deufel
James Erdmann, Ph.D.
Charles Fentress
Sandra Garrett, Ph.D.
Paul Jolly, Ph.D.
Thomas J. Kennedy, Jr., M.D.
Joseph A. Keyes, Jr.
Mary McGrane
Anne Scanley
John F. Sherman, Ph.D.
Kathleen Turner

(Guests)

Steven C. Beering, M.D.
Edward J. Brandt, Jr., M.D., Ph.D.
Pamelyn Close
Jack Graettinger, M.D.
Ed Schwager

I. Call to Order

The meeting was called to order at 9:05 am.

II. Report of the Chairman

Dr. Janeway reported on several items considered by the Executive Committee at its meeting preceding the Board's:

- The Executive Committee discussed and gave preliminary approval to a proposed 1984 income and expense budget for the AAMC. The final budget will be presented to the Executive Council for its consideration at the June 30, 1983 meeting. Action by the Executive Committee was required at this time to permit salary notification letters to be distributed to the staff on May 1st.
- The Committee discussed the dispute between the ACE and the residents of One Dupont Circle--The National Center for Higher Education, relating to rent increases and the equity position of the tenants. The AAMC President was authorized to withhold the execution of the lease until the ACE gave assurances which appropriately reflected the intention of the Kellogg Foundation in awarding the grant to permit the establishment of the National Center.
- Based on the less than enthusiastic response by the pharmaceutical companies in committing funds, the AAMC's planning for a National Research Awareness Month has been halted. Dr. Janeway noted that those who were involved in the negotiation process agreed that the contacts made with the leadership of the pharmaceutical industry were quite valuable and would provide a valuable entree for future working relationships.
- Dr. Madoff from Tufts University presented a proposal to the AAMC regarding the joint sponsorship of a conference to focus on a prototype method for determining the cost of medical education within HMOs. The Executive Committee judged that it was inappropriate for the Association to be involved in a forum which defined and set uniform methods for determining those costs. However, the Committee did agree to cooperate with Dr. Madoff in sponsoring a Sunday evening forum at the Association's 1983 Annual Meeting to discuss various methods used by members to assess costs associated with training medical students in an HMO setting.

In addition, the AAMC agreed to jointly publish with Dr. Madoff, the results of their respective surveys which looked at the degree of involvement of medical students in HMOs.

- Dr. Janeway commended the informal session held on the preceding evening with Dr. Edward Brandt, Assistant Secretary for Health and described it as both useful and worthwhile.
- Dr. Janeway summarized the position of the Executive Committee regarding the Baby Doe. It was the consensus of the group, that, just as the AAMC had refrained from taking a position on the abortion issue, the Association should not take a position at this time. The

philosophical differences that most likely exist among the AAMC argued for a position of neutrality, especially at the current stage of litigation surrounding the regulation.

Dr. Cooper noted that he did write to Secretary Heckler objecting both to the process of issuing the regulations and the proposed methodology used to monitor compliance, i.e., posted notices and hotlines.

A lengthy discussion ensued in which Board members stated their strong opposition to the regulations, and argued that, should the issue arise in a form that called upon the AAMC to state a position, the Association ought not to remain silent.

It was suggested that we support the President's Commission for the Study of Ethics and Biomedical and Behavioral Research as presenting balanced treatment of the issues and recommended a more appropriate mechanism for resolving them.

It was the consensus of the Board that if it became necessary to take a position before the Board met again, the Executive Council should authorize a statement opposing the regulations on the grounds that: they were based on an unacceptable strained interpretation of the 1973 law, they specified an inappropriate level of government involvement in the relationship between parents, physicians, and others involved in the difficulty and heavily emotion laden process of decision-making on this important matter.

III. Approval of the Minutes

The minutes of the January 20, 1983 meeting of the Administrative Board were approved without correction.

IV. Action Items

A. Criteria for Entry into Graduate Medical Education in the United States

The Board noted that an apparently inadvertant omission from the third paragraph of the policy statement operated to exclude a whole group of graduates from non-LCME approved schools. The first sentence in the third paragraph should read: "In addition to passing the English language skills examination, all graduates and trainees from schools not accredited by the LCME or the AOA, as well as all fifth pathway students, shall be required to pass a written exam designed to ...".

Concern was also expressed regarding the standards used to determine a passing grade on the examination. It was suggested

that the language be changed to read: "The standards for passing this examination shall be equivalent to the standards required to pass the NBME Part I and Part II examinations."

On motion, seconded and carried, the Board endorsed the recommendation to the Executive Council as amended.

B. Elaboration of Transitional Year Special Requirements

Ed Schwager expressed the views of the Organization of Student Representatives Administrative Board regarding the definition of broad based curriculum as described in the Special Requirements for the Transitional Year Residency.

After substantial discussion, mostly directed at clarifying the OSR's intent and identifying appropriate language to effectuate it, the Board agreed to amend lines 18 and 19 on page 25 of the document to read: "at least 50% of the resident's curriculum must be spent in two or more of the broad based clinical disciplines as defined above."

On motion, seconded and carried, the Board recommended to the Executive Council the endorsement of the Elaboration of Special Requirements for Transitional Year programs as amended.

C. The President's Commission for the Study of Ethics in Medicine and Biomedical and Behavioral Research: AAMC Support for Renewal

The Board discussed at length the efficacy of supporting Senator Kennedy's proposal for continuation of the President's Commission or a substitute proposal initiated by Senator Qualye which suggests the use of "a non-political existing body to pursue the goals of the Commission (e.g., the National Academy of Sciences, the Hastings Center and the Kennedy Institute at Georgetown University." The Board strongly favored the availability of a forum for the discussion of important ethical issues related to biomedicine. However, the Board argued that the role of government should be to support the exploration of such issues without directing or controlling either the process or outcome.

On motion, seconded and carried, the Board recommended that the Executive Council support an active effort to have a body, preferably not government, to explore the general concerns in the sphere of ethics, and therefore, by implication does not support the staff's recommendation for the renewal of the President's Commission at this time.

D. Regulation on Nondiscrimination on the Basis of Handicap

Discussed under the Report of the Chairman.

E. MCAT Related Projects

Dr. Luginbuhl expressed concern regarding both the security of the MCAT and the specific ways in which the exam is used. He agreed to meet with Jim Erdmann, Director of the AAMC's Division of Educational Measurement and Research, to collect additional data and suggested that this issue be placed on a future Board agenda.

Ed Schwager also related the concern of the student representatives regarding the purpose and the usefulness of the essay exam. Discussion ensued regarding the need for measuring the level of literacy of the medical students and assessing their ability to communicate both orally and in writing. The Board agreed that all of the ramifications of the essay exam had not been identified or analyzed. For this purpose, a pilot program was needed. It was suggested that one important consequence of the essay exam would be the signal it would send to the undergraduate faculty that students who are interested in medicine will need to be literate and have developed skills in oral and written communications.

On motion, seconded and carried, the Board recommended to the Executive Council that the staff continue the development of an essay exam and a Diagnostic Service Program for initiation on a pilot basis. Commendation was given to Dr. Erdmann for his excellent presentation on the MCAT at the COD Spring Meeting.

F. Loan Forgiveness for Physicians in Research Careers

Due to time constraints, and the perceived importance of this issue on the part of several Board members, it was recommended that this item be put on the June agenda.

G. OSR Report

Due to time constraints, the OSR Report was deferred to the Joint Administrative Board luncheon.

V. Discussion Items

A. Recap of the 1983 COD Spring Meeting

It was the consensus of the group that the 1983 COD Spring Meeting was excellent and commendations were given to the Planning Committee members for their efforts.

B. Preliminary Discussion of the 1984 COD Spring Meeting Program and Topics

This agenda item was deferred to the June meeting of the Board.

C. Preliminary Discussion of the 1985 COD Spring Meeting Dates and Location

Mr. Keyes reviewed with the Board possible meeting dates and locations for the 1985 COD Spring Meeting. The Board expressed a preference for early meeting dates in March.

On motion, seconded and carried, the Board unanimously approved the return to The Cottonwoods Resort in Scottsdale, Arizona for its 1985 COD Spring Meeting. The dates for this meeting will be confirmed at the June Administrative Board meeting.

D. AAMC 1983 Annual Meeting COD Program/Special Session

It was the consensus of the Board that it would like to have the Council's time at the Annual Meeting addressed to issues of particular interests of the deans. No specific topics were identified at this time, but there was a forceful recommendation that the COD Business Meeting format be altered.

E. Proposed Consultant Roster Service

The members was asked to review the proposal for a Consultant Roster Service and to forward their comments to Mr. Keyes at their convenience. It was agreed to discuss this item further at the next Board meeting in June.

F. Trends in Graduate Medical Education Positions

On motion, seconded and carried, the Board recommended that the staff be requested to study and develop a recommended course of action for consideration at the June Board meeting.

G. Status of Indirect Costs

Dr. Sherman reported that the Association perceived the issues surrounding indirect costs as quite divisive and that the faculties were becoming more militant than many college Presidents and Deans may appreciate. He hoped that efforts could be implemented at the institutional level to reduce the tension and explore the issues surrounding the Indirect Costs Controversy. It was suggested that the AAMC recommend that each institution mount a voluntary cost containment effort to control indirect costs. This proposal was not adopted.

Dr. Sherman reported that the CAS had passed a resolution to support the increase in the NIH FY84 budget by \$487 million as a primary way to resolve the short term problem. The CAS added a codicil which stated that if it became necessary to reduce the budget these reductions would be shared between direct and indirect

costs giving priority funding for direct costs. The Board agreed with the CAS to support increasing the appropriations, but rejected the idea that any shortfalls be shared between direct and indirect costs.

On motion, seconded and carried, the Board recommended to the Executive Council that it endorse the request made to Director Wyngaarden by the AAU, ACE, and the NASULGC, namely, that DHHS establish a group including representatives of ACE, AAU, NASULGC, AAHC, ASM, FASEB, and the AAMC to examine: 1) whether the existing criteria for determining allowable costs of research are appropriate to biomedical research, or whether some special condition attached to that research require different criteria, and 2) whether methods of appropriating the costs among university functions and among research projects were fair. The AAMC should also continue to add its support for the increases in the NIH budget to take a visible position in recognizing that indirect costs are a real concern to the member institutions.

H. Legislative Update

- Dr. Kennedy stated that the AAMC had joined in a coalition with other scientific societies, voluntary health groups, agricultural interests, and the pharmaceutical industry to promote a study of the animal welfare issue and oppose all legislation pending completion of the study. Toward this end, Dr. Kennedy urged the Board members to contact their senators and to have them join Senators Hatch and Kennedy in co-sponsoring the study in the Senate and suggested that faculty members send telegrams to their representatives supporting the Madigan (R. Ill.) study amendment and opposing the Walgren (D. Penn.) animal welfare provisions in the NIH renewal legislation. This legislation is scheduled for markup by the full House Energy and Commerce Committee.
- Dr. Kennedy reported on the Administration's request for the NIH budget and indicated that the Administration had redesigned the budget to provide 5,000 new and competing grants, but had done so through cost shifting. The bottom line of the budget remains at \$4,077.1 million.
- Dr. Kennedy announced that of the 60 centers which are coming up for competing renewal grants, 49 will be terminated. The termination of these programs is predicated on the anniversary date of the project period rather than on the quality of the programs. The funds originally allocated for the centers have been shifted into the project grant pool.
- After discussion of the NIH renewal legislation and the appropriateness of the Association supporting or opposing the Waxman bill and/or a proposed substitute Madigan bill, the board concluded that it could not support either proposal at this time.

On motion, seconded and carried, the Board proposed that the Executive Council ask the staff to prepare a statement of principle which supports the value of NIH and the need for it to function free from political interference. The statement would then be used as a metric against which to evaluate legislative proposals and would be given wide publicity.

I. Four Regional Seminars on Prospective Payment

Dr. Cooper reported that after the COD Spring Meeting discussion of the new Prospective Payment legislation and the effects on academic medical centers, the Southern Deans endorsed the proposal that the AAMC conduct a special seminar on the topic. The staff of the AAMC agreed that it was an important and appropriate venture and consequently designed four 1-1/2 day seminars scheduled for:

June 8-10	at the Shamrock Hilton in Houston
July 6-8	at the Claremont Hotel in Oakland, CA
July 13-15	at the Hyatt O'Hare in Chicago
July 20-22	at the Franklin Plaza in Philadelphia

The focus of the seminars will be on issues related to prospective payment and modified physician payment regulations.

Invitations will be sent to the deans who will be encouraged to invite up to four people. It is suggested that the invitees be the chairmen of medicine and surgery and the hospital administrator(s) of their affiliated hospital(s).

The faculty will be composed of the staff of DOTH and outside speakers. Dr. Cooper stressed that the objective of the seminars is not to make the dean an expert in the details of reimbursement, but rather to gain insight regarding the mechanics of DRG's and strategies that will have to be implemented if the academic health center is to thrive and prosper.

In addition, the seminars should facilitate the process of institutional accommodation to the demands of the new system by alerting the key clinical chairman of the new constraints on hospital payments and the effects on physician practice. The Board complemented the leadership of the Association on its rapid response to constituent concerns regarding additional information of prospective payment.

VI. Adjournment

The meeting was adjourned at 1:15 pm.

FACULTY EMPLOYMENT POLICIES AND PROCEDURES

I. Background

Policies and procedures related to tenure and its implications for medical schools have been issues of significant concern of the staff of the Association of American Medical Colleges as evidenced by the following activities:

- In February 1979, the Department of Institutional Development published Tenure and Promotion in Schools of Medicine: A Policy Simulator. With support from the National Library of Medicine, Kenneth L. Kutina, Ph.D. and his staff at Case Western Reserve University designed and tested a faculty flow simulation model to determine the implications of current and proposed appointments, promotions, and tenure policies.
- In September 1980, the Department published its second report entitled, Academic Tenure in Medical School Settings. Also supported by the National Library of Medicine, Cheves McC. Smythe, M.D. and Amber Jones surveyed five medical schools to assess their practices and attitudes towards tenure. In addition to these reports, the topic of tenure has been most recently explored at both the 1981 and 1982 AAMC Annual Meetings.
- In 1981, the Women in Medicine Program of the AAMC presented a session entitled, "Symposia on Academic Tenure" at which Amber Jones, Vice President for Planning at Albany Medical College, Dr. Edward Stemmler, dean of the University of Pennsylvania School of Medicine, and Dr. Paul Friedman, professor of radiology at University of California, San Diego presented various perspectives on tenure and its impact on academic medicine.

At the 1982 AAMC Annual Meeting, the Group on Business Affairs invited Amber Jones to present the keynote address entitled, "The Paradox of Academic Tenure: Less for More" in which she reviewed the purposes, processes and products of traditional tenure policies. At an additional GBA session, Dr. Stemmler gave an enlightening presentation entitled, "Modifying Faculty Policies in a Changing Environment--A Case Presentation" in which he described the non-tenure clinical educator track recently implemented at the University of Pennsylvania School of Medicine.

Considering the wide circulation of the Association's two major reports on tenure and the multiple presentations given at well-attended Association forums, the following evidence leads us to believe that tenure is still a matter of current interest and deserves continued investigation:

- At the 1982 Officer's Retreat, the issue of tenure again emerged and inquiries were made regarding the Association's investigation efforts.

- At the 1982 Spring Meeting, Mrs. Betty Higgins, director of the AAMC's Faculty Roster met with eight institutional representatives interested in exploring the multiple and diverse faculty appointment policies and procedures in the medical schools. As a result of that meeting, Mrs. Higgins will circulate a periodic letter describing changes in faculty promotions and tenure policies. In addition, Mrs. Higgins is developing a datagram for the Journal of Medical Education based on the information received from the Faculty Roster which is updated annually by the Deans Office.
- The staff of the Department of Institutional Development also receive periodic requests for information on promotion and tenure policies and procedures. Specific issues have included: descriptions of co-terminous appointments; number of institutions with extended probationary periods; and institutions involved in developing alternatives to traditional tenure tracks.
- Tenure has also been selected by the Southern Deans as a possible focus of their Fall Meeting.
- The most recent evidence of the currency of this topic emerged this spring at a planning meeting convened by John Duefel, director of administration and finance, and nine members the Group on Business Affairs.*

The purpose of this meeting was to design a questionnaire on faculty employment policies and procedures in effect in U.S. and Canadian medical schools. Consistent with their past publications, the Group on Business Affairs wished to develop a directory containing information on policies and procedures currently in effect and those undergoing change at the institutions and the names of resource persons to contact for additional information. The directory will establish a network system among medical school managers whose institutions share similar employment characteristics and who may be anticipating or are involved in modifications of these policies and procedures. In developing the questionnaire it became evident that tenure was the most complex and controversial issue confronting this group.

*The members of the GBA planning committee included: Robert E. Reynolds, associate dean for administration, Johns Hopkins University School of Medicine (Chairman); Frank Evans, assistant dean for financial affairs, Creighton University School of Medicine; E. Alun Harris, associate director of administrative and fiscal affairs, University of Alabama School of Medicine; Amber B. Jones, Vice President for Planning, Albany Medical College of Union University; Cyril Kupferberg, associate dean for management and finance, The University of Cincinnati School of Medicine; Mario Pasquale, vice chancellor for administration, University of Colorado School of Medicine; Clarence Stover, associate dean for administration, University of North Carolina at Chapel Hill School of Medicine; Richard Webster, associate dean for administration, University of Southern California School of Medicine; Sandra S. Garrett, senior staff associate, Department of Institutional Development, AAMC; and Betty Higgins, staff associate, Division of Operational Studies, AAMC.

Because of their continuing involvement in tenure related issues, the staff of the Department of Institutional Development is collaborating with the staff of the Office of Business Affairs to develop the questionnaire. The first draft was distributed to the Council of Deans Administrative Board at its April 21, 1983 meeting. Based on the feedback received from the Board members, and members of the GBA planning committee, a revised questionnaire is now enclosed for your review and consideration.

II. Discussion

According to Chart and Ford "over the next several decades tenure policies and procedures will significantly influence the quality of the faculty, nature of the curriculum, attractiveness of the profession and the flexibility and financial liquidity of each institution." Institutions therefore have a substantial stake in the present and future tenure policies that they support.

Economic conditions are severely testing the adaptability of traditional tenure policies. The number of faculty approved for tenure is beginning to exceed the resources available for faculty support. As a result, one of two events seems to be occurring: (a) the number of tenure lines are implicitly, if not explicitly, limited so that the committee can fill only those lines that are available, or (b) the school or university begins to deny tenure to qualified candidates on the basis of unavailable resources. These events need to be tracked.

While medical school faculties tend to be less "tenured-in" than their university counterparts, some basic science departments are completely composed of tenured faculty. As a result, these departments have limited opportunities to recruit new members and initiate new areas of research. Systems for "freeing-up" tenured-in departments need to be explored.

The development of the non-tenure clinical track is becoming more common. This appointment description provides a mechanism for keeping clinical educators on the faculty. Institutions considering this option will benefit from the experiences gained at other institutions which have undergone these changes.

Probationary periods are being extended and the consequences on faculty promotion and tenure policies need to be investigated.

The projected enrollment of medical students is decreasing and may affect the established faculty-student ratios in both the clinical and basic sciences. Methods for projecting future faculty needs will have to be developed and tested.

Given the extended mandatory retirement age and the limited growth phenomenon, medical schools will need to identify new strategies for recruiting, appointing, and retaining young faculty members. Simultaneously, the medical schools will need to implement strategies for retraining tenured faculty no longer involved in productive research as a means of keeping these members vital contributors to the institution.

Many medical schools are currently analyzing and redefining their basic tenure policies and procedures. According to a 1981 study by Alun Harris, Ph.D., associate director of administration and fiscal affairs at the University of Alabama School of Medicine, thirty-three medical schools are currently considering or are actively involved in changing their tenure policies. At present the Association is not able to track these changes. The proposed questionnaire could serve as such a mechanism.

III. Questions for Discussion

1. Is the proposed questionnaire a worthwhile project?
2. Will the data generated from such a questionnaire be useful to the management decisions currently facing the deans?
3. Are there additional issues that need to be addressed?
4. How should the questionnaire be disseminated? Who should be responsible for completing the questionnaire?

1. Chait, Richard P., Ford, Andrew T. Beyond Traditional Tenure: A Guide to Sound Policies and Practices. Jossey-Bass, Inc., San Francisco, California. 1982.

RECOMMENDATION: That the Board review, critique and endorse the Faculty Employment Policies and Procedures document and questionnaire.



association of american medical colleges

MEMORANDUM

TO: U.S. and Canadian Medical School Deans

FROM: John A.D. Cooper, M.D., Ph.D.

SUBJECT: Questionnaire on Faculty Employment Policies and Procedures

The enclosed questionnaire was initially developed in response to a request from the Group on Business Affairs who wished to survey current faculty employment policies and procedures at U.S. and Canadian medical schools. The information collected from the questionnaire will be collated and presented in a directory, in abstract form, including the name of a resource person to contact for additional information.

In the process of developing the questionnaire, it became evident that tenure was the most complex and controversial issue confronting the GBA. Because of their continued involvement in tenure related issues, the staff of the Department of Institutional Development collaborated with the staff of the Office of Business Affairs to develop the questionnaire.

As a result of this collaboration, the questionnaire is being sent to both you and your business officer. I understand that your business officer is prepared to assist you, at your direction, in completing the questionnaire. He will then assume responsibility for getting the completed questionnaire back to the AAMC. We recognize that some of the items address sensitive issues at your institution and therefore may be difficult or impossible to answer.

If you have any questions, please contact Joe Keyes at (202) 828-0510. Thank you for your participation in this effort.

Attachments



association of american medical colleges

MEMORANDUM

TO: GBA Principal Business Officers

FROM: Mario Pasquale, Chairperson

SUBJECT: Questionnaire on Faculty Employment Policies and Procedures

The enclosed questionnaire on Faculty Employment Policies and Procedures came about as the result of the enthusiastic response shown by the GBA membership to last year's annual meeting program about tenure and its financial implications. There has been a recognition within the GBA for some time that many of us are struggling to devise new methods of operation to meet today's harsh financial realities. One enormous stumbling block to some of our institution's fiscal health is having to live with faculty employment policies and procedures that were formulated in another era.

This questionnaire has been designed to uncover salient characteristics of policies and procedures currently in effect at our institutions as well as what new ones are being considered and who can be contacted if additional data is needed. It is hoped the publication that results from this questionnaire will be of assistance to medical school management as they attempt to deal with or change long-standing policies and procedures.

Because this topic is of great interest to other segments of the medical education community, the GBA approached the Administrative Board of the Council of Deans and the staff of the AAMC Department of Institutional Development about participating in the project. They were very enthusiastic about it and have been instrumental in designing the questionnaire. As a result of this collaboration, the questionnaire is being sent to the dean of your institution as well as yourself. It is our hope that you and the dean will work together to complete the questionnaire or that the two of you will locate the most appropriate person within your institution to do so. In whatever way your institution chooses to handle the completion, would you please assume responsibility for getting it back to the AAMC.

The questionnaire is easy to complete. You may find that some of the questions involve sensitive issues at your institution and some may be difficult or impossible to answer.

Please return the questionnaire to the AAMC by _____. We expect the results to be published this fall.

D R A F T

QUESTIONNAIRE
FACULTY EMPLOYMENT POLICIES AND PROCEDURES
IN UNITED STATES AND CANADIAN MEDICAL SCHOOLS

Institution

Date

Questionnaire prepared by

Title

INSTRUCTIONS:

1. Most questions can be answered with a yes/no response. When multiple responses are listed, check all the items that apply. When explanations are requested, respond in the spaces provided.
2. All questions refer to full time faculty unless otherwise noted.
3. The term "institution" refers to that entity checked in question #1 (medical school and/or university).
4. Those questions designated with an asterisk apply only to those institutions which have a tenure system. If your institution does not have such a system, pass over those questions.
5. Please attach a copy of the faculty appointment and promotion policies currently in effect at your institution. Make sure that the source of the statement and the effective date of the by-laws or policy document are included. If specific policies and procedures have recently undergone revision, please include the dated revisions.

I. Current Faculty Employment Policies and Procedures

A. Definition

1. Do the attached policies and procedures apply to:

- _____ only the medical school
- _____ the total university
- _____ the total university with exceptions for the medical school

Please describe any exceptions.

2. Are any of these policies and/or procedures currently undergoing formal review and/or revision?

yes _____
no _____

If yes, describe the areas under review/revision:

3. Does your institution have annual written employment contracts for faculty such as appointment certificates, letters of renewal of appointment, etc.

yes _____
no _____

- *4. Does your institution have a tenure appointment system?

yes _____
no _____

5. Have your faculty elected a collective bargaining agent?

yes _____
no _____

If yes, has there been any negotiation or contractual agreement between the medical school or university and the collective bargaining agent affecting the tenure policies of the institution?

yes _____
no _____

6. Does your institution provide an alternative form of guaranteed continuing employment, (for example, a five-year contract) other than a tenured appointment?

yes _____
no _____

B. Tenure Appointment

*7. Does your institution have an official definition of tenure?

yes _____
no _____

*8. Does your institution have official eligibility criteria for obtaining tenure?

yes _____
no _____

*9. Does the acquisition of a tenured position guarantee:

- _____ teaching salary
- _____ percentage of some stated figure
- _____ total salary
- _____ tenure of title only
- _____ tenure of hospital appointment
- _____ other (please describe)

*10. Is there a difference between the titles given to tenured and non-tenured faculty?

yes _____
no _____

Please list the specific titles given to your faculty:

	Basic Sciences	Clinical Sciences
Tenured Faculty	_____	_____
	_____	_____
	_____	_____
	_____	_____
Non-Tenured Faculty	_____	_____
	_____	_____
	_____	_____
	_____	_____

*11. Is there a minimum rank that must be achieved before being eligible for tenure?

yes _____
no _____

If yes, what is the rank? _____

*17. Is there a time limit after which a faculty member no longer has the option to move from one track to another?

yes _____
no _____

18. Does your institution offer faculty appointments that are co-terminous with appointments at affiliated hospitals?

yes _____
no _____

If yes, are faculty members who have co-terminous appointments at hospitals eligible for tenure?

yes _____
no _____

*19. If a faculty member, holding a co-terminous appointment is granted tenure, what does "tenure" guarantee?

teaching salary _____
percentage of some stated figure _____
total salary _____
tenure of title only _____
other (please explain) _____

*20. Does your institution have criteria for granting promotions to non-tenured faculty?

yes _____
no _____

*21. Are the non-tenure earning track appointments generally granted as:

_____ one-year renewable contracts?
_____ multi-year contracts?
_____ indefinitely renewable contracts?

D. Probationary Period

*22. What is the length of the probationary period for tenure in the:

Clinical sciences? _____
Basic sciences? _____

*23. Are there any exceptions to the length of the probationary period in the:

clinical sciences? yes _____
 no _____
 basic sciences? yes _____
 no _____

*24. Can the probationary period be waived?

yes _____
 no _____

*25. If a faculty member does not receive tenure at the end of the probationary period, will employment be terminated?

yes _____
 no _____

*26. Does your institution usually waive the probationary period and automatically grant tenure to a faculty member who acquired tenure at another institution?

yes _____
 no _____

*27. Does your institution conduct formal evaluations of faculty during the probationary period?

yes _____
 no _____

E. Faculty Composition

*28. What percentage of your basic science faculty has tenure? (please check)

0%	_____	41-50%	_____
1-10%	_____	51-60%	_____
11-20%	_____	61-70%	_____
21-30%	_____	71-80%	_____
31-40%	_____	81-90%	_____
		90-100%	_____

What percentage of your clinical science faculty has tenure? (please check)

0%	_____	41-50%	_____
1-10%	_____	51-60%	_____
11-20%	_____	61-70%	_____
21-30%	_____	71-80%	_____
31-40%	_____	81-90%	_____
		90-100%	_____

*29. Is there a limit on the number of tenured positions granted at your institution?

yes _____
no _____

If yes, percentage of faculty positions can be tenured? _____

*30. Has the number of faculty granted tenure over the last five years:

- _____ greatly increased
- _____ slightly increased
- _____ remained the same
- _____ slightly decreased
- _____ greatly decreased

*31. Does your institution grant tenure to Ph.D's whose primary appointments are in clinical departments?

yes _____
no _____

*32. How many tenured faculty have left your institution in the last five years?

- | | |
|-------------|--------------------|
| 0 _____ | 16-20 _____ |
| 1-4 _____ | 21-25 _____ |
| 5-10 _____ | more than 25 _____ |
| 11-15 _____ | |

How many of these position(s) have been filled?

*33. Is your institution limited in its ability to promote junior faculty because the available tenured positions are filled?

- _____ very limited
- _____ somewhat limited
- _____ not limited

If limited, is this more of a problem in the:

basic sciences? _____ clinical sciences? _____

*34. Is your institution currently involved in manpower studies to assess the number of tenured faculty positions that will be available.

yes _____
no _____

F. Fringe Benefits and Perks

*35. Do non-tenured earning track faculty receive the same fringe benefits as tenured faculty?

yes _____
no _____

36. Does your institution offer a tuition waiver for dependents of faculty members?

yes _____
no _____

*37. Are non-tenured faculty allowed to take sabbatical leave?

yes _____
no _____

38. Does your institution have a policy regarding the number of days a faculty may be engaged in private consulting activities?

yes _____
no _____

39. Is there a stated cap on the amount of funds that can be earned outside of the institution by a full-time faculty member?

yes _____
no _____

40. Does your institution have a merit pay or bonus system for rewarding exemplary actions of a faculty member?

yes _____
no _____

G. Financial Implications

*41. Who has the direct responsibility for meeting the financial obligation incurred by tenured positions?

- _____ academic department
- _____ college of medicine
- _____ university
- _____ hospital
- _____ other (please explain)

*42. Are the number of tenured positions contingent upon available funds?

yes _____
no _____

yes _____
no _____

I. Future Needs

51. Is your institution considering a nine-month contract for non-tenured basic sciences faculty?

non-tenured yes _____
 no _____

tenured yes _____
 no _____

* 52. Is your institution considering eliminating the tenure appointment system?

yes _____
no _____

If yes: _____ for clinical faculty only
 _____ for basic sciences faculty only
 _____ for all faculty

* 53. Is your institution considering not offering any new tenured positions/appointments?

yes _____
no _____

* 54. Is your institution considering placing a freeze on the number of eligible tenured positions in specific departments?

yes _____
no _____

55. Is your institution currently involved in re-tooling faculty for other areas of academic pursuit?

yes _____
no _____

J. Information Systems

*56. Does your institution maintain a faculty data base which includes:

_____ the age distribution of full time faculty
_____ an estimate of faculty between the ages of 65-70 years
 who will voluntarily retire in the next five years?
_____ the percentage of faculty who voluntarily leave the
 institution each year?

- _____ the percentage of faculty who continue through the probationary period and do not earn tenure?
- _____ the average time between promotions from assistant to associate professor; from associate to full professor?
- _____ other data bases

Please forward the completed questionnaire to:

AAMC
One Dupont Circle
Suite 200
Washington, DC 20036

Dear _____ (Dean, Hospital CEO):

The AAMC's Management Education Programs Planning Committee urged that the Association develop a system to provide its members with information regarding consultants who have direct experience in dealing with management issues arising at academic medical centers. To accomplish this objective, the staff of the Department of Institutional Development is developing a Consultant Roster Service. We will maintain profiles submitted by individual consultants including brief biographical information, descriptions of specific services provided to academic medical centers, related activities, publications, and references. Most important is the identification of persons who have provided useful services in the past, together with an appraisal of their areas of expertise.

To develop these files, we seek your assistance in identifying consultants. The criteria for inclusion in the Roster is that the consultant or consultant group must have performed work at a member institution, and be recommended by a supporting letter from the dean, CEO, or institutional official most directly involved with the project. Please complete one of the enclosed Consultant Profile Forms for each consultant you would like to recommend. Unless you object, we intend to make your profile form and supporting letter available for review by your colleagues. If you do not want your evaluations distributed we will honor your preference; please indicate this on the profile sheet. In any event, we need your help in identifying consultants, if this endeavor is to be useful.

The purposes for retaining a consultant are as varied as the management issues confronting the leadership of academic medical centers. We are interested in the whole spectrum: from someone retained to help with such broad issues such as the definition of the school's mission and objectives, strategies for improving health and medical school relationships, or institutional strategic planning, to the more specifically focused issues such as revision of the practice plan or review of tenure policies.

Once the files have been established, you will be able to use this service in two ways: (1) when you are seeking consultant assistance in a particular area but have not identified specific individuals, we may be able to provide profiles of consultants who have worked with your colleagues on that issue; (2) if you have already identified one or several consultants and would like additional information, i.e., a description of specific services provided at academic medical centers, references, etc., we may be able to provide specific consultant profiles. We will recommend that you contact the references before making a final decision on the appropriateness of any particular consultant.

Again, the success of this service will depend on your contributions. When we receive your responses, we will contact consultants you recommend for additional information. We look forward to receiving your suggestions. If you have any specific questions, I would be happy to discuss them with you.

Sincerely,

John A. Keyes, Jr.
Director
Department of Institutional
Development

Enclosures

CONSULTANT PROFILE

Your Name

Consultant Name

Title

Address

Institution

City, State, Zip

Name and Title of the Individual
Who Retained the Consultant if
Other Than You

Telephone Number

If you retained the consultant, how did you first learn of him/her?

Names and titles of individuals at your institution who worked directly with the consultant.

1. _____
Name

3. _____
Name

Title

Title

2. _____
Name

4. _____
Name

Title

Title

How many times did the consultant meet with you and/or members of your staff during the time he/she was retained?

Over how long a period of time was the consultant retained? (Months)

DESCRIPTION OF SERVICES

Please provide a brief summary of: (1) the institutional issues addressed by the consultant; (2) specific roles and responsibilities; and (3) products, if any, produced by the consultant as part of your agreement.

A. Issues Addressed:

B. Roles and Responsibilities (tasks performed):

C. Products Produced:

EVALUATION OF OVERALL PERFORMANCE

_____ Excellent, I strongly recommend

_____ Good, I recommend with reservation. These reservations include:

Comments: (Please provide additional information which could help your colleagues assess the effectiveness of the consultant. Describe specific factors leading to successful/unsuccessful outcomes, i.e., personality differences, institutional obstacles, presence or lack of knowledge regarding the institutional issues; (in)effective catalyst in stimulating strategies; (in)effective facilitator of group dynamics.)

DISTINGUISHED SERVICE MEMBER NOMINATIONS

Under the current bylaws, "Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who have made major contributions to the Association and its programs."

The Bylaws further provide that:

"Distinguished Service Members shall be recommended to the Executive Committee by either the Council of Deans, the Council of Academic Societies, or the Council of Teaching Hospitals. The Executive Committee shall present Distinguished Service Member nominations to the Executive Council." (Article 1, Section 3E)

The procedures followed by the Administrative Board have been:

1. The establishment of a three member nominating committee consisting of COD Board members.
2. Solicitation of the COD membership for recommendations to the Board to be considered by the committee.
3. Consideration of the committee's recommendation and forwarding a short list to the Executive Council.

The solicitation to the COD membership included the following requirement:

"Each candidacy must be supported by a description of the "active and meritorious participation of the candidate in the affairs of the AAMC while a member of the Council of Deans."

RECOMMENDATION: That the Board adopt the course of action used in previous years.

THE STATUS OF THE MANAGEMENT OF STUDENT FINANCIAL ASSISTANCE
AT U. S. MEDICAL SCHOOLS

The purpose of this paper is to explore whether the management of student financial assistance at U. S. medical schools is optimal and, if not, strategies by which it might be improved. Such improvement, coupled with maintenance of existing federal programs, would comprise the Association's effort to maximize funding for medical students.

Prior to 1960 educational costs were relatively low and there was little need for student financial assistance. Beginning with the National Defense Education Act in 1958 and followed by the advent of the Guaranteed Student Loan Program in 1965 and the Health Professions Student Loan and Health Professions Scholarship Programs in the mid-1960's the federal government began what has evolved into its role of major provider of student financial aid. During the 1960's and early 1970's funds for students from federal, state and other sources were generally more than sufficient to provide medical students with adequate resources to meet educational costs. By the middle 1970's, however, the cost of medical education had increased to the point that many medical students were dependent upon resources other than their own and those of their family to pay for their education. In 1977-78 over 36 percent of the income of medical students came from sources other than themselves, their spouses or their family. By 1981-82 over 80 percent of all medical students received some type of outside financial assistance to help defray their educational expenses. In 1970-71 tuition and fee levels were \$2,000 at private schools and \$683.00 for state residents at public medical schools. The comparable 1981-82 levels were \$9,568 and \$2,699 respectively. In 1974-75, it was reported that medical students received a total of \$119.3 million in external financial support. By 1981-82 this amount had grown almost four times to \$465.4 million.

During the 1960's and early 1970's the role of the financial aid officers at U. S. medical schools was essentially to assess financial need, to disburse the various forms of financial assistance to students according to that assessment, and to keep records of these assessments and aid awards for the sake of audit. In addition, the financial aid officers provided exit interviews upon graduation to advise students of their repayment obligations for any loans they had received. Parallel to the growth in tuition and fees and the dependency upon financial resources other than those of the family, the role of the financial aid officer in the 1970's and 1980's also burgeoned to include counseling students on budgets, general financial planning, and debt management as well as in many instances to be a raiser of funds and collector of loans. The accrual of these responsibilities was a gradual process which occurred principally during a period of contraction and retrenchment in many areas of medical education. Federal capitation funding disappeared. The Graduate Medical Education National Advisory Commission proclaimed a surplus of physicians. First-year new enrollments at medical schools evidenced a decline for the first time since World War II. Funding for research diminished and shifts in physician reimbursement threatened practice plans as a source of revenue at many schools. The combined gradual expansion of the demands upon aid officers and restriction of resources available in general to medical schools created an environment in which many aid officers and aid offices proved

inadequate to their responsibilities. Growing complexity and diversity of federal, state and other financial aid programs and an approximate 20 percent annual turnover in financial aid personnel at the schools have added to this problem.

As indicated at the outset, in addition to continuing to press for optimal federal programs, the Association requests the advice of the Council of Deans Administrative Board on whether to pursue a management advancement program for financial aid officers. Phase one of this effort, a financial planning and management manual, for use with students is already in the process of being developed and could be made available at nominal cost to all schools requesting it. Phase two, if deemed appropriate, would be a series of workshops designed to improve the management of student financial assistance at individual medical schools. These workshops could be divided into two half-day segments with content as follows:

Segment I Introduction
(For Financial Aid Officers)

1. Establishing Student Budgets
2. Analyzing Student Resources
3. Determining Financial Need
4. Matching the Financial Aid Award to the Student
5. Managing and Documenting Office Records
6. Counseling on Finances
7. Controlling and Managing Indebtedness
8. Loan Collection Strategies

Segment II Advanced Financial Management Principles
(For Financial Aid Officers and Other Administrators Associated
with Student Financial Aid)

1. Defining the Financially Dependent and Independent Student
2. Determining the Role of the Parent
3. Considering Extraordinary Expenses
4. Packaging Aid in Exceptional Cases
5. Dealing with Inaccurate Information from the Student
6. Relating Academic Standing to Finances
7. Utilizing other Institutional Counseling Resources
8. Modifying Student Life styles
9. Evaluating the Role of the Spouse

The format for Segment I would be predominantly lecture. The format for Segment II would be the use of case studies to describe and clarify the issues.

These segments together or separately could be offered regionally, for example, in conjunction with the regional meetings of the Group on Student Affairs, or be contracted for by medical schools individually or in groups. The cost to the schools would be consultants, consultant travel, and materials or about \$2,500 per workshop. Regional programs could utilize consultants who would normally

attend the meeting and thereby save travel costs.

There would be a cost for developing the case studies. It would vary according to the number of cases desired and the number of people involved in the development. These funds could be provided by AAMC or sought outside the Association.

The first goal would be to identify the student financial assistance management principles to be elucidated in the seminars. To accomplish this goal a group of development consultants would be identified. These individuals could include representatives from public and private institutions, different geographic regions, racial and cultural minorities, medical school and university based financial aid administrators, policy and operational people, i.e., associate and assistant deans and financial aid officers, and medical students and AAMC staff. A group of 11 is suggested to include two school representatives from each region, one from a private school and one from a public school, one an assistant or associate dean and one a financial aid administrator. In addition, one medical student and two AAMC staff would be included.

The second developmental task would be to select cases from a minimum of five prospective cases provided by each school representative. Thus, at least five 40 sample cases would be available to choose from. The bulk of this developmental work could be done in the equivalent of four working days at each individual's home institution. In addition, one four-day meeting involving five of the consultants including the student and two AAMC staff could be required.

The charge might be to develop 10 cases; two financially disadvantaged racial minority underrepresented in medicine, two financially disadvantaged ethnic, two financially disadvantaged non-minority non-ethnic and four lower and middle income two of whom would be racial minorities underrepresented in medicine. This distribution would provide four racial minorities, two ethnic minorities and four non-racial non-ethnic minorities and six from financially disadvantaged backgrounds, two from lower income backgrounds and two from middle income backgrounds.

It is important to note that demonstration of the principals in the cases would not rely on reference to specific federal, state or other types of aid programs. General categories of high-interest loans, low-interest loans, scholarships and possibly scholarships with a service commitment would suffice. The cases could thus transcend the periodic renewal and modification of these programs.

The advice of the Council of Deans Administrative Board is sought about whether the quality of the management of student assistance would benefit from the development of workshops such as those described in these materials.

TRENDS IN GRADUATE MEDICAL EDUCATION POSITIONS

The continued availability of an adequate number of graduate medical education positions for graduates from LCME accredited medical schools is essential. In the mid 1970s the number of positions offered in the match and the number of U.S. graduates appeared to be approaching unity, but each year the number of positions increased sufficiently to maintain a ratio of about 1.2 (Figure 1 and Table 1). In 1981 the ratio fell to 1.17 and this year the ratio was 1.11.

The number of positions offered in the match this year was 17,952--a decrease of 348 from 1982 (Table 2). Had not emergency medicine participated in the match for the first time, over 500 fewer positions would have been available. Except for internal medicine, which increased by 16, and orthopaedic surgery, which increased by 13, all other specialties offered fewer positions in 1983 than in 1982.

The number of active participants in the match increased dramatically from 18,410 in 1982 to 20,044--a ratio of .8 positions per applicant (Table 3). This increase was due to a 47 percent increase in U.S. foreign medical graduates and a 55 percent increase in alien foreign medical graduates. However, applicants in these categories did not fair well. Forty-nine percent of U.S. FMGs matched and only 26 percent of the alien FMGs matched. Figure 2 shows that U.S. graduates have matched at a constant rate during the past nine years. As the total position/applicant ratio has decreased to below unity, the non-U.S. graduate match rate has decreased reciprocally.

The analysis of matching in internal medicine in 1982 shown in Figure 3 illustrates that there are a cluster of programs that are unattractive to U.S. graduates. In that year 1,498 positions were offered by programs that filled from 0 to 49 percent of their positions. Only 230 graduates from LCME accredited schools were matched into these positions. There were 523 U.S. and alien foreign medical graduates matched and 745 positions were left unfilled.

The reasons why these programs are unattractive have not been determined. Their unattractiveness to U.S. graduates means that the true availability of first-year positions in internal medicine is quite restricted. If the 1,498 positions were removed from the match, 96 percent of the remaining internal medicine positions would have been filled.

There are two interactive factors causing the reduction in the number of positions. First, economic forces are making the maintenance of graduate medical education programs less advantageous to hospitals and, second, the residency review committees have been given greater authority to raise their educational standards under the new Accreditation Council for Graduate Medical Education. Meeting these higher standards often requires more resources. This year for the first time hospitals removed positions from the match after the final lists of available positions were published in December, and two hospitals refused to sign contracts with some students after the match.

The Administrative Boards and Executive Council should discuss the implications of the trend in availability of graduate medical education positions and recommend actions that the AAMC should consider.

Table 1

RATIO OF POSITIONS/APPLICANTS IN NRMP, 1978-1983

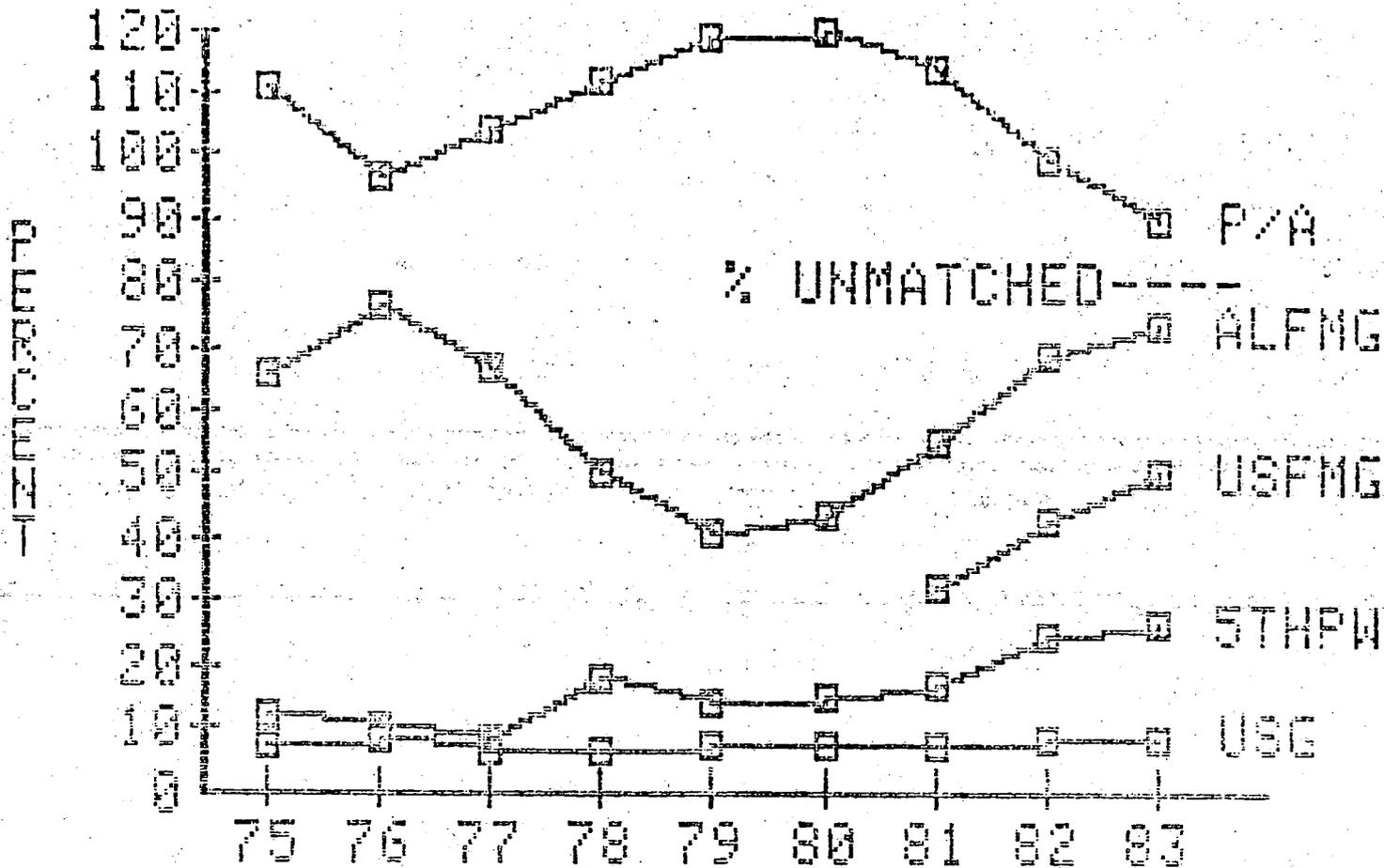
	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
Total Active Applicants	1.12	1.18	1.19	1.14	.99	.89
Active U.S. Graduate Applicants	1.35	1.36	1.37	1.18	1.30	1.29
Total U.S. Graduates	1.20	1.19	1.19	1.17	1.14	1.11

Table 2
POSITIONS OFFERED IN MATCH

	1978		1979		1980		1981		1982		1983	
	NO.	%										
FAMPRC	2111	12.26	2251	12.63	2340	12.96	2370	12.93	2362	12.91	2353	13.11
GENPRC	35	0.20	19	0.11	0		0		0		0	
INT MD	5571	32.35	5829	32.70	6043	33.47	6129	33.44	6260	34.21	6276	34.96
PEDIAT	1776	10.31	1833	10.28	1808	10.01	1833	10.00	1810	9.89	1795	10.00
OB/GYN	897	5.21	966	5.42	981	5.43	1008	5.50	1035	5.66	1010	5.63
PSYCH	939	5.45	966	5.42	933	5.17	923	5.04	922	5.04	867	4.83
MEDSPC	135	0.78	108	0.61	117	0.65	109	0.59	109	0.60	97	0.54
DERMAT	8		8		11		8		9		6	
NEUROL	86		73		74		74		72		67	
OPHTLM	41		27		32		27		28		24	
GEN SG	2310	13.42	2393	13.43	2369	13.12	2407	13.13	2340	12.79	2274	12.67
SURGSP	409	2.38	402	2.26	434	2.40	431	2.35	553	3.02	554	3.09
NEURSG	37		39		41		45		40		48	
ORTHOP	242		240		257		250		305		318	
OTOLAR	49		44		46		52		96		81	
UROLOG	81		79		90		84		107		104	
PLSTSG									5		3	
SUPPSP	1593	9.25	1623	9.11	1649	9.13	1672	9.12	1566	8.56	1558	8.68
ANESTH	448		466		518		526		507		437	
EMERMD	0		0		0		0		0		190	
PATHOL	582		612		573		574		557		484	
PHYSMD	88		89		116		105		92		92	
DX RAD	397		373		369		383		336		292	
RX RAD	78		83		73		84		72		52	
NUC MD									2		11	
TRANS	1443	8.38	1434	8.05	1381	7.65	1449	7.90	1343	7.34	1168	6.51
TOTAL	17219	100.	17824	100.	18055	100.	18331	100.	18300	100.	17952	100

AFFLIC	1978		1979		1980		1981		1982		1983		
	%		%		%		%		%		%		
TOTAL	100	18301	100	17883	100	17993	100	19155	100	22126	100	24900	100
WITHDR	16.55	2947	16.10	2903	16.23	2764	15.36	3051	15.93	3716	16.79	4856	19.50
ACTIVE		15354		14985		15129		16104		18410		20044	
MATCH	80.48	13376	87.12	13430	89.62	13619	90.02	14144	87.83	14949	81.20	15218	75.92
UNMTCH	19.52	1978	12.88	1555	10.38	1610	10.64	1960	12.17	3461	18.80	4826	24.08
USG	100	14308	100	14792	100	14972	100	15496	100	15788	100	15553	100
WITHDR	11.11	1642	11.48	1766	11.94	1650	11.02	1791	11.56	1644	10.41	1584	10.18
ACTIVE		12666		13036		13222		13705		14144		13969	
MATCH	93.90	11875	93.75	12135	93.09	12371	93.56	12724	92.84	13023	92.07	12874	92.16
UNMTCH	6.10	791	6.25	901	6.91	951	7.19	981	7.16	1121	7.93	1095	7.84
STHPWY	100	403	100	458	100	506	100	456	100	528	100	447	100
WITHDR	17.94	68	16.87	83	18.12	95	18.77	106	23.25	98	18.56	81	18.12
ACTIVE		335		370		411		350		430		366	
MATCH	92.11	275	82.09	319	86.22	349	84.91	290	82.86	323	75.12	271	74.04
UNMTCH	7.885	60	17.91	51	13.78	62	15.09	60	17.14	107	24.88	95	25.96
USFMG								785	100	1348	100	1988	100
WITHDR								249	31.72	405	30.04	683	34.36
ACTIVE								536		943		1305	
MATCH								362	67.54	536	56.84	644	49.35
UNMTCH								174	32.46	407	43.16	661	50.65
OSTEOP	100	198	100	173	100	180	100	233	100	246	100	256	100
WITHDR	33.13	84	42.42	79	45.66	53	29.44	81	34.76	114	46.34	121	47.27
ACTIVE		114		94		127		152		132		135	
MATCH	77.57	82	71.93	67	71.28	88	69.29	99	65.13	85	64.39	94	69.63
UNMTCH	22.43	32	28.07	27	28.72	39	30.71	53	34.87	47	35.61	41	30.37
CANAD	100	100	100	142	100	112	100	84	100	98	100	104	100
WITHDR	36.84	34	34	64	45.07	62	55.36	31	36.90	51	52.04	50	48.08
ACTIVE		66		78		50		53		47		54	
MATCH	81.25	56	84.85	62	79.49	39	78	49	92.45	36	76.60	44	81.48
UNMTCH	18.75	10	15.15	16	20.51	11	22	4	7.547	11	23.40	10	18.52
ALFMG	100	3059	100	2027	100	1853	100	1731	100	3504	100	5422	100
WITHDR	29.14	984	32.17	769	37.94	710	38.32	604	34.89	1112	31.74	1804	33.27
ACTIVE		2075		1258		1143		1127		2392		3618	
MATCH	33.13	1021	49.20	743	59.06	645	56.43	510	45.25	751	31.40	949	26.23
UNMTCH	66.87	1054	50.80	515	40.94	498	43.57	617	54.75	1641	68.60	2669	73.77
USMD	100	233	100	291	100	370	100	370	100	614	100	1130	100
WITHDR	50.22	135	57.94	142	48.80	194	52.43	189	51.08	292	47.56	533	47.17
ACTIVE		98		149		176		181		322		597	
MATCH	71.17	67	68.37	104	69.80	127	72.16	110	60.77	195	60.56	342	57.29
UNMTCH	29.83	71	31.63	45	30.20	43	27.84	71	39.23	127	39.44	255	42.71

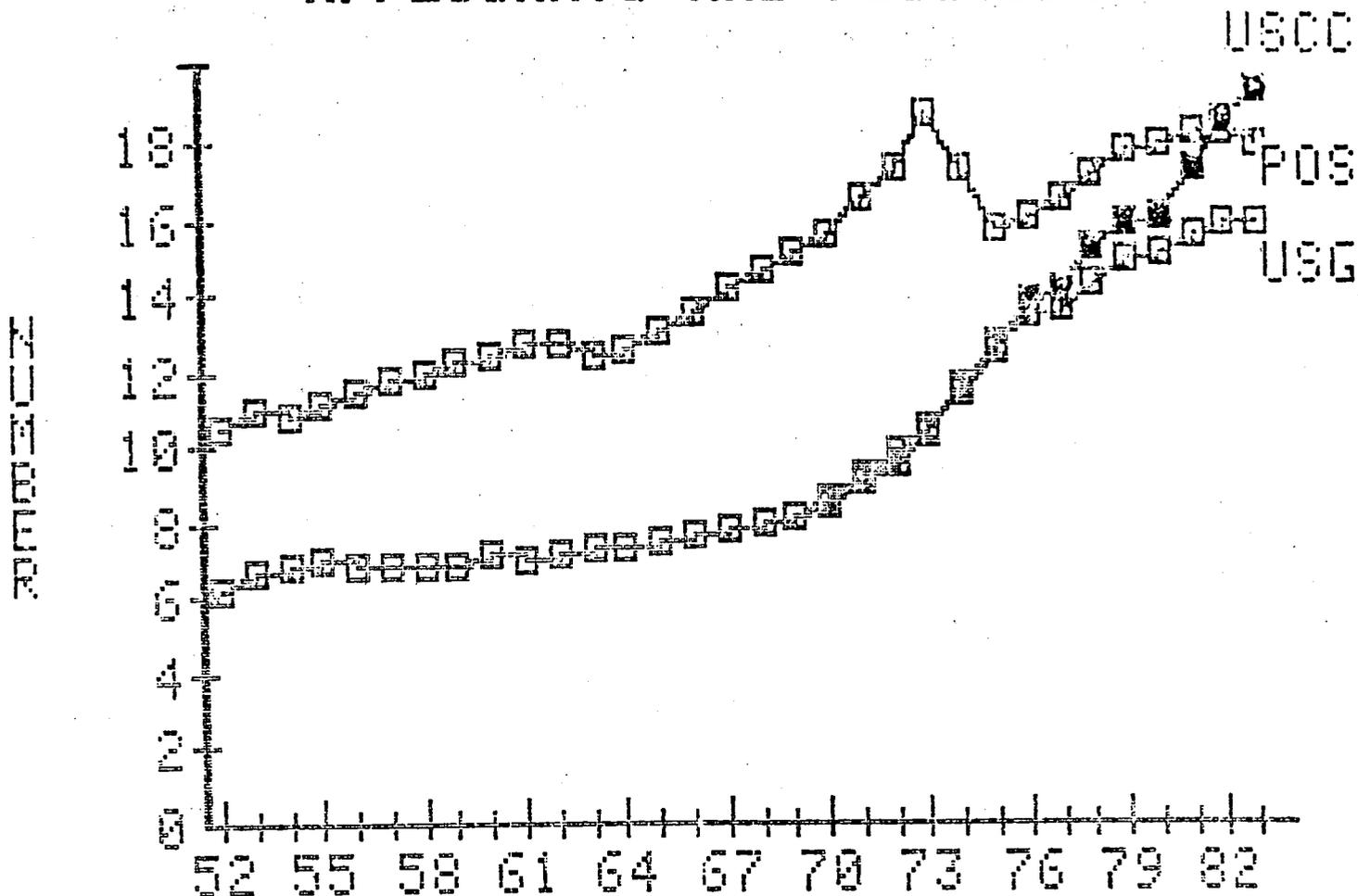
POSITIONS/ACTIVE APPLICANTS



RELATIONSHIP OF POSITION/APPLICANT RATIO TO UNMATCHED APPLICANTS

FIGURE 1

APPLICANTS AND POSITIONS



U S-CANADIAN CITIZENS
 POSITIONS IN MATCH
 U S GRADUATING STUDENTS

FIGURE 2

INTERNAL MEDICINE 1982 MATCH

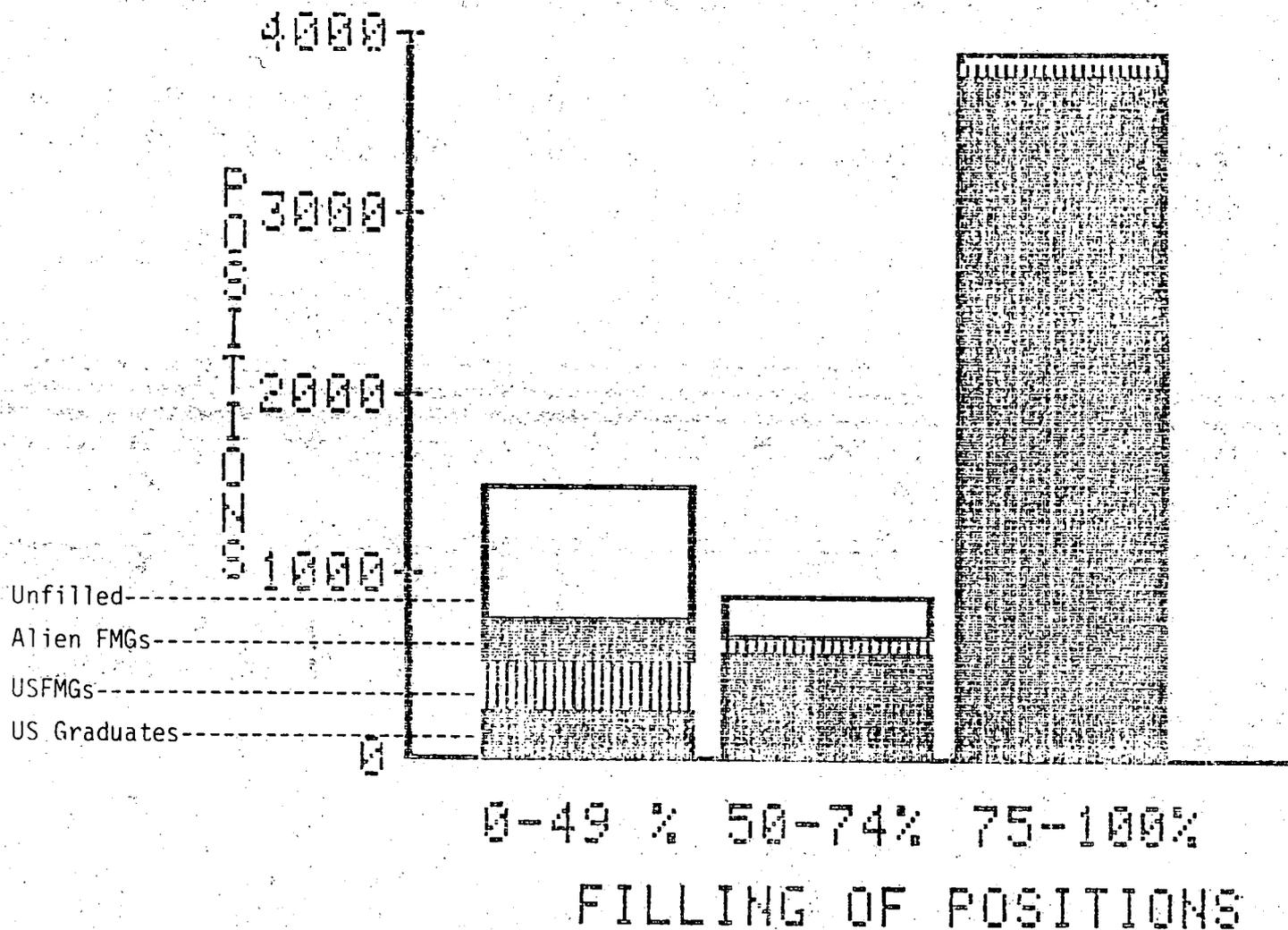


FIGURE 3

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1983 ANNUAL MEETING PLENARY SESSIONS

International Ballroom
Washington Hilton Hotel
Washington, D. C.

THEME: Creativity: The Keystone of Progress in Medicine

Monday, November 7

- 9:00 am The Transformation of Medicine Since 1945
Julius R. Krevans, M.D.
Chancellor, University of California, San Francisco
- 9:30 am Medical and Scientific Advances: Social Cost or
Social Benefit?
Uwe E. Reinhardt, Ph.D. (tentative)
Professor of Economics & Public Affairs
Woodrow Wilson School of Public and
International Affairs, Princeton University
- 10:00 am Break
- 10:30 am Preserving the Scientific Enterprise
James B. Wyngaarden, M.D.
Director, National Institutes of Health
- 11:00 am Sustaining the Revolution of Medical Care
Robert G. Petersdorf, M.D.
Vice Chancellor, Health Sciences and Dean
University of California, San Diego School of Medicine

Tuesday, November 8

- 9:30 am Presentation of Award for Distinguished Research and
Flexner Award
- 10:00 am Medical Progress: A Challenge to Education
J. Michael Bishop, Ph.D.
Professor of Microbiology
University of California, San Francisco School of Medicine
- 10:30 am Can the Nation Afford to Keep Medicine Moving Ahead?
Eli Ginzberg, Ph.D.
Director, Conservation of Human Resources
Columbia University
- 11:00 am AAMC Chairman's Address
- General Session - GPEP (Dr. Swanson)



association of american medical colleges

March 1983

Dear Friends of the Association of American Medical Colleges:

The AAMC is pleased to announce that its 94th annual meeting will be held:

November 5 - 10, 1983
Washington Hilton Hotel
Washington, D. C.

Theme: "Creativity: The Keystone of Progress in Medicine"

The plenary sessions will discuss the impact of medical and scientific advances on medical education and consider the potential for new progress in these areas.

In addition, the AAMC will sponsor a Special General Session on its General Professional Education of the Physician project.

The following schedule has been established for formal AAMC sessions:

	SAT.	SUN.	MON.	TUES.	WEDS.	THURS.
Morning	OSR	OSR		ASSEMBLY	Programs	Groups
	Groups	Groups	PLENARY		Groups	Societies
	Societies	Societies	SESSION	PLENARY	Societies	Open
	Open	Open		SESSION	RIME; Open	

Afternoon	OSR	OSR	AAMC	SPECIAL	Groups	Groups
	Groups	Groups	Council	GENERAL	Societies	Societies
	Societies	Societies	Business	SESSION	RIME	Open
	Open	Open	Meetings		Open	
			RIME; Open			
Evenings are Open						

If you wish to schedule meeting space for your group, please read the following, paying particular attention to deadlines.

MEETING SPACE

- All Hilton meeting space is reserved by the AAMC and all meeting arrangements must be made directly with us.
- Space is limited so some flexibility may be required for multiple room requests.
- Notify us if you wish to avoid conflicts with a particular group.
- Space is available during "Open" slots on chart.
- If there is no overlap in membership, meetings may be scheduled during AAMC Council Business Meetings and Tuesday Special General Session.

PROPOSED DATE FOR THE 1985 COD SPRING MEETING

At its April 21st meeting, the Board unanimously approved the return to The Cottonwoods Resort in Scottsdale, Arizona for its 1985 COD Spring Meeting. At this time, the Board expressed a preference for early meeting dates in March.

On the basis of an examination of holidays and already scheduled meetings which might conflict with the COD Spring Meeting, the staff has contracted with the hotel the following dates for its 1985 COD Spring Meeting:

March 19th - 23rd

association of american
medical colleges

June 3, 1983

Richard Janeway, M.D.
Dean
The Bowman Gray School of Medicine
300 S. Hawthorne Road
Winston-Salem, North Carolina 27103

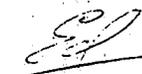
Dear Dr. Janeway:

At the Annual Meeting last November, the OSR membership encouraged its Administrative Board to develop a proposal for ongoing housestaff involvement in the AAMC. While this has not surfaced as a burning issue in the other Councils of the Association, greater housestaff input has been an important OSR goal for several years.

Enclosed is a brief proposal delineating the OSR recommendation as formulated by its Administrative Board which I request be placed on the June COD Administrative Board agenda.

Your consideration of it will be most appreciated.

Best wishes,



Ed Schwager, M. D.
OSR Chairperson

ES/gct
Enclosure
cc:

✓ John A. D. Cooper, M. D.
Joseph Keyes
Edward Stemmler, M. D.
August Swanson, M. D.

CONTRIBUTIONS OF HOUSESTAFF TO THE AAMC

Current economic, legislative and institutional changes influencing graduate medical education are more likely to accelerate and to multiply than to abate. Since the AAMC has increasingly recognized that medical education is a continuum, with award of the M.D. degree marking more a midpoint than an ending, and that residents play a pivotal role in undergraduate medical education, these changes are naturally of great concern. The following issues come immediately to mind:

1. Decline in the number of residency positions concurrent with a continuing increase in applicants.
2. Withdrawal of residency positions after listing in the Match.
3. Financial constraints on teaching hospitals affecting the whole gamut of teaching resources.
4. Hospital reimbursement for patient care provided by residents and attendings.
5. Fostering housestaff teaching skills.
6. Ability of residents to repay education debts.
7. Career decisions of residents, e. g., to seek research training, to switch specialties.
8. Flex I, II implementation

Adequate discussion of these dynamic areas must include residents if the Association's program and policy deliberations are to take into account the span of educational and other variables involved.

That residents (other than past OSR officers) have not come forth requesting the AAMC to establish a housestaff division or organization should not be used as argument against the AAMC's seeking greater resident contributions since the majority are totally unfamiliar with the role and purpose of the Association. The Resident Physician Section of the AMA was not founded with the goal of improving the quality of graduate education. Local housestaff organizations focus primarily on personnel issues and institution-specific patient care problems. Residents have many concerns about the quality and scope of their education, and the AAMC would benefit from keeping abreast of these. Moreover, a national forum in which housestaff and others in academic medicine can exchange perspectives and working jointly to address problems is sorely needed.

Establishment of a housestaff division within the Association has been discussed on occasion in the past. Several options for housestaff representation were evaluated at the 1976 Officers' Retreat but none were adopted. Instead the group chose to recommend inclusion of individual houseofficers on

committees and task forces of the Association. In 1978 an ad hoc committee again decided against a formal system of housestaff participation but proposed an AAMC-sponsored housestaff conference, and one was held to discuss the Graduate Medical Education Task Force Report. The issue has been discussed at subsequent Officers' Retreats, and a second housestaff conference on clinical evaluation was held in January 1981, with a third scheduled for November 1983.

Such conferences mark a beginning but cannot substitute for continuing, broad-ranging input of residents. Certainly the logistics of achieving this input can be perceived as a stumbling block but consist mainly of questions of a secondary nature, if the Association first agrees that resident participation is important.

The OSR Administrative Board, therefore, requests the COD Administrative Board to approve the following recommendation for Executive Council consideration:

That the Association recognizes the need to tap on a continuing and on-going basis, the information base of a major constituent, that is, residents, and that a mechanism be created to explore how this input might best be accomplished.