association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

ADMINISTRATIVE BOARD

WEDNESDAY, JANUARY 23, 1985

5:30 PM - 7:00 PM

GEORGETOWN WEST ROOM

THURSDAY, JANUARY 24, 1985

8:00 AM -12:00 NOON

HAMILTON ROOM

WASHINGTON HILTON HOTEL

one dupont circle, n.w./washington, d.c. 20036

COUNCIL OF DEANS
ADMINISTRATIVE BOARD MEETING

Washington Hilton Hotel
Washington, DC

AGENDA

Wednesday, January 23, 1985

5:30 pm - 7:00 pm

I. Dr. Buchanan, chairman of the Committee on Financing Graduate Medical Education, will report on the progress of the Committee and lead a joint Administrative Boards meeting.

Thursday, January 24, 1985

8:00 am - 12 noon

I. Call to Order

II. Report of the Chairman

III. Approval of Minutes

IV. Action Items

A. ACGME Revisions in General Requirements
(Executive Council------p. 23)

B. Vaccination Injury Compensation
(Executive Council------p. 28)

C. Low-Level Radioactive Waste Disposal
(Executive Council------p.32)

V. Discussion Items

A. GPEP Follow-up Activities
(Executive Council------p. 42)

B. AAMC Survey on Faculty Practice Plans
(Executive Council------p.50)

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

MINUTES

Wednesday, October 31, 1984
9:00 a.m. - 1:00 p.m.
Private Room
Conrad Hilton
Chicago, Illinois

PRESENT

(Board Members)

Arnold L. Brown, M.D.
William Butler, M.D.
D. Kay Clawson, M.D.
Robert Daniels, M.D.
Louis J. Kettel, M.D.
Walter Leavell, M.D.
Thomas Meikle, M.D.
Richard Moy, M.D.
Henry Russe, M.D.
Edward J. Stemmler, M.D.

(Guests)
Richard Janeway, M.D.

(Staff)

John A.D. Cooper, M.D, Ph.D.
Debra Day
Robert Jones, Ph.D.
Thomas Kennedy, M.D.
Joseph A. Keyes, Jr.
James R. Schofield, M.D.
John Sherman, Ph.D.

(Absent)
L. Thompson Bowles, M.D., Ph.D.
John Naughton, M.D.

I. Call to Order

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

II. Welcome to New Board Members

Arnold Brown, M.D., opened the meeting by welcoming three new members to the Board, Walter F. Leavell, M.D., Meharry Medical College School of Medicine, Thomas Meikle, M.D., Cornell University Medical College, and Henry P. Russe, M.D., Rush Medical College of Rush University. At Dr. Brown's invitation, Joseph Keyes introduced Robert F. Jones, Ph.D., as a new member of his staff who will be involved in policy-related institutional studies for the Department of Institutional Development. Dr. Brown also described the luncheon program, devoted to industry-academia relations and featuring Dr. Rita Wroblewski, Director of Medical Affairs at Pfizer Pharmaceutical, and Dr. Robert Becker, Chairman of Psychiatry at Southern Illinois University School of Medicine.

III. Participation on the AAMC Executive Council

Dr. Brown encouraged the members-at-large to attend the quarterly Executive Council Meetings and functions throughout the year. He noted that the attendance at these meetings by the Executive Council members themselves had dropped to a very disappointing level and he emphasized that during the coming transition period, the Executive Council, acting as the AAMC Board of Directors, would be called upon to make major decisions significantly affecting the Association's future. He expressed the hope that deans would be well represented in the deliberations and that this Board would take a leadership role in thinking through and proposing appropriate courses of action.

A discussion ensued concerning various constraints on deans' attendance and participation at these meetings. Highlighted were considerations related to travel schedules and the structure of the meeting. Drs. Moy and Kettel commented that limited airline traffic to their destinations required that they stay an extra evening or leave during the afternoon and miss part of the meeting. Drs. Clawson and Butler stated their belief that the meeting time was underutilized, particularly Wednesday evening sessions and the Thursday luncheons. The various reports took significant time but proved to be redundant with other communications and therefore neither interesting nor useful. Dr. Stemmler suggested that the staff of the AAMC examine the current meeting structure with the view of maximizing the participation and efficient use of the time of those attending. He indicated that the Executive Council Meetings tended to be pro forma rather than deliberative sessions and suggested that may also be a factor in poor attendance.

IV. Purpose of the Meeting and Discussion

Dr. Brown stated that the purpose of this meeting was to discuss the issue paper which had been drafted for the Council of Deans and those drafted for the Council of Academic Societies and the Council of Teaching Hospitals. He noted the heightened interest of the deans during the Annual Meeting in the affairs of the Council and the AAMC. Discussion of the issue papers was seen as particularly relevant to the upcoming presidential search. One objective of this meeting was to give advice to Drs. Brown and Clawson who will represent the Council at the Officer's Retreat. This year's retreat will be attended by members of the search committee who will be attentive to the concerns of the various Councils as they formulate criteria for the identification of a new president.

Discussion initially focused on: 1) the approach that the COD should take to the issue papers as they relate to future directions for the AAMC; 2) definition of the AAMC's mission; 3) the primacy of medical student education in that mission; and 4) the need to reinforce the AAMC role as an association of medical schools.

Dr. Butler spoke to the similarities he found among the three documents and his desire for greater cross-fertilization among the working groups from the various Councils in discussing these issues. Dr. Daniels also noted his pleasure at finding a certain balance among issues of medical

education, research, and clinical patient care in the CAS and COTH documents, which he had not expected. Dr. Stemmler followed-up on these points by advising the Council to continue to take the broader perspective to these deliberations, akin to that which deans normally assume in the governance of their institutions, and to resist approaching the issues provincially.

This lead to a more global discussion of the AAMC's mission introduced by Drs. Meikle and Moy. Dr. Meikle particularly urged the group to focus on mission rather than structure as changes in the latter are seen as the province of the incoming president. In discussing the mission of the AAMC, two related points emerged as matters of general agreement: there should be a renewed focus on medical student education and there was little sentiment for a more expansive view of the AAMC's role such as would be implied in a name change to "The Association of Academic Medical Centers" or "The Association of American Medical Centers". Dr. Daniels stated his belief that GPEP was a response by the AAMC to focus on a neglected function: undergraduate medical education. Dr. Leavell spoke from his experience as a former member of GSA and MAS. He reminded the group of the GPEP recommendation for a separately budgeted academic unit in medical schools to focus on medical student education and noted the absence of such a unit in the AAMC governance structure. The GSA and GME who are most involved with medical student education at the grassroots level are not connected formally to the AAMC's governing bodies. Dr. Stemmler, noting his and Dr. Meikle's experience in GSA, reinforced this point. He spoke to the current detachment of GSA and GME from the COD and even CAS and suggested that there was an urgent need to deal with that issue during the transition.

Dr. Moy and Dr. Clawson reported the consensus of the Midwestern Deans reached at their breakfast meeting in opposition to the suggestion made at the COD Business Meeting regarding a change in name for the AAMC to Association of Academic Medical Centers. Dr. Brown responded that the suggestion has been discussed informally since at least the AAMC retreat last year. At least part of the rationale has been that such a name would be more congenial to the COTH members in contrast to the current name which appeared to exclude them. A motion suggested by Dr. Meikle to re-affirm the name of the AAMC was introduced, seconded, and discussed. Several deans spoke in sympathy with the motion, but concern was also expressed about its implications for relationships with COTH. Dr. Janeway stated that his and Dr. Tosteson's remarks on this point at the Business Meeting were meant to encourage discussion of this issue and not to invite motions. He believed that one of the main issues to be faced up to in the next year is maintaining teaching hospitals in the AAMC and preserving a sense of full-fledged membership. He warned that such a motion may send a wrong signal to this group. Dr. Stemmler spoke in support of avoiding formal motions at this meeting which he regarded as deliberative.

The motion was subsequently withdrawn, while discussion and debate continued on the issue of the organization's name, the changing role of deans in academic medicine and the AAMC organization, and a mission statement for the AAMC. While the sentiment of the group was for retaining the AAMC's name, there was continued recognition of the many

interdependent institutions and groups involved in medical education. There was widespread agreement that indeed the strength of the AAMC was in its ability to provide balanced representation of these institutions and groups.

Drs. Butler and Meikle both proposed mission statements which were discussed by the group. The current statement which describes the purpose of the organization as "the advancement of medical education" was noted. After some deliberation, Dr. Stemmler opined that simple statements, such as the current one, are often best in articulating very complex missions. This point was reinforced by Dr. Cooper who joined the meeting. He reminded the group that the current statement has allowed continued re-interpretation by the Executive Council as the structure and organization of medical education has evolved. After some further discussion, a sense developed that the current statement was appropriate and that medical education implied a concern for research and patient care activities. Medical education is properly conducted in a scholarly environment where the limits of current understanding are fully appreciated and the search for new knowledge is nurtured. Similarly, medical education is possible only in the context of the care of patients by expert clinicians; thus the cultivation of a proper patient care environment and the facilitation of appropriate medical practice by clinician-educators are legitimate and necessary concerns of an organization devoted to "the advancement of medical education." The current mission statement was properly viewed in this light.

Since these discussions were intended to provide input to the search committee, Dr. Janeway was asked to speak to the nature of this committee and the search process. Dr. Janeway told the group that the selection of search committee members was based not on the positions individuals currently held, but on their breadth of experience in the Association and academic medicine. He emphasized the importance of selecting people for the committee with a broad view of the external environment in which the AAMC operates and a historical understanding of the governance and structure of the AAMC and other organizations. Consideration was also given to public/private and geographical representation, but the wisdom, experience, and perspective of the individuals were paramount criteria in his selection decision.

Dr. Stemmler, reporting on the discussion at the last Executive Council Meeting, stated his understanding that the search committee is being assigned by the Executive Council the task of securing the sense of the organization as to future directions and requirements for a new president, but does not itself have the authority to determine future directions for the Association. Rather it is to report its conclusions to the Executive Council for approval. Similarly, the search committee would be asked to deliberate and prepare for approval by the Executive Council recommendations for duration of employment, procedures for review, and possibly, revision of the bylaws dealing with search, appointment, and termination. Dr. Janeway re-affirmed Dr. Stemmler's understanding that the Executive Council remains the governing body of the Association through this process and has final approval on any recommendations made by the search committee.

Some further discussion took place on the representation on the search committee of current deans functioning in the current dean's role, the tentative time table for the process, and the role and function of an executive search firm that might be retained. Dr. Brown, a member of the search committee, assured the group that he would be speaking for the COD Administrative Board and the COD at-large. Dr. Janeway stated that one initial activity of the search committee would be to spend 2-3 months in deliberation about the ideas which emerge from the Officer's Retreat and in consultation with members of Congress, foundation heads, and representatives of the AMA, AHA, and AAHC. The March 1985 Executive Council Meeting was viewed as the likely forum for a report on the committee's initial activity. Dr. Janeway also explained the value of an executive search firm in this process from the point of view of the AAMC and interested candidates, although he allowed the possibility that one may not be needed if the choice becomes quickly self-evident.

Since the discussion which took place precluded a detailed examination of the issues papers which had been planned, various suggestions were made as to how AAMC staff might synthesize, correlate, or index the documents in a way that would focus discussion at the next Administrative Board Meeting. It was finally agreed that each Board member would write a brief essay on the issues raised in the documents as they relate to future directions for the AAMC and send them to Mr. Keyes who will compile them into a report for further discussion.

V. Luncheon Program - Industry/Academia Relations-Pfizer Pharmaceuticals

During the luncheon, Dr. Wroblewski from Pfizer Pharmaceuticals spoke about some common perceptions that industry and academia have of each other and which have tended to impede relationships between the two. She described several conferences sponsored by Pfizer to improve communications. She also outlined several Pfizer programs which were of interest to the deans. The Pfizer Scholars Program for New Faculty offers a $50,000 annual grant to a sponsoring medical school or university for a minimum two-year period. The program's objective is "to encourage, and provide an opportunity for developing, the research potential of physicians during the years just after completing their formal training." The Pfizer Postdoctoral Fellowship Program offers a $30,000 annual award for 1-3 years. Its purpose is "to help develop and enhance research training opportunities for selected physicians who wish to pursue, in an academic environment, biomedical research in the following specialty areas: cardiovascular medicine, rheumatology, biological psychiatry, diabetes, and infectious diseases." Pfizer also sponsors a program for Visiting Professorships in Psychiatry and one for Visiting Lectureships in Clinical Pharmacology. Drs. Wroblewski and Becker provided the deans with various written materials and brochures on their programs.

During the discussion, the deans suggested that Pfizer consider mounting a program of research fellowships for medical students. They also noted their commonality of interests with industry on public policy matters affecting biomedical research. These include support for federal funding of biomedical research and federal policies related to the use of animals in biomedical research. It was pointed out that the

pharmaceutical companies have a stake in these issues and might join forces with the AAMC in advocacy for their mutual interests. A specific first step suggested was for someone at the AAMC to write to the president of Pfizer concerning this.

VI. Adjournment

The luncheon program and meeting adjourned at 1:00 p.m.

GPEP FOLLOW-UP

Appearing on the following pages are the assessments of each of the GPEP recommendation developed by the four GPEP "Readers", (Drs. Brown, Stemmler, Moy and Chapman). The assessments are formatted to follow the text of each recommendation. Unfortunately, it proved impossible to schedule a meeting of this group in advance of the preparation of this agenda. A telephone conference call scheduled for January 17, permits a further iteration of this process prior to the Board meeting.

Dr. August Swanson, Director of the AAMC Department of Academic Affairs and Project Director for the GPEP Panel will join the Board to participate in its discussion of follow-up activities. See also page 8 in the agenda and page 42 in the Executive Council agenda for related materials.

CONCLUSION 1

Recommendation 1

In the general professional education of the physician, medical faculties should emphasize the acquisition and development of skills, values, and attitude by students at least to the same extent that they do their acquisition of knowledge. To do this, medical faculties must limit the amount of factual information that students are expected to memorize.

Stemmler:

The balance between acquisition and development of skills, values, and attitudes by students and the need for students to acquire this knowledge must be left up to the faculty of the individual school. Clearly the need to acquire knowledge and the culture into which that knowledge is placed has always been a dilemma in education and will continue to be. The interpretation of this problem and the plans towards its resolution constitute the fundamental style of any individual school.

Brown:

primarily the responsibility of the medical schools and their faculties; help could be provided by the AAMC to schools and faculties by developing and giving seminars, courses, and texts relating to the acquisition of the necessary skills and concepts to effect this recommendation

Moy:

AAMC should advocate this to the individual institutions as well as to the LCME. Specifically, I think that each institution should be expected to state publicly the general objectives that they wish to achieve in their graduates by the time they have finished the curriculum and also to have in place sufficient mechanisms of evaluation that they can be sure that they have reasonably achieved these objectives. Except for this general expectation, however, I would expect that the institutions would be given broad degrees of freedom to define their goals and evaluation mechanisms.

Chapman:

There must be a balance between the development of skills, values and attitudes and the acquisition of knowledge such that the combination provides a useful outcome. Knowledge without access to the target of that knowledge is not useful and access to the target is not useful without the background of information and skill.

The institutional profile is an institutional strategic policy plan of the school.

The Association might play an important role in the identification of schools by profile in a manner such that schools may identify the profile and, accordingly,

either emphasize or modify that profile in accord with institutional strategic design.

Recommendation 2

> The level of knowledge and skills that students must attain to enter graduate medical education should be described more clearly. This will require closer liaison between those responsible for general professional education and those responsible for graduate medical education.

Stemmler:

Our Association may play a leadership role in exploring, along with the community of medical schools, the possiblility of defining the level of knowledge and skills that students should attain as a requirement for receipt of the M.D. degree. This requires a broad examination of the total acquisition of knowledge and skills acquired by an individual studying medicine up to the time of board certification. Although this would be a formidable undertaking it is one worth considering if the recommendation made in number 2 is serious.

Brown:

This will require a national effort that should be led by the AAMC.

Moy:

AAMC general advocacy of this recommendation is entirely appropriate. Here again, I think that a more specific insistence that institutions clearly write out their commencement objectives as mentioned in Recommendation 1 is appropriate and that this should be advocated through the LCME. I think AAMC should also continue to point out the inappropriate use of National Boards as currently constructed for the selection of residents, particularly when only Part I is available.

Chapman:

Institutions need to identify the relationship between requirements to enter and the efforts required once entered. Further, the relationship between what is understood and practiced as students in requirements for the M.D. degree must be viewed as approaches to further education and training. The Association might play a useful role by profiling students in relationship to the points of emphasis identified by school emphasis.

Recommendation 3

> Medical faculties should adapt the general professional education of students to changing demographics and the modifications occuring in the health care system. Future practice will be shaped more by these changes and

modifications than by the traditional medical care system of the past three decades.

Stemmler:

Individual schools, public or private, assume different responsibilities in order to fulfill their missions. How a school adapts to its external environment depends upon its interpretation of what constitutes its mission. This recommendation should be left up to individual school's descretion.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC is very effective in identifying such issues and making debate upon them and recommendations concerning them available to its major constituencies; such as the Council of Deans, Council of Teaching Hospitals, and Council of Academic Societies. It could well be appropriate for AAMC staff to identify ways to more directly include students in the debates or make available to faculties resources and programs that would more directly involve students in these ambient affairs.

Chapman:

The general professional education of students must include the ecology of medical care as well as the substance of the care of patients and must be incorporated into the institutional strategic plan as implemented by departments and faculty.

Recommendation 4

Medical students' general professional education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease.

Stemmler:

Whether a school chooses to include the broad concerns of communities and the promotion of health and prevention of disease is a choice that should be left up to the individual faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC should provide general advocacy for this goal, but I do not think it should be more prescriptive than that.

Chapman:

Medical students must engage the excitement of health promotion and disease prevention in the same way that most now engage treatment and remedy. The Association can serve as a clearing house for circumstances which encourage these efforts.

CONCLUSION 2

Recommendation 1

> College and university faculties should require every student, regardless of major subject or career objective, to achieve a baccalaureate education that encompasses broad study in the natural and social sciences and in the humanities.

Stemmler:

Our Association ought to initiate a collaborative effort shared by the major associations of higher education, to achieve the purposes of this recommendation. We are here speaking about the kind of education that should be possessed by an educated public. Included herein would be a broad study not only of the natural, social sciences, and humanities, but, also, a fundamental understanding of human biology. The baccalureate degree has not been compromised just for preparation for medicine. Rather, the entire cultural shift toward preparation for future employment has permeated undergraduate education. We can certainly associate ourselves with a movement of renewal initiated by higher education itself, a movement that is so necessary for the future of our society.

Brown:

this will require the development of a broad concensus that can only be obtained by the joint efforts of the medical schools and baccalaureate level colleges. This can be best catalyzed by the AAMC

Moy:

AAMC should provide general advocacy for the achievement of a baccalaureate degree before entering medical school. There is no longer any cogent need to take students after three years of college. My own experience suggests AAMC advocacy for broader educational experience would be best directed at college presidents and university vice presidents of academic affairs rather than premed advisors.

Chapman:

Preparation for a position in society is the principal effort reflected in a collegiate education. The "topping" upon this substance should orient toward medicine though it should not divert one from the substance of this purpose. The institution determines this goal; the faculty implements it. A statement of this objective and its expected outcomes could be an effective means whereby evaluation of this recommendation is achieved. m 319/

Recommendation 2

> In framing criteria for admission to medical school, faculties should require only essential courses. Whenever possible, these should be part of the core courses that all college students must take. Medical school admissions committees' practice of recommending additional courses beyond those required for admission should cease. Some institutions may wish to experiment by not recommending any specific course requirements.

Stemmler:

Our Association could lead a discussion of admissions requirements. Here I would strongly recommend that the discussion focus itself, not on course requirements, but rather on the knowledge content required by individuals who are to enter medicine. By approaching the question in this way, we leave open the possibility that the colleges themselves may reorganize their course content toward the streamlining of education in science. Another approach to this question would be to stimulate a broad national study of biological science education in America. The purpose of such a study would be to address the need for simplicity and integration in the study of modern biology.

Brown:

primarily the responsibility of the medical schools and their faculties with strong support of the deans.

Moy:

AAMC should provide general advocacy for the concept, but not be directly prescriptive, to medical schools. One role for the AAMC might be to study the admissions results of classes of medical schools that have different policies in regard to required and recommended courses to see if there are any measurable differences.

Chapman:

Admission requirements could be based in a context related to an understanding or skill or approach which has a reasonable expected outcome in adult life as related to the requirements of the profession. The statement of a requirement should reflect a needed outcome upon which wise judgements, effective actions and constructive approaches can be mounted as adult citizens of a community with special emphasis in medicine. Scholarship and scholarly endeavor should be

defined by precept at all levels of the educational experience and interaction with those of scholarly approach must be the experience at all levels. It is the individual interaction between teacher and learner which defines the attitiude and approach which leads to scholarly endeavor as a way of life. Medical students are admitted to study with the faculty. Decisions regarding admission to this status are properly a faculty matter within the broad institutional policy. Faculty members who make such decisions must be encouraged to evaluate the decision-making process in relationship to the basis for that decision made in a retrospective look as well as a prospective plan for the future. The Association may be helpful in identifying relationships between criteria used, observations made and outcomes experienced.

Recommendation 3

College faculties should make the pursuit of scholarly endeavor and the development of effective writing skills integral features of baccalaureate education.

Stemmler:

Our Association should prod our colleague associations in higher education to address this fundamental requirement of scholarship. To be candid, the colleges themselves should be pressing for better preparation of students by the elementary and secondary schools.

Brown:

this must be worked out at the local level between the medical schools and the colleges from which their students come

Moy:

AAMC should provide general advocacy, but with the specific continued exploration, of a composition section of the MCAT.

Chapman:

Scholarship and the ability and facility to communicate the basis and outcome of scholarship is essential to the substance and progress of the profession. The accreditation and certification process of medical education must require these qualities in the educational program. The Association, as a party interested in medical education, can have an important effect in this regard.

Recommendation 4

Medical school admissions committees should make final selection decisions using criteria that appraise students' abilities to learn independently, to acquire critical analytical skills, to develop the values and attitudes

essential for members of a caring profession, and to contribute to the society of which they are a part.
They should use the Medical College Admission Test only to identify students who qualify for consideration for admission. Medical faculties should determine whether the relative weights accorded by their admissions committees to the scores in the six sections of the Medical College Admission Test are consistent with the best use of the examination as a predictive instrument.
The Association of American Medical Colleges is encouraged to continue its efforts to add an essay section to the Medical College Admission Test.

Stemmler:

Recommendations of this sort directed at admissions decisions have always suffered because of the lack of discernable criteria needed to predict success. To the extent possible, our Association might promote efforts to identify such discriminators.
The role and function of the MCAT are clearly under our purview. I do believe that we should take the time to examine the positive and negative outcomes of the current form of MCAT and to determine whether adjustments ought to be made. This would require an active undertaking by our Association.

Brown:

both the schools and the AAMC will have to address this recommendation; the schools by the criteria they use in their admission process and the AAMC in any modification of the MCAT

Moy:

I agree that the AAMC should continue to explore the use of the essay. It would be very difficult to demand, let alone enforce, the use of the MCAT's as recommended by GPEP. AAMC might challenge the institutions to study the results of their use of the MCAT to see if high scores, particularly at the expense of other attributes, result in the quality product they apparently expect.

Chapman:

The judgment regarding the balance among objective measures of performance and ability as modified by judgment based on subjective criteria should be a policy decision of faculty represented by properly constituted committees. Preparation, ability and motivation are all essential to a successful program of learning. The Association may be helpful in helping schools to identify the balance in the process which now exists and accordingly help schools to modify this process where it is felt desirable.

Recommendation 5

Communication between medical school and college faculties about the criteria medical faculties use to select students for admissions should be improved.

Stemmler:

The communication between the medical school and college faculties is, in general, the business of individual schools. Nonetheless, the AAMC may wish to consider programs which facilitate such communication.

Brown:

primarily the responsibility of the medical schools

Moy:

AAMC should give general advocacy.

Chapman:

The communication needs to be improved in ways which inform through understanding. The Association may be very helpful through interaction with the organization of Health Professions advisors and other related groups. Individual schools can also be important in this regard at their own initiative.

CONCLUSION 3

Recommendation 1

> Medical faculties should adopt evaluation methods to identify: (a) those students who have the ability to learn independently and provide opportunities for their further development of this skill; and (b) those students who lack the intrinsic drive and self-confidence to thrive in an environment that emphasizes learning independently and challenge them to develop this ability.

Stemmler:

The evaluation of students is the responsibility of individual faculties. Techniques to evaluate students who have the ability to learn independently by some explicit standard may require the development of those standards. The Association may or may not wish to be involved in such an undertaking.

Brown:

primarily the responsibility of the medical schools and their faculties; the role of the AAMC should be to collect and circulate the appropriate literature on such evaluation methods.

Moy:

AAMC should provide general advocacy for this recommendation. More specific advocacy should come from the LCME; however, it does anticipate the availability of potentially complex and sophisticated evaluation mechanisms that the schools perhaps should have, but I suspect that many of them don't. The area of

problem-solving skills and the capacity for independent learning might be something AAMC should study at the level of the MCAT examination or undergraduate content.

Chapman:

Students who have a zest for learning differ significantly from those students who do not. Evaluation and the results of evaluation are the common currency for the identification of success or the lack of it. It is essential that medical faculties adopt methods to evaluate those who do and those who do not express this zest for learning on a continuing basis. Medical faculties should arrange the curriculum to have sufficient structure to afford guidance and sufficient flexibility to encourage initiative. Information transfer is not necessarily teaching nor is it necessarily learning. The institution should adapt the mode of teaching and the expectation of learning to the anticipated optimal outcome as to behavioral development in the learner. The Association may be helpful in identifying the spread and variation of approaches in this regard and share these with institutional membership.

Recommendation 2

> Medical faculties should encourage students to learn independently by setting attainable educational objectives and by providing students with sufficient unscheduled time for the pursuit of those objectives.

Stemmler:

The management of time is the responsability of school faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

All are necessary corollaries of Recommendation 1.

Chapman:

Time management in relation to educational objectives should be an interaction between students and faculty. The Association could be very helpful in identifying schools by unscheduled time in relationship to student attitudes, student performance and student outcomes as measured by some independent effort. This observer is not entirely consonant with meeting obtainable educational objectives through unscheduled time coefficients. I am, however, willing to be taught that there is an important relationship between the two. There may be--there may not be. Perhaps the Association can be helpful identifying the relationship, if any.

Recommendation 3

> Medical faculties should examine critcally the number of lecture hours they now schedule and consider major reductions in this passive form of learning. In many schools, lectures could be reduced by one third to one half. The time that is made available by reducing lectures should not necessarily be replaced by other scheduled activities.

Stemmler:

The reduction of lecture hours is the responsibility of school faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

All are necessary corollaries of Recommendation 1.

Chapman:

There is a potential premise expressed in the recommendation that lecture hours equal a passive form of learning. Perhaps the Association can be helpful in identifying means whereby lecture hours can be guidance efforts toward a more active form of learning.

Recommendation 4

> Medical faculties should offer educational experiences that require students to be active, independent learners and problem solvers, rather than passive recipients of information.

Stemmler:

The nature of the educational program within an individual school is the responsiblity of the school faculty.

Brown:

primarily the responsibility of the medical schools and their faculites

Moy:

All are necesary corollaries of Recommendation 1.

Chapman:

The style and emphasis of the educational program as to active/passive or positive/negative in the independent learning and problem-solving sphere is a matter of school profile. The Association could be helpful in assisting each school to identify that profile in a meaningful way which can be measured and, accordingly, altered if thought feasible by the faculty.

Recommendation 5

> In medical schools whose programs emphasize the development of independent learning and problem-solving skills, the evaluation of students' academic performance should be based in large measure on faculty members' subjective judgments of students' analytical skills rather than their ability to recall memorized information. The Association of American Medical Colleges should institute a program to assist faculties in adopting and using evaluation methods to judge medical students' abilities and to analyze and solve problems.

Stemmler:

Again evaluation methodology belongs to the school faculties. The emphasis in the utilization of faculty member's subjective judgments offers some risk that must be balanced by the utiliztion of more objective measurements. This has been a problem in education since the beginning of education and will continue to be so.

Our Association might well attempt to institute programs aimed at assisting faculties in using methods which can judge the ability of medical students to analyze and solve problems.

Brown:

primarily the responsibility of the medical schools and their faculties; the AAMC should develop courses, seminars, and workshops for faculty on the use of such evaluation methods.

Moy:

I strongly disagree with the word "subjective" since several institutions have come up with reasonable objectives, reproducible mechanisms for evaluating clinical competence, skills, and behavior. However, I do agree that the AAMC can assist institutions by continued identification and testing of these sophisicated mechanisms and making them more broadly available to other institutions. As stated previously, I feel strongly that institutions should be called upon to

clearly state their overall objectives and the demonstrate that they have the internal evaluation mechanisms to determine that they have achieved these objectives. Step 1 is simply the application of the same scholarship and discipline to education that institutions expect from their laboratory researchers and clinicians. Step 2, however, does require the establishment of new, sophisticated evaluation mechanisms and I think most institutions will require considerable assistance over the next several years to achieve that. I think this is a clear and important role for the AAMC.

Chapman:

Evaluation is the common currency of how people understand and place a priority value on achievement. A profile is more desirable than a grade. The attached profile used by this observer has been found to be satisfactory if endorsed and used fully and vigorously by the faculty. The latter is an important issue and occasionally an important problem. The Association might well help in assisting faculties to develop methods which are both valid and reliable in this regard.

Recommendation 6

> Medical schools should designate an academic unit for institutional leadership in the application of information sciences and computer technology to the general professional education of physicians and promote their effective use.

Stemmler:

It is the business of the school to determine whether or not it should designate an academic unit for the application of information sciences and computer technology.

Brown:

the responsibility of the medical schools

Moy:

I think this recommendation is too directive. I think AAMC can identify that there are institutional needs to be met, but that institutions should be allowed to meet this need within their own structures and traditions.

Chapman:

The use of mechanical representation of information, its storage and application is a means by which human factors of management and analysis may be enhanced. These powerful tools need to be a part of the program of study and achievement in all schools. Many schools are seeking to move in this direction by adopting a methodology without clear indication of where that methodology leads nor what its outcome will be. The Association may be helpful in identifying those institutions with clear vision of outcome and relating it to methodology whereby that outcome is approached.

CONCLUSION 4

Recommendation 1

Medical faculties should specify the clinical knowledge, skills, values, and attitutes that students should develop and acquire during their general professional education.

Stemmler:

The explicit designation of the clinical knowledge, skills, values, and attitudes that students should develop and acquire is the fundamental responsibility of a school of medicine. Our Association might well take an active role in providing a forum by which the schools can share their efforts toward this end.

Brown:

primarily the responsibility of the medical schools and their faculties; the role of the AAMC would be to develop general criteria that individual schools could consider

Moy:

Quite obviously I very strongly agree with this and feel it should not be only a clear expectation by the AAMC, but should be a requirement of the LCME for accreditation. If an institution submitted a program project research grant involving many departments and had no clearly defined objectives as to what it was they were trying to achieve, it not only would fail to be funded, but would reflect very badly on the sophistication of the institution.

Chapman:

Clinical knowledge, clinical skills, clinical values and those attitudes addressing the clinical situation should be identified in ways which can be addressed in descriptive terms relating that description to the performance of each student in the clinical context. The approach used at this institution is reflected on the attached evaluation program.

Recommendation 2

Medical faculties should describe the clinical settings appropriate for required clinical clerkships and, in conjunction with deans, department chairmen, and teaching hospital executives, plan organizational strategies and resource allocations to provide them.

Stemmler:

The description of the appropriate clinical setting for clinical clerkships is the business of the school's faculty. Our Association might well provide a forum through which the schools share information toward that end.

Brown:

primarily the responsibility of the medical schools, teaching hospitals and faculties

Moy:

AAMC should give general advocacy to this concept, but the specific identification and judgment of clinical settings is more properly the responsibility of the LCME.

The setting in which clinical care is provided, taught, and received must be a joint endeavor among those who have the responsibility for clinical care of the patient, responsibility for the setting in which that care is given and responsibility for the teaching and learning exercised in that care. In the ordinary circumstance, the department is the initiating point in charge of that setting as it relates to patient care. Where the department is also the clinical service, the chief or chairman of that department or service is integral to the proper functioning of both service and academic department. The Association may be helpful in identifying agreements and arrangements consonant with effective teaching and learning, effective care and agreeable circumstances.

Chapman:

The setting in which clinical care is provided, taught and received must be a joint endeavor among those who have the responsibility for the clinical care of the patient, responsibility for the setting in which that care is given and responsibility for the teaching and learning exercised in that care. In the ordinary circumstance, the department is the initiating point in charge of that setting as it relates to patient care. Where the department is also the clinical service, the chief or chairman of that department or service is integral to the proper functioning of both service and academic department. The Association may be helpful in identifying agreements and arrangements consonant with effective teaching and learning, effective care and agreeable circumstances.

Recommendation 3

Those responsible for the clinical education of medical students should have adequate preparation and the necessary time to guide and supervise medical students during their clinical clerkships.

Stemmler:

The nature and qualifications of the faculty utilized to educate medical students is the business of the schools.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC's role here should be strong general advocacy aimed primarily at the expectation that medical schools will hold a very high priority for the commitment to the faculty to undergraduate medical education. They are being paid to do it, they have the faculty title that expects that they do it, and they should bring to it the same scholarly discipline that they bring to their other professional activities.

Clinical education of medical students requires more that appropriate care of patients and must be provided in a timeframe and with a support system consonant with those responsibilities. The point that the experience should be sufficiently flexible to provide for a controlled initiative is important here. The functioning of the student as part of the group effort toward the welfare of the patient is also an important goal in this regard. Faculty members who practice the art of care, the science of medicine and the effort of teaching should be so rewarded in status or otherwise.

Chapman:

Clinical education of medical students requires more than appropriate care of patients and must be provided in a timeframe and with a support system consonant with those responsibilities. The point that the experience should be sufficiently structured to afford guidance and safety and sufficiently flexible to provide for a controlled initiative is important here. The functioning of the student as a part of the group effort toward the welfare of the patient is also an important goal in this regard. Faculty members who practice the art of care, the science of medicine and the effort of teaching should be so rewarded in status and otherwise.

Recommendation 4

Medical faculties should develop procedures and adopt explicit criteria for the systematic evaluation of students' clinical performance. These evaluations will provide a cumulative record of students' achievements as they progress through their clerkships. Faculty members should share timely evaluations with students: they should reinforce the strengths of their performance, identify any deficiencies, and plan strategies with them for needed improvement. These procedures should facilitate the recording of faculty members' impressions of the students' personal characteristics and attitudes.

Stemmler:

The procedures used to evaluate clinical clerks or clinical performance of medical students is the business of the schools. Our Association should continue its effort to provide assistance to the schools as they further refine the fulfillment of these responsibilities.

Brown:

primarily the responsibility of the medical school and their faculties

Moy:

Obviously I strongly agree with this recommendation except for the now implied assumption of subjective faculty evaluation. Evaluation of skills, judgment, behavior and problem solving is extremely important and I think it is most timely to solve this whole problem since obviously it is now possible. I would recommend strong AAMC advocacy and strong LCME expectation.

Chapman:

Evaluation and how an organization evaluates and reports performance is one of the hallmarks of an organization which has a defined program of quality which can be modified in ways which support the enhancement of that quality. Evaluating clinical performance carries with it a different type of responsibility. The means whereby this institution evaluates our clinical performance is provided in the attachment.

Recommendation 5

Medical faculties should encourage their students to concentrate their elective programs on the advancement of their general professional education rather than on the pursuit of a residency program.

Stemmler:

Our Association should do more than to make such a recommendation but, rather, provide some leadership to minimize the adverse effects of current competition for residency positions upon the undergraduate medical curriculum.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC should provide general advocacy not only to institutions but also to LCME and ACGME, but should not be further prescriptive.

Chapman:

Electives have become a prominent part of American medical education. Selectives have developed as intermediates between required and fully elective pursuits. Pursuit of a residency position has become an emotional imperative for many students. Departmental specialty groups are perpetuating a circumstance which, at times, promotes this anxiety and diminishes what could be a better spent elective program. The Association may be helpful in identifying these circumstances where they appear to exist and counsel with those specialties and organizations which appear to be encouraging a less than wholesome opportunity in the elective experience.

Recommendation 6

> Where appropriate throughout the general professional education of physicians, basic science and clinical education should be integrated to enhance the learning of key scientific principles and concepts and to promote their application to clinical problem solving.

Stemmler:

The nature of a school's curriculum is clearly the business of the individual faculties.

Brown:

the responsibility of the medical schools

Moy:

Here also AAMC should give general advocacy to institution but not be prescriptive.

Chapman:

Circumstances wherein understanding is enhanced through multi-disciplinary participation could be highlighted in ways which provide institutions the opportunity of focusing upon the problem and its solution rather than upon the discipline and its content. The "territoriality" of the curriculum needs to be modified in such a way that the focus is not possession of territory in the curriculum but responsibility for teaching an approach toward the solution of a problem or problems. Perhaps a problem-oriented curriculum could be designed in a way that individual schools and, within schools, departments could select from the approach; that approach which seems best in the context of the individual school. Financial support for the educational program must necessarily be multi-variant and will be distinctly school related with the integrity of the school relying heavily upon the integrity of departments. The Association can provide leadership through seminars and other information generating efforts that address economic matters for deans, departmental chairmen and others having similar responsibilities.

CONCLUSION 5

Recommendation 1

Medical school deans should identify and designate an interdisciplinary and interdepartmental organization of faculty members to formulate a coherent and comprehensive educational program for medical students and to select the instructional and evaluation methods to be used. Drawing on the faculty resources of all departments, this group should have the responsibility and the authority to plan, implement, and supervise an integrated program of general professional education. The educational plan should be subject to oversight and approval by the general faculty.

Stemmler:

The organization and supervision of a school's curriculum is the business of the individual schools.

Brown: primarily the responsibility of the medical schools and their faculties

Moy:

AAMC should give general advocacy for this need, acknowledging the more direct oversight of the LCME. Here again, there is a need to be met, but I think that the specific structures should be left to the individual institutions.

Chapman:

The organization to which the school turns for coordination and development is ordinarily the department. Rarely does an institution-wide committee have sufficient "muscle" that circumstances can be modified significantly. The department chairs are integral in this regard as are the departments. A person within the dean's office who has principal responsibility of overseeing, coordinating and developing the curriculum through tactical expertise is essential for a developing educational program. In the final analysis, it will be a departmental decision implemented by departmental members.

Recommendation 2

The educational program for medical students should have a defined budget that provides the resources needed for its conduct. Expenditures from this budget should be as distinctly related to the educational program as are other funds restricted to specific purposes, such as research or research training.

Stemmler:

How a school organizes its finances toward the implementation of its educational program is clearly the business of the schools.

Brown:

responsibility of the deans of the medical schools

Moy:

I find this a very troublesome recommendation. While I can see the potential power of it in clearly identifying to faculty that they are being significantly paid to perform quality undergraduate medical education and may provide some further leverage to the administrative structure; on the flip side, however, are all the perils of coming up with readily available, but probably not sophisticated estimates of the costs to educate medical students which can be compared and contrasted across institutions. We may come to this as a result of the insistence of state legislatures and the "unbundling" of teaching hospitals, but I am concerned about being able to get this genie back in the bottle.

Chapman:

The identification of budget in relationship to educational program is properly the responsibility of individual schools. It is doubtful to this observer that a direct relationship between income for education and expenditure for education will be possible or, perhaps, even desirable. With current realities, Recommendation 2 does not appear to this observer to be amenable to precise interpretation in implementation. However, a budgetary allocation for education can be implemented and should be. That it be the entire support for education, I think, overstates the response.

Recommendation 3

> Faculty members should have the time and opportunity to establish a mentor relationship with individual students. The practice of having a large number of faculty members, each of whom spends a relatively short period of time with medical students should be examined critically and probably abandoned.

Stemmler:

This recommendation is aimed at the nature of the internal culture of a school. It belongs under the responsibility of the schools.

Brown:

responsibility of the medical schools and their faculties

Moy:

Here again, I would advise general advocacy realizing the LCME also has oversight here, but avoid being too prescriptive.

Chapman:

The interaction of a student and a faculty member is fundamental to the learning process and, for most faculty, fundamental to faculty satisfaction. Departments should support it, faculties should practice it, and schools should endorse it as a working principle or a rule. Faculty members must proficiently practice their professional role while, at the same time, broaden the base of their activities such that students view them both as professionals in a discipline specific to their interests and training as well as physicians and scientists of a more generic form. Faculty status and faculty promotion should be accorded with these points in mind. While individual faculty members should be directly related to individual medical students, a general program of student affairs and counseling students in the context of their career could be a prominent part of the organizational framework of the school of medicine. The priority of education and the development of both faculty and students as an integral part of the responsibility of the dean and the chairmen is a hallmark by which a school should be known as well as that hallmark related to research and service.

Recommendation 4

> Medical schools should establish programs to assist members of the faculty to expand their teaching capabilities beyond their specialized fields to encompass as much of the full range of the general professional education of students as is possible. The Association of American Medical Colleges should facilitate the development of these programs.

Stemmler:

The responsibilities to be assumed by faculty members in the undergraduate medical education come under the auspice of the schools. Here our Association might well consider initiating a program of grants to selected faculty for the development of competence in the field of general professional medical education.

Brown:

primarily the responsibility of the medical schools and their faculties; the AAMC must provide courses, seminars, workshops, and gather the appropriate literature

Moy:

I agree that the AAMC could provide very important leadership here. The general assumption is that a mentor would have to be a highly sophisticated generalist. While this is desirable, it is not necessarily true. The important factor is that in self-directed learning you are assisting the student in learning for themselves, not giving them the answers, and in fact, the mentor as well as the other members of the small group can learn a great deal from the student who has effectively solved his own assigned learning needs. This is, however, very much a skill and can be acquired. I think this could be a very important role for the AAMC.

Chapman:

Teaching teachers how to teach is, in this observer's view, not a highly productive program of effort. Channeling energies and providing opportunities for understanding as well as providing prototypes for consideration can be important contributions on the part of the Association. Recognition awards for teaching, both locally and nationally, can also be helpful either by the Association or otherwise at the local level. Special grants such as those from the national funds for medical education can also be helpful.

Recommendation 5

Medical faculties should provide support and guidance to enhance the personal development of each medical student.

Stemmler:

This is clearly the responsibility of school faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC can advocate and raise the level of concern. Here again, LCME provides specific oversight to see that these support mechanisms are in place.

Chapman:

Personal development of the medical student is a very personal matter to the student which can, through guidance from faculty and offices of student affairs and others, be facilitated though it is a highly personal thing. Experience on a national level to how students interact with thier schools through student affairs and faculty advisory systems might be helpful. In general, the faculty advisory system beyond the mechanical process of enrollment and registration has been disappointing. Areas in which greater success have been achieved would be of interest to schools generally and might be an effort on behalf of schools by the Association.

Recommendation 6

Experience indicates that the commitment to education of deans and departmental chairmen greatly influences the behavior of faculty members in their institutions and their deparments. By their own attitudes and actions, deans and departmental chairmen should elevate the status of the general professional education of medical students to assure faculty members that their contributions to this endeavor will receive appropriate recognition.

Stemmler:

This belongs to the individual schools.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC can provide considerable assistance here by keeping the agenda of quality general professional education of the physician actively before the Council of Deans and the Council of Academic Societies.

Chapman:

Certainly the commitment to eduction of deans and departmental chairmen is integral to the behavior of faculty members. Deans can interact with the process through their recruitment efforts of chairmen and chairmen throught their recruiment efforts of faculty and for deans, the selection of the deanship as academic leader of the faculty and students should be a prominent part of the consideration of any selection. Medical education as an ancillary effort is an unacceptable set of circumstances. One important Association contribution is the annual questionnaire to graduating seniors who are asked to reflect upon the most positive and most negative aspects of their educational experience. In my view, this is an important activity which should be continued and even enhanced based upon input from the several deans and from faculty.

FUTURE DIRECTIONS FOR THE AAMC

Attached is a compilation of Board members' essays into a single document that remains faithful to the original words and ideas, but which, for ease of reference, sets them in an organizational framework.

It is remarkable how differently each member approached his task. Dr. Daniels focused his effort on recommended modifications to the issues paper; Dr. Meikle, working with his staff, proposed a framework for the AAMC to approach its strategic planning task. Dr. Butler described the various stages of his involvement with the AAMC and his varying levels of satisfaction with each; Dr. Stemmler emphasized matters of AAMC governance and the search process; Dr. Kettel highlighted his interest in having the AAMC act as an umbrella for more groups which have an influence on medical education; the views of Drs. Leavell, Brown, Clawson and Bowles are more discursive assessments of the AAMC; Drs. Russe and Naughton have not as yet been able to respond to this matter.

In general, the papers were quite thoughtful and that the process appears to be a very useful way to capture the perceptions of the Board members. The compilation highlights areas of concurrence and identifies areas of divergence for future discussions.

TABLE OF CONTENTS

I. MISSION

The AAMC . . . requires a mission statement which is concise, consistently contemporary and reflective of the organization's basic orientation. The current mission statement, without modification, meets these criteria.

Walter F. Leavell

It is hard for me to see why its function should be significantly changed.

L. Thompson Bowles

The primary concern of the AAMC should be medical education.

Arnold L. Brown

(w)e should reaffirm that our primary mission is medical education.

D. Kay Clawson

It is evident that the purpose of the organization is to improve the quality of medical education throughout the country.

William T. Butler

(The AAMC's) activities thus must center about the mission of advancing medical education in its broadest sense.

Louis J. Kettel

The focus of the Association should continue to be on medical student education with graduate education being an important variable in the continuum of this educational process.

Walter F. Leavell

It should be the job of the AAMC, and it has been, to continually remind those in the medical education establishment of what their basic and most important responsibility is.

Arnold L. Brown

The Association until the last two years has not emphasized sufficiently. . .its interest in medical education.

Robert S. Daniels

I strongly support the concept that medical schools are the prime focus of our organization and that it should be all medical schools.

Richard M. Moy.

We (should) maintain a narrow focus on the issues that relate to the functions of medical schools, hospitals and faculties.

Edward J. Stemmler

I. Mission, including identification of constituencies: options

A. Society for advancement of medical schools and teaching hospitals

1. more restrictive than AAHC, excluding other health professional schools, etc.
2. broader than present mission, as reflected in By-Laws.
3. reflects increased importance of teaching hospitals: co-equal.
4. president might be primarily experienced in hospital affairs.

B. Society for advancement of medical schools

1. broader mission than only medical education.
2. includes research, service in addition to education.
3. missions of teaching hospitals not comprehensively considered.

C. Society for advancement of medical education

1. represents current mission, statement which fails to reflect current activities and governance of AAMC.

2. might suggest person should be a known medical educator.

Thomas H. Meikle

II. STRUCTURE

Assessment

It is extremely important that we maintain this organization as representing multiple constituencies and multiple institutions. The medical college, medical education, and the deans must be the first among equals. This primacy should not be exploited, however, and in no way should we de-emphasize or depreciate the other functions, agencies, or people. The strength and creativity of the AAMC has been its capacity to adapt to the socioeconomic circumstances of particular times and represent many viewpoints and many manpower interests. We cannot afford to fragment this organization. I believe that it would be very bad for everyone.

Robert S. Daniels

It would appear that the membership is not seeking a specific organizational change in structure, but wishes to be assured that the Association is truly representative of all participants, is dynamic, adaptable, maintains flexibility and is responsive to the input and concerns of its membership.

Walter F. Leavell

The current organizational structure appears to have the necessary flexibility to accommodate new constituent groups or constituent interests as the need identifies itself.

Walter F. Leavell

The Group on Student Affairs and the Group on Medical Education, as examples, are freestanding entities, essentially reporting to staff. There is no mechanism for regular dialogue or direct communication with these groups.

William T. Butler

While there are fairly frequent contacts between the three councils, just as there are locally, there seems to be little effort to integrate such bodies as the GME, GSA, or RIME into the general flow of information and contacts of the Association. This also is a reflection of the local situations.

Arnold L. Brown

Organizationally, too, I believe that it would be wise to articulate the groups interested in education in the AAMC with the policy making and governance structures. There should be clarity between the goals of most associations and the specific functions of education, research, and clinical care.

Robert S. Daniels

- COD: does the current strcture foster and support interactions among medical schools with common interests

should the relationship of GSA, GME, OSR, etc. to the COD be defined better
should regional groups be actively encouraged and supported
Thomas H. Meikle

(T)here is no other home for the faculty medical educators...nor while there are fairly frequent contacts between the three councils, equivalent in the clinical arena to the hospital staff section of the AMA...(T)here is not a group of housestaff in the AAMC equivalent to the Organization of Student Representatives (OSR), (n)either is there a precise home for directors of licensing boards, housestaff program directors, and the like within the AAMC.
Louis J. Kettel

My impression is that (the CAS has) not represented education well nor represented the faculties well. However, their statement is balanced and comprehensive so perhaps they are modifying their historic position.... (their) interests and activities should include not only medical student education but graduate medical education as well (housestaff and fellows).
Robert S. Daniels

I suspect, for example, that there is relatively little active participation in the Council of Teaching Hospitals by the administrators of the hospitals affiliated with community-based medical schools for a variety of reasons, but in part because the COTH has been traditionally accommodated by and concerned with the problems of more traditional university owned and operated institutions.
Richard H. Moy

We should reexamine the relationships among the various components of our Association. The Council structure works well and is not an issue. What is an issue is the interface between the Councils. The relationship among Councils is presently not well served through the Executive Council but could be.
Edward J. Stemmler

Staff Organization

-do the departments and divisions of AAMC and their levels of staffing reflect the associations priorities.
Thomas H. Meikle

Recommendations

Serious consideration ought to be given to ways in which the various groups within the Association can communicate more effectively within the governance structure. This is not an argument to make groups part of the governing body but to establish more effective lines of communication.

Edward J. Stemmler

At the Administrative Board meeting, each of us has some understanding of the issues in our respective schools, but we may not understand collectively the problems and concerns of the GSA, for example, in the other 128 schools. Thus, a formal mechanism to integrate these functions would provide a more meaningful base of information for decision making by the respective councils.

William T. Butler

While simplistic, straightforward solutions lie in the formation of a faculty group equivalent to the Group on Student Affairs called the Group on Faculty Affairs (GFA) and an organizataion of housestaff representatives (OHR) equivalent to OSR. Within the Group on Medical Education a subset for program directors, CME directors, licensing directors, and the like, could be created. Representation on the Council of Deans Administrative Board could occur from the several groups and organizations within the AAMC parallel to the successful OSR membership on the Board.

Louis J. Kettel

I would like to have thought given to the substructures of the Association or, at least, the Council of Deans. Our only official substructures are the four geographic regions which, as we have observed, are not terribly functional with the current exception of the Southern deans. On the other hand, there are groups that appear to be functional and to be meeting needs. These are state groups. (For example, the New York deans and the Illinois deans which have active state organizations, met together in Chicago for the first time and found common interests which will prompt them to meet again.) There also is a group of free-standing schools and the community-based schools.

Richard H. Moy

The group, which was formerly known as The New and Developing Community-based Medical Schools, is choosing to drop the New and Developing and essentially commit itself to representing those medical schools, old or new, and those components which are community based and, thus, share unique concerns or unique variations of general concerns as compared to more traditional schools. At their meeting in Chicago, this group asked their new president, Bill Sawyer, to explore having official status within the Council of Deans or the AAMC.

Richard H. Moy

In my judgment, if the Association is to have credibility as it would relate to the implementation of the GPEP Report, focusing on our primary mission of medical education, the structure of the AAMC must be organizationally representative in a demonstrable manner.

Walter F. Leavell

I am skeptical and, for now, opposed to creating a new Council for faculty. I am also opposed to the AAMC taking on health science programs beyond those relating to the education of medical doctors.

L. Thompson Bowles

What I am proposing is the formation of standing committees comprised of a number of deans, faculty, COTH members, and students to meet on a regular basis. The majority of committee members would not be members of the Ad Boards although all Ad Boards would be represented, and one Ad Board member would serve as chairman. The committees would be advisory to each of the respective councils, and each council would benefit from the diversity of opinions, and each council would benefit from the divesity of opinions expressed in their deliberations. How many such standing committees would be needed or useful needs careful study.

William T. Butler

The COTH increasingly must examine its interfacing relationship ship with the medical school. This examination is not being done on a philosophical basis, since by definition COTH would not exist unless it is structured as an academic health care delivery system. However, it must also maintain its existence and competitiveness in the marketplace.

Walter F. Leavell

III. GOVERNANCE

Assessment

Recently, I have recognized that the Executive Council really was not the deliberative body that I had expected it to be and think that attention should be given to having far more open deliberations at that body, rather than a perfunctory approval of the actions that have been taken by the various Councils.

D. Kay Clawson

The function of the Executive Council as the governing body of the Association needs greater recognition during this period of transition. Council meetings have been rather pro-forma and there is little opportunity for the Council to function as a deliberative or governing body.

Edward J. Stemmler

It is important to recognize that many deans have felt disenfranchised and isolated from the process of deliberation on the issues and from other components of the organization. Admittedly, this is an extremely difficult problem, because the creation of a more deliberative process which involves many people may slow the machine down to the point that consensus cannot be attained before a critical vote in Congress or a final decision is required.

William T. Butler

The issues of governance are currently dominant, yet I am impressed that the present system has served us well.

D. Kay Clawson

There is some danger to the Association's operation if the Executive Council becomes too powerful a body. This issue of the balance in power between the President and Council is one to consider seriously. I am acquainted with other voluntary organizations in which the Council or Board structure has so much to say that the actions of the president are held in unreasonable check. On the other hand, there should be some awareness that lack of exercise of accountability by the Council may provide too much freedom for the President. John Cooper has managed this balance quite effectively.

Edward J. Stemmler

Governance:

- are COD, COTH, CAS co-equals; should they be equally represented on Executive Council

- COTH: should hospital CEO be representative of TH
  is membership too broadly defined
  is widespread constituent participation fostered
  is regional representation balanced

- CAS: is CAS co-equal with COD and COTH
  is CAS effective within AAMC
  does CAS communicate adequately with constituent societies

Thomas H. Meikle

Recommendations

We should be more concerned about the extent to which the Executive Council is really integrating the activities and developing policies of the various constituencies and functions of the AAMC. Currently, formal integration takes place only at the top when most issues are nearing the 'rubber stamp' level and apparently sometimes after many deans have gone home.

William T. Butler

Since (the Executive Council) does represent the point of accountability for the search and recruitment, and since it also represents the body which must approve any restatement of the mission and job description, the opportunity for more thoughtful meetings should be provided. This may require rescheduling of the Executive Council to a time when its members can attend and there may be other accommodations which the staff might consider and propose as well.

Edward J. Stemmler

Procedures could be developed to assist the Administrative Boards' members in having a better feel of the 'pulse' of the membership's thoughts on policy matters. This input may have to be actively sought because I believe that most non-Ad Board members tend to be somewhat passive participants. We need to discuss additional ways to enhance this functional representation, through involvement, participation and communication.

William T. Butler

I do not believe we should have more, different organizations inputting into the governance of the AAMC, but do believe that the various constituent bodies that are functioning should have a relationship with an appropriate Council in order to improve communications.

D. Kay Clawson

I believe that the Officers Retreat would benefit greatly by retaining the immediate past chairman as participants. I am struck by how much one learns during the course of the year as chairman...I admit that there is a risk of excessive intrusiveness on the part of a past leader, but the value of having an experienced perspective when one plans a future, surmounts the bad risk, in my opinion.

Edward J. Stemmler

IV. PROGRAM PRIORITIES

Assessment

The AAMC has performed very well the several functions of a service association. Its leadership has carefully sought the opinions of the members and based its advocacy upon them. As the legislative and executive branches of government, and the public generally, become even more concerned and involved in medical practice, reasoned and informed presentation of our views will become ever more important. The leadership of the Association must express these views from a reservior of experience, accomplishment, and conviction that will provide the assurance that those arguments proceed from the basic precept of the organization--the concern for the quality of medical education.

Arnold L. Brown

The central purpose of the Council of Deans is to defend excellence in medical education and biomedical research.

Sherman M. Mellkinkoff

Both the COD and CAS express strong sentiments in their position papers concerning adequacy of research funding and the support that this traditionally has provided the academic institutions. The Council of Teaching Hospitals, likewise, are cognizant of the important role of research. However, they must also concern themselves with cost containment and have the need to be assured that research is paving its own way.

Walter F. Leavell

There are many issues surrounding research, such as, funding, industry-university relationships, and research fraud which deserve the attention of the AAMC. I realize that some of these topics have been dealt with in the past, but I believe more work needs to be done on a continuing basis.

Hibbard E. Williams

I continue to worry about the absence of any organized leadership by the Association in the area of medical practice plans. It is not just the mechanics of practice plans but the effective organization of health services for the purpose of medical education that should be addressed. By our silence we are losing our constituents.

Edward J. Stemmler

The COD, COTH and CAS are each equally concerned about the necessity and dependency on clinically derived income for supporting medical education and the consequences of this dependency, as it would relate to changes in policy by third party payers and legislative bodies.

Walter F. Leavell

There appears to be a uniformity of concern regarding the most appropriate means of funding medical education. The COD expresses an aggregate and comprehensive concern in terms of institutional support, as well as availability of loans and scholarships for students. The CAS similarly is concerned while the COTH expresses a need for identifying support for academic programs within its constituent environment.

Walter F. Leavell

I am becoming more and more discontented with the amount of time and effort that goes into the discussion of financial matters in the medical school. Somehow, we have to balance this with discussions and efforts in more scholarly things. The AAMC should lead the way in these kinds of activities.

Hibbard E. Williams

Should the Association and its members undertake to inform the public better about the extraordinary career opportunities which exist in medicine and to encourage young people to take more seriously the possibility of choosing this career? Further attention to the finance of tuition and living expenses is indicated and the need to promote low-interest loan funds in the service of improving the financial feasibility of medical education is important. Mention might also be made of the real experiences with women and minorities since the 1960's and the potential that the professional may be undergoing as restructuring in that more physicians will practice in large organizations, more will be employed and salaried, more will work fewer hours, and the life of a physician will be more regularized.

Robert S. Daniels

The AAMC must also concern itself with the quantity and quality of the applicant pool and, therefore, concern itself with some aspects of the undergraduate educational process. COD approaches the issue through strong support of the recommendations of the GPEP, while CAS added the dimension of accreditation, licensing and certifying authority.

Walter F. Leavell

The educational programs, at least for the COD, have been relevant, informative, and well conducted. This is an important activity of the AAMC and should be continued.

Arnold L. Brown

Thought should be given to renewing the courses in pedogogical technique for both deans and faculty.

Arnold L. Brown

In terms of providing the membership with timely information concerning our environment as well as gathering and analyzing a widerange of appropriate data, the Association has done very well.

Arnold L. Brown

Program Areas = problems confronting constituents

A. Medical Schools

1. undergraduate medical education

- student selection; role of MCAT
- should enrollments be reduced; how to regulate supply/demand
- how to discourage study in inferior foreign medical schools
- will adequate numbers of qualified applicants be available
- how to broaden racial and socio-economic diversity
- how to encourage and finance needed changes in medical curriculum
- how to obtain increased financial aid for needy students
- how to avoid continuing large increases in tuition
- what is appropriate role of LCME; NBME

2. graduate medical education

- how to control quality and by whom
- how to finance
- should FMGs continue to be accommodated
- should supply of specialty positions be regulated
- how to attract graduates to underserved areas

3. continuing medical education

- is CME successful in improving the quality of health care

4. medical school financial support

- how to maintain fiscal stability in environment of change
- how to preserve appropriate balance of research/educaton with increased commercialization of medical service
- how to control faculty practice plans
- how to determine educational costs

B. Teaching Hospitals

1. patient care activities

- how to maintain physicians control of patient management
- how to evaluate quality of care in era of cost containment
- how to adapt to a competitive environment
- how to respond to investor-owned initiatives
- how to identify appropriate marketing strategies
- how to develop management/financial data
- how to fund the care of charity patients
- how to determine costs per case
- how to handle ethical problems

2. educational activities

- what are alternate methods of financing educational costs
- how to maintain reimbursement policies which support medical education and research

3. research activities

- how to maintain indirect support for clinical research

C. Faculty

1. educational activities

- how to improve quality of teaching
- how to increase teacher-student interaction
- how to increase importance of teaching and education in medical school environment
- how to support faculty for educational activities directly

2. research activities

- how to attract bright, creative young faculty in era of reduced or at least stabilized funding for research
- how to maintain graduate programs in research with decreased federal support
- how to make research careers attractive especially to MDs
- how to insure stable, adequate funding for biomedical/behavioral research and research training
- how to achieve balance between support for program projects and individual investigator-initiated projects
- how to improve funding for new equipment and the construction of renovation of research facilities
- how to achieve appropriate balance between direct and indirect support of research costs
- how to develop appropriate regulations for control of research wastes, animal and human subjects in research, and genetically engineered research products
- how to encourage and appropriately utilize research support from industry

D. Funding - support

- is the AAMC too dependent on MCAT revenues
- are the dues appropriate for each constituency
- should more support be sought from foundations and governments

E. Major activities or functions in support of programs

- advocacy of AAMC positions
- information for constituents
- education of constituents and others interested
- liaison with other organizations
- research on appropriate topics
- participation-communication among constituents

Thomas H. Meikle

V. EXTERNAL RELATIONS

Assessment

Our external relationships...(our engage[ment] in the broad array of health policy organizations) deserve a more systematic evaluation.

Edward J. Stemmler

The environmental impact in relationships might be expanded and developed [in the COD Issues Paper]. Are we still respected and are we listened to by legislative and public administrative bodies? The collaborations with other bodies representing constituencies (the other associations) are also very important.

Robert S. Daniels

Do we need more interaction with outside organizations? I do not really have sufficient understanding of the working relationships which now exist to comment constructively. On the other hand, the development of appropriate coalitions may be essential if we are to be effective in bringing about change.

William T. Butler

Our interface with international medicine is not developed well enough at all. I do believe that we should provide more organized recognition of the common interest of medical education in the world.

Edward J. Stemmler

VI. COMMENTARY ON THE ISSUES PAPER

The 'Background' statement is a good one. I would expand it by including a statement on the multiple functions--education, research and clinical care. Comments on trends in each of these in terms of activity and financial support would be appropriate. The Association has such data in its recent testimonies to Congress. This information could be woven into 'The Issues' paragraph.

Robert S. Daniels

In the introduction it would be useful to make clear that this statement has as its purpose the posing of questions to which the Association and its member institutions should turn their attention. This statement attempts to address a three to five-year agenda for the rest of this decade (the 1980's).

Robert S. Daniels

The 'Foreign Medical Graduates' section should be moved to close proximity to the paragraph on size. It would be worthwhile to emphasize the importance of a comprehensive approach to manpower issues which assure adequate numbers; there should not be large over-population there must be assurances about quality; the decision should be made on quality bases and a good evaluation system.

Robert S. Daniels

In the 'Financing' paragraph there might be some further comment about the possible commercialization of the academic medical center, the need to evaluate new corporate forms, both for-profit and not-for-profit, and the possibilities of new and diverse functions.

Robert S. Daniels

I continue to believe that our statement is a useful one. Along with the other two papers, there could be generated a synthesized statement about which there could be a consensus. Such a statement would be very valuable. It should not, however, be focused on the answering of questions. It should concentrate, rather, on raising questions which then might direct the search by suggesting important functions and activities and necessary skills and strengths.

Robert S. Daniels

The three (3) position papers (COD, COTH, CAS) are concurrent on the mission. The COTH paper relates to the complexities of being a teaching hospital in support of the mission, while simultaneously maintaining competitiveness in a rapidly changing environment.

Walter F. Leavell

VII. SELECTION OF THE NEW AAMC PRESIDENT

One central issue surrounds the definition of the role of the President...A specific job description should be written and approved by the Executive Council prior to the appointment of a new president.

Edward J. Stemmler

(T)here must be a stated policy on (the president's) term of office, the review process for performance, and the procedures which are to be used for continuation or termination...all of these issues are silent within our current bylaws but should not be.

Edward J. Stemmler

We can only be effective on a national scope by supporting and working with an intelligent, honorable, well-educated, altruistic, conscientious and talented president like John Cooper.

Sherman M. Mellkinkoff

The new president of the AAMC must be a distinguished medical educator.

Arnold L. Brown

More important, though, is to find the best and strongest person. I would be suspicious of a search focused too much....We need a strong generalist with broad interests and experience who can oversee and develop the many different aspects of the Association.

Robert S. Daniels

One of the great strengths of the Association has been the quality and continuity of the senior staff that John has brought together. It would be my hope that the process of the search, as well as its result, would maximize the likelihood of these people continuing with the organization and that when they must be replaced, it is by people of the same general caliber.

Richard H. Moy

1985 COD SPRING MEETING

Attached is a schematic of the COD Spring Meeeting as developed by the Spring Meeting Planning Committee consisting of: Dr. Brown, Dr. Stemmler, Dr. Clawson, Dr. King, Dr. Behrman, Dr. Byran and Dr. Ross.

The COD Spring Meeting planning committee was conscious of the fact that the transition in the Association's leadership and the attention being devoted to the three Council issues papers give continuing prominence to the matter of Association mission and future. This, together with the high level of satisfaction with the last COD Spring Meeting and the frequent expressions of interest in small group discussions, resulted in the proposal that a significant proportion of the Spring Meeting be assigned this topic in a format which would facilitate maximum participation. The meeting has been structured to dedicate the second half of the first morning and the first hour of the second morning to this.

It is Dr. Brown's current plan to introduce the matter immediately after the coffee break with some instruction and orientation and then convene the small groups for a solid hour and a half discussion. Each board member was asked to serve as discussion leader of a nine or ten member group constructed so as to be as heterogeneous as possible. (See attached for the proposed make-up of the groups.) The Board member/discussion leaders will meet for lunch for the purpose of developing a collation and synthesis of the various groups' views for a single report back the following morning. The report back segment will be as brief as possible, simply highlighting areas of convergent and divergent views, to permit most of the hour to be reserved for general discussion.

Questions for consideration:

1) Should the small group discussions be given any guidance with respect to topic or format?

   a) Should there be any attempt to assure comprehensive coverage of appropriate topics by the deans?

   b) Should there be any effort to minimize overlaps between groups?

   c) Are there topics that need special or detailed attention?

2) Is there some product to be sought from the small groups?

   a) Are we, for example, seeking a prioritization of issues and programs of the Association?

3) What stimulus materials should be provided to the groups or the Council as a whole, for preparation for this discussion?

Document developed to date relating to this topic include:

- three Councils' issues papers;
- three short papers that were written for the Retreat agenda book;
- Dr. Cooper's paper;
- October COD Administrative Board minutes;
- Board member essays and compilation of these.

In addition, it has been suggested that a precis or executive summary of the COTH and CAS issues papers be prepared to highlight for the deans matters of concern to those groups.

4) Is it desirable to use any specific group discussion techniques, such as, for example, the nominal group process?

5) Are the proposed small group assignments satisfactory?

Distribution of COD Among Board Members

Louis J. Kettel

James A. Pittman
Robert U. Massey
Philip M. Foreman
Jay P. Sanford
Harry S. Jonas
Hendrik H. Bendixen
Tom M. Johnson
Harry Prystowsky
Claud Kern Wildenthal
Edward J. Lennon

Henry P. Russe

Thomas A. Bruce
John F. Stapleton
Harry N. Beaty
Daniel C. Tosteson
M. Kenton King
Arthur Hull Hayes, Jr.
Colin Campbell
Sol Sherry
Louis A. Faillace
Enriquez Mendez, Jr.

D. Kay Clawson

Stanley Van den Noort
William B. Deal
John W. Eckstein
Henry H. Banks
Charles A. Dobry
Robert J. Joynt
Manuel Tzagournis
Marcus W. Newberry
Cecil O. Samuelson
Raja Khuri (?)

L. Thompson Bowles

Stanley E. Crawford
Leon Rosenberg
John R. Tobin
John I. Sandson
James F. Glenn
Richard E. Behrman
Thomas Detre
George T. Bryan
Raul A. Marcial-Rojas
William Stoneman, III

Richard H. Moy

Hibbard E. Williams
Russell L. Miller
Walter J. Daly
Robert E. Tranquada
Richard L. O'Brien
Saul J. Farber
John P. Kemph
David S. Greer
Timothy Caris
Pedro J. Santiago-Borrero

Thomas H. Meikle

Sherman M. Mellinkoff
Bernard J. Fogel
Robin D. Powell
W. Donald Weston
Robert M. Daugherty
Richard Schwarz
William D. Sawyer
J. O'Neal Humphries
William H. Luginbuhl
Paul Royce

John Naughton

Robert G. Petersdorf
Andor Szentivanzi
Donald R. Kmetz
Peter A. Ward
Robert W. McCollum
Marvin Kuschner
Charles B. McCall
Robert H. Quinn
Richard G. Lester
Louis J. Sullivan

Edward J. Stemmler

Henry L. Nadler
Paul D. Webster, III
Perry G. Rigby
Franklyn G. Knox
Fairfield Goodale
Richard C. Reynolds
John W. Kendall
Robert L. Summitt
Leo J. Dunn

William T. Butler

David Korn
Donald W. King
Richard S. Ross
Norman C. Nelson
Robert L. Friedlander
Stuart Bondurant
Joseph S. Gonnella
Robert S. Stone
Robert W. Coon

Robert S. Daniels

Rudi Schmid
Richard M. Krause
Paul F. Larson
Henry L. Nadler
Vincent Lanzoni
George F. Reed
Larry D. Edwards
Herschel L. Douglas
Norman Knorr
William P. Bristol

Walter F. Leavell

Allen W. Mathies
Terence A. Rogers
James T. Hamlin, III
David M. Brown
Arthur C. Christakos
Leonard M. Napolitano
John R. Beljan
John E. Chapman
David C. Dale

Arnold L. Brown

Joseph St. Geme
Marshall Falk
Marjorie P. Wilson
William Bradshaw
Dominick P. Purpura
William E. Laupus
Alton I. Sutnick
J. Ted Hartman
Richard DeVaul

1985

SPRING MEETING
of the
COUNCIL OF DEANS

March 20-23, 1985
The Cottonwoods

PROGRAM

Wednesday, March 20th

1:00-5:00 pm, Hotel Lobby
ARRIVAL & REGISTRATION

SESSION I

5:30-7:00 pm, Ballroom
WELCOME & OVERVIEW
PRESIDENT'S REPORT
John A. D. Cooper, M.D.

7:00-8:00 pm, Poolside
RECEPTION

Thursday, March 21st

SESSION II

8:30-10:30 am, Ballroom

Moderator: Donald W. King, M.D.

Hilary Koprowski, M.D.
Wistar Professor of Research Medicine
University of Pennsylvania
Director, Wistar Institute

Moderator: D. Kay Clawson, M.D.

REVIEW OF BASIC SCIENCE TEACHING
Ernst Knobil, Ph.D.
H. Wayne Hightower Professor in the Medical Sciences & Director of the Laboratory for Neuroendocrinology
The University of Texas
Health Sciences Center at Houston

10:30-11:00 am, Ballroom
BREAK

SESSION III

11:00-1:00 pm, Ballroom

Moderator: Arnold L. Brown, M.D.

FUTURE DIRECTIONS FOR THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Small Group Discussions

1:00 pm
UNSCHEDULED TIME

Friday, March 22nd

SESSION IV

8:30-10:30 am, Ballroom

Moderator: Arnold L. Brown, M.D.

FUTURE DIRECTIONS FOR THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Moderator: Edward J. Stemmler, M.D.

REPORT ON THE TASK FORCE ON FINANCING GRADUATE MEDICAL EDUCATION

10:30-11:00 am, Ballroom

BREAK

SESSION V

11:00-1:00 pm, Ballroom

Moderator: Richard H. Moy, M.D.

TEACHING CLINICAL MEDICINE IN THE AMBULATORY SETTING
Gerald T. Perkoff, M.D.
Professor of Family Medicine
University of Missouri
School of Medicine

Moderator: Robert Beran, Ph.D.

MCAT ESSAY PILOT PROJECT

-Edward White, Ph.D.
Former Director, Statewide Calif. State University English Equivalency Exam
-Marliss Strange
Associate Director, Counseling
University of Oregon
-Zen Camacho, Ph.D.
Associate Dean
Baylor College of Medicine
-Terry Leigh, Ph.D.
Associate Dean, Student Affairs & Admissions
University of Kentucky

1:00 pm
UNSCHEDULED TIME

SESSION VI

8:30-12 noon, Ballroom

COD BUSINESS MEETING

12 Noon

ADJOURNMENT

PROGRAM PLANNING COMMITTEE

Richard E. Behrman, M.D.
Arnold L. Brown, M.D.
George T. Bryan, M.D.
D. Kay Clawson, M.D.
Donald W. King, M.D.
Richard S. Ross, M.D.
Edward J. Stemmler, M.D.

AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS SPRING MEETING

Program

March 20-23, 1985
The Cottonwoods
Scottsdale, Arizona

COUNCIL OF [redacted] SPRING MEETING

1985 Preliminary Program

	Tuesday March 19	Wednesday March 20	Thursday March 21	Friday March 22	Saturday March 23
7:00 am			**Regional Breakfast**	**Regional Breakfast**	**New & Dev Deans Bkfst**
8:30 am			New Science Topic: Dr. Koprowski	AAMC Futures Report Back	
9:00 am		New Deans Orientation	Review of Basic Science Teaching Dr. Knobil	Financing GME: Buchanan, Kettel, Weston, Stoneman, Petersdorf	Council of Deans Business Meeting
10:30-11:00 am			* BREAK *		
			AAMC Futures: -½ hour intro -instruction/ warm-up -1½ hour small group disc	Teaching Clinical Medicine in Ambulatory Setting: Gerry Perkoff MCAT Essay Pilot Panel: (see attached)	
1:00 pm		Registration	Discussion Leaders Meeting & Lunch	**COD Administrative Board Luncheon**	
			"UNSCHEDULED"	"UNSCHEDULED"	
5:30 pm	New Deans - Orientation	-Welcome -Overview of Meeting -President's Report -Intro of Bus Mtg Issues			
6:30 pm	Reception New Deans			Cookout	
7:00 pm		COD RECEPTION			

ESSAY PILOT PROJECT PANEL

Recent Advances in Writing Assessment

--Edward White, Ph.D.
Department of English
Calif. State University, San Bernardino

Director, Statewide California State University
English Equivalency Examination - 11 years

Topic Selection

--Marliss Strange
Associate Director, Counseling Office
University of Oregon
Health Professions Advisor

Pros and Cons of Scoring

--Zen Camacho, Ph.D.
Associate Dean
Baylor College of Medicine

Evaluating the Impact - Review of Research Plan

--Terry Leigh, Ph.D.
Associate Dean, Student Affairs & Admissions
University of Kentucky College of Medicine

Moderator: Robert Beran, Ph.D.
Associate Director
Dept. of Educational Measurement and Research
AAMC

St. Louis University
Medical Center

School of Medicine
1402 S. Grand Blvd., St. Louis, Mo. 63104
314/664-9800

Office of the Dean

October 17, 1984

Mr. Joseph A Keyes, Jr.
Director, Department of
Institutional Development
AAMC
One Dupont Circle, N.W.
Washington, DC 20036

Dear Joe:

I am writing at the suggestion of Ed Stemmler with whom I discussed the following matter on the telephone yesterday. It is his suggestion that you attempt to provide space on the Council of Dean's Agenda under New Business for this subject.

Subject -- Encroachment by specialty residency program directors on the undergraduate clerkships.

Background -- With increasing competition by medical students for positions in desirable specialty residencies, including, but not limited to the surgical subspecialties, program directors are increasingly requesting candidates to spend an elective clerkship at their institutions prior to graduation. In the past it has been possible to accommodate this during elective time in the senior year subsequent to completion of the junior year core clerkships. However, with more and more of these specialties working outside the NRMP match, increasing pressure is being placed on student candidates to visit during their junior year. This problem is growing rapidly and will require concerted action by medical schools, the LCME, and an appropriate strategic approach to the other entities who are a part of the problem (among them many of our own department chairmen). It would seem imperative that medical schools assume a unified position in this matter.

Action -- Between now and the time of the Chicago meeting, I will have sought advice from a variety of sources on actions

which might be taken outside the AAMC in addition to action by the Council of Deans. Certainly the Section on Medical Schools of the AMA should consider taking a position. I believe the problem is very widespread and will be prepared to suggest a strategic course. I would presume that the action of the Council would be to refer the problem to the Administrative Board.

Sincerely,

Bill

William Stoneman III, M.D.
Dean

WS:jb

cc: Dr. Edward J. Stemmler

SOCIETY FOR HEALTH AND HUMAN VALUES
1311A DOLLEY MADISON BLVD., SUITE 3A, McLEAN, VA 22101 • (703) 556-9222

December 6, 1984

Dr. Arnold L. Brown
Dean of Medicine
University of Wisconsin
Madison, WI 53715

Dear Dr. Brown:

I am writing to you as President of the Society for Health and Human Values. We are a member of the AAMC and encompass physicians, other Health Professionals, and Humanities Scholars actively engaged in or interested in the relationship between the Humanities and Medicine in Medical Centers. A copy of our brochure is attached to this letter.

The reason I am writing you is to enlist your support for a possibility of holding a joint session at the Council of Deans Spring meeting and perhaps at our annual meeting at the AAMC on the GEPEP Report. In order to discuss the implications of this report from the perspective of improving Medical Education and the role of the Humanities in that improvement, we would like to call upon some of our past-presidents who have been Deans of Medicine. I am thinking of such persons as Edmund D. Pellegrino, MD, Joseph M. White, MD and Andrew Hunt, MD.

If you are interested in pursuing this, I would like to ask persons of this caliber to work with Council of Deans in developing a joint presentation.

Sincerely yours,

David C. Thomasma, Ph.D.
Professor of Medicine and Philosophy
Director: Medical Humanities Program
President: Society for Health and Human Values

DT/jb
Enc.
cc: George Degnon

association of american medical colleges

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

(202) 828-0460

January 4, 1985

Mr. Edward Pratt
President
Pfizer Pharmaceutical
235 East 42nd Street
New York, NY 10017

Dear Mr. Pratt:

At this year's AAMC Annual Meeting, the Council of Deans Administrative Board, the leadership group of our institutional members, learned in some detail of the very constructive efforts of the Pfizer Company to bridge the gap between academic medicine and the pharmaceutical industry. I am writing both to congratulate you on those initiatives so ably described by Dr. Rita Wroblewski and to suggest that additional dialogue may be warranted. I think that it might be be useful to explore whether additional efforts in the domain of industry--academe collaboration might be undertaken which would serve interests of both the Pfizer Company and the AAMC and its members.

At the previous meeting, Dr. Wroblewski solicited Board members' suggestions for activities that might be undertaken. This ellicited three ideas already confirmed to Dr. Wroblewski in a letter from the chairman of the Council of Deans, Dr. Brown. The Board suggested that Pfizer might take a leadership role in three areas:

- supporting opportunities for undergraduate-medical students to engage in biomedical research,
- developing a more intense collaborative effort to assure continued freedom to use appropriately animals in biomedical research, and
- stimulating a greater involvement of the pharmaceutical industry in support of adequate Federal funding for biomedical research.

A subsequent AAMC staff discussion surfaced additional ideas. The first was that Pfizer might have an interest in supporting Association efforts now being planned to enhance the teaching effectiveness of our medical school faculties. The second related to a growing perception among the Association's leadership and staff that this country is very minimally involved in the development of the professional medical resources of Third World countries. This contrasts starkly with the activities of Cuba and the Soviet Union and we believe portends a major diplomatic problem for the future. The AAMC member medical schools and pharmaceutical industry might cooperate to mount an appppropriate program on their own or in conjunction with an appropriately aroused Federal Government.

One Dupont Circle, N.W. Washington, D.C. 20036

In any event, I would welcome the opportunity for you and your representatives to join with us in further discussions of these or other suggestions.

Let me again commend you on the initiatives you have undertaken. I look forward to hearing from you.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

ADVISORY COMMITTEE

NATIONAL INVITATIONAL CONFERENCE ON CLINICAL EDUCATION IN THE UNDERGRADUATE MEDICAL CURRICULUM

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Howard University
520 W Street, N.W.
Washington, D.C. 20059
(202) 636-6270

A NATIONAL INVITATIONAL CONFERENCE ON CLINICAL EDUCATION IN THE UNDERGRADUATE MEDICAL CURRICULUM

TECHNICAL PROPOSAL

Submitted in response to RFP# HRSA 240-BHPr-85(4)

July 31, 1984

Submitted by:
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

For information concerning this proposal, please contact:

August G. Swanson, M.D.
(202) 828-0430

TABLE OF CONTENTS

Project and Approach

During the last three years the Association of American Medical Colleges has conducted a major project entitled The General Professional Education of the Physician and College Preparation for Medicine (GPEP), during which the status of clinical education for medical students was scrutinized. Additionally, for six years the Association has been working with the major clinical departments in our medical schools to develop more effective ways to evaluate the performance of students in clinical educational settings. From these projects, it has emerged that the traditional clinical clerkships in which medical students receive their initial clinical education may not be achieving their expected goals, namely, to provide students the opportunity to acquire broad, fundamental clinical knowledge and skills and to instill the values and attitudes that all physicians should possess in caring for patients.

Medical students on average spend 90 weeks in clinical clerkships. Approximately 44 weeks are spent in required clerkships in five major disciplines (see Exhibit A - Table 15). Elective clerkships make up the balance (see Exhibit A - Tables 16 and 17). This investment of time merits maximal attention to its effective use. Yet, in answer to the question in a questionnaire distributed during the GPEP project, "Do evaluation methods and the organization of evaluation data from the clerkships ensure that deficiencies in students' knowledge, skills, and attitudes are identified?", 79.9 percent of 403 clinical faculty members responded, "No." To the question, "Because teaching hospitals' fiscal viability requires that they continue to provide complex medical services, must special pedagogical approaches be developed to

make them satisfactory settings for junior clerkships?", 64.5 percent of 403 clinical faculty members and 67.9 percent of 112 teaching hospital chief executive officers answered, "Yes." These responses indicate an awareness that the clinical education of medical students needs reexamination.

Why is there a lack of confidence in the evaluation of medical students' performance in clinical settings and what special pedagogical approaches are needed to improve medical students' clinical education are subjects worthy of exploration. Accordingly, the Association proposes to hold a national invitational conference on clinical education for medical students. The tentative title for the conference is "The Clinical Clerkship: A Traditional Educational Experience in Need of Reexamination." The major goals of the conference will be to identify the changes in the educational process and the resources needed to assure that clinical clerkships are effective educational experiences for medical students, and to seek approaches to implement change.

The conference will be held in Washington, D.C. in the fall of 1985. The invitation list will include the dean of each U.S. medical school; the dean of each college of osteopathic medicine; the chairmen of the departments of medicine, surgery, obstetrics/gynecology, pediatrics, psychiatry, and family practice in each of the 127 medical schools that are members of the Association; and the chief executive officers of the hospitals that are members of the Council of Teaching Hospitals. In addition, key individuals in the Health Resources and Services Administration and the Health Care Financing Administration will be invited. However, since such a large group (over 1,300) cannot be accommodated, the number of participants will be limited to 400 on a first-come basis with due regard to a balance among the deans, clinical disciplines, and teaching hospital representatives.

The final conference agenda and format will be decided in consultation with an advisory committee (see below), but will principally focus on four areas:

- o The goals of clinical education for medical students in the areas of:
  - a) knowledge
  - b) skills
  - c) values and attitudes
- o The environment for the clinical education of medical students:
  - a) the tertiary hospital
  - b) alternative settings
- o The role of basic science, clinical faculty and residents in the clinical education of medical students
- o The evaluation of the performance of medical students during their clinical education

The conference schedule will involve two days beginning at 10:00 a.m. on the first day and adjourning at 3:00 p.m. on the second. There will be a combination of plenary and small group discussion sessions (20 participants per group).

The proceedings of the conference will be prepared and distributed to deans, clinical department chairmen, teaching hospital chief executive officers, and others interested in the clinical education of medical students.

Distribution as a supplement to the Association's Journal of Medical Education will be considered. Additional funding for publishing a supplement in the Journal will be required.

A six member advisory panel will guide the planning and execution of the conference. It will be composed as follows:

1. A dean of a Liaison Committee on Medical Education (LCME) accredited medical school
2. A chief executive officer of a member hospital of the Council of Teaching Hospitals
3. A chairman of a department of medicine, family medicine, or surgery
4. An associate dean responsible for medical student education
5. A medical student representative from the AAMC's Organization of Student Representatives
6. A representative of the Multidisciplinary Resources Development Branch, Division of Medicine, Public Health Service

The panel will meet within two months of the effective date of the contract (EDOC) to plan the conference and identify the speakers. The second meeting will be held within nine months of the EDOC to review final plans. The third meeting will be at the time of the conference. All meetings will be one day in length and will be held in Washington, D.C.

Organizational Expertise and Experience

The Association of American Medical Colleges is an organization of institutions and organizations involved in the education of medical students in the United States. Our membership is composed of 127 accredited medical schools, 415 teaching hospitals, and 76 biomedical academic societies. Through a Council of Deans, a Council of Academic Societies, a Council of Teaching Hospitals, and an Organization of Student Representatives, all of

those involved in medical education in the United States are represented within the Association.

The Association was founded for the purpose of improving the quality of medical education in the United States. During the past 108 years it has conducted programs and developed national policies pursuant to this purpose. In collaboration with the American Medical Association, the Association participates in the accreditation of United States medical schools through the Liaison Committee on Medical Education.

During the past seven years the Association has conducted two major projects directed toward the improvement of medical education. A Task Force on Graduate Medical Education was established in 1977 and its report, entitled Graduate Medical Education: Proposals for the Eighties, was published as a supplement to Volume 56 of the Journal of Medical Education in September 1981. In 1982 the Association established a panel for a project on the General Professional Education of the Physician and College Preparation for Medicine. This panel, after an extensive study, is now preparing its final report which will be published under the title Physicians for the Twenty-First Century as a supplement to Volume 59 of the Journal of Medical Education in November 1984. In the course of this project, a pamphlet entitled, "Emerging Perspectives on the General Professional Education of the Physician: Problems, Priorities, and Prospects" was published (Exhibit B). Over 15,000 copies have been distributed.

An ongoing project of the Association is an assessment of the evaluation of students in their clinical clerkships. A booklet entitled, "The Evaluation of Clerks: Perceptions of Clinical Faculty" has been widely distributed (Exhibit C). Clinical faculties in eight medical schools are now participating

in a pilot project to assess their procedures for the evaluation of clinical clerks using a format developed with the assistance of the advisory panel shown in Exhibit D.

The Association staff has vast experience in the provision of conferences for medical educators. The range of these is shown in the preliminary program of the 95th AAMC Annual Meeting (Exhibit E).

Exhibits A through D demonstrate the expertise of the Association's staff in the development of educational materials and professional reports.

Personnel

Project Director: August G. Swanson, M.D.
Director, Department of Academic Affairs

Dr. Swanson is a neurologist who, before joining the AAMC staff in 1977, was on the faculty of the University of Washington School of Medicine where he served as Director of the Division of Neurology, Associate Dean for Academic Affairs, and Acting Dean. Among other responsibilities, he has served as Project Director for the Association's Task Force on Graduate Medical Education and the General Professional Education of the Physician Project.

Project Coordinator: Barbara D. Roos
Staff Assistant, Department of Academic Affairs

Ms. Roos joined the AAMC staff in 1982. She was the Assistant Project Coordinator for the General Professional Education of the Physician Project. She is skilled in organizing and managing meetings and conferences.

Editor: Mary H. Littlemeyer
Senior Staff Associate, Department of Academic Affairs

Ms. Littlemeyer has been with the AAMC since 1960. She is a skilled editor and has directed the composition and publication of numerous AAMC reports. Most recently she served as editor for the GPEP Project.

An internal staff committee will work with the project director and coordinator in planning and will participate in the meetings of the advisory committee and in the conference.

James B. Erdmann, Ph.D.
Director, Division of Educational Measurement and Research

Dr. Erdmann has been on the AAMC staff since 1970. He is knowledgeable about all aspects of medical student education.

Xenia Tonesk, Ph.D.
Staff Associate, Division of Educational Measurement and Research

Dr. Tonesk has been with the Association since 1973. She is directing the project on Evaluation of Students' Clinical Performance.

M. Brownell Anderson
Staff Associate, Division of Educational Measurement and Research

Ms. Anderson joined the AAMC staff in 1983. Prior to that she was involved in the Division of Medical Education at Southern Illinois University School of Medicine.

Richard M. Knapp, Ph.D.
Director, Department of Teaching Hospitals

Dr. Knapp has been on the AAMC staff since 1968. He is extremely knowledgeable about the operations of teaching hospitals.

John A. D. Cooper, M.D.
President, AAMC

Dr. Cooper, President of the AAMC since 1969, is a nationally recognized leader in medical education.

Facilities

The facilities for this project will be the Association's office at One Dupont Circle, N.W., Washington, D.C., where all of the necessary equipment can be provided. The conference will be held in an as yet undesignated hotel in the Washington, D.C. area.

PROJECT SCHEDULE

Month	
1	DEC Select Advisory Committee
2	JAN Advisory Committee meets to plan program and select speakers
3	FEB Recruit speakers and commission papers
4	
5	
6	APRIL Invitations sent to prospective participants
7	
8	
9	JUNE Second Advisory Committee meeting
10	JUL/AUG Final participant roster selected
11	
12	SEPT Conference held
13	
14	
15	
16	Draft of Proceedings to Division of Medicine
17	
18	Proceedings published and distributed