COUNCIL OF DEANS
ADMINISTRATIVE BOARD MEETING

Omni Shoreham Hotel
Washington, DC

AGENDA

Wednesday, September 11,1985

6:00 pm - 7:00 pm

Page

I. Joint meeting with the Council of Academic Societies

"Future Policy Implications for the NIH Budget" 1

Guest Speaker: Norman Mansfield
Director
Division of Financial Management
National Institutes of Health

7:00 pm

Reception & Dinner

Thursday, September 23, 1985

8:00 am - 12:00 pm

C. Medical Student Alternative Loan Program
(Executive Council------p. 84)

D. 1986 COD Spring Meeting Planning

E. 1985 AAMC Annual Meeting

VI. Information Items

A. Ad Hoc MCAT Review Committee
(Executive Council------p. 85)

B. Ad Hoc Committee on Faculty Practice
(Executive Council------p. 86

VII. OSR Report

VIII. Old Business

IX. New Business

X. Adjourn

FUTURE POLICY IMPLICATIONS FOR THE NIH BUDGET

In the years immediately before 1978, the number of new and competing renewal research project grants funded by the NIH often varied widely from year to year as depicted in Figure 1.

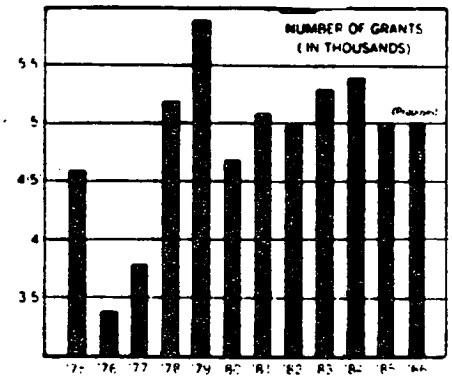

Figure 1

Former NIH Director Donald S. Fredrickson was among the leaders in the effort to convince the Congress of the desirability of funding an inviolable minimum number of new and competing project grants each year to provide stability for the biomedical research enterprise. Based on historic trends, 5,000 was originally proposed as the minimum number of project grants to be awarded; however, the budgetary constraints of recent years have transformed this "floor" into a "ceiling" on the number of new and competing renewal grants per year.

More recently, the biomedical community has argued to Congress that a target of 5,000 grants has no basis in terms of scientific quality and has, in fact, become restrictive in view of the increasing number of high quality grant applications being submitted. Thus, a congressional investment in real growth in order to capitalize on increasing research opportunities requires an appropriation sufficient to fund more than 5,000 competing grants per year. Such an investment was made in fiscal 1985 when Congress appropriated $937.6 million to support approximately 6,500 competing grants at the NIH.

The biomedical research community, perhaps optimistically, assumed that this action meant a congressional commitment to provide sufficient funds to sustain a new "floor" of 6,500 competing project grants a year. It appears in retrospect that neither the biomedical research community nor the Congress fully projected nor understood the budgetary implications of 6,500 competing grants per year. The Office of Management and Budget (OMB) did recognize the rapidly accelerating costs associated with such a sustained increase in the number of grants and attempted to hold NIH to the "traditional" limit of 5,000 grants. In August, as part of the fiscal 1985 supplemental appropriation, Congress reaffirmed its commitment to real growth in the NIH budget by ordering that the fiscal 1985 appropriation be spent to fund at least 6,200 competing project grants and 533 center grants.

This resolution of the deadlock over the number of NIH grants for fiscal 1985 has produced a cohort of new grantees whose second and third years must be supported in fiscal 1986 and 1987 rgardless of how many new grants are awardedin these years. It would be most unfortunate if Congress were to respond to this need for additional funding by a return to the pre-1978 solution of reducing the number of new grants in future years.

Four scenarios are possible. First is the solution proposed by OMB; that is, the cost of such an increase is too great and, therefore 6,500 grants cannot be allowed. The Congress has already rejected this option. Second would be to freeze the amount of funds appropriated in fiscal 1986 at the fiscal 1985 level. The increased amount of funds needed to support the continuing grants plus the rising costs of the grants themselves would mean a preciptious drop in the number of competing grants awarded in fiscal 1986. Third would be to provide for enough additional funds above fiscal 1985 to pay for 5,000 competing grants in fiscal 1986. Fourth would be to provide a substantial increase in funds to permit a continuation of the "new baseline" of between 6,000 and 6,500 grants in FY86 and 87. At present it is unclear which of the latter three options Congress is prepared to support.

A final point needs to be addressed. The NIH budget experienced minimal real growth during the 1970s. In order to sustain even 5,000 fully paid grants with a steadily increasing cost per grant, has meant that RO1 grants have consumed an increasingly large portion of both the extramural portfolio and the NIH budget since 1977 (Figure 2). Any discussions of future budget

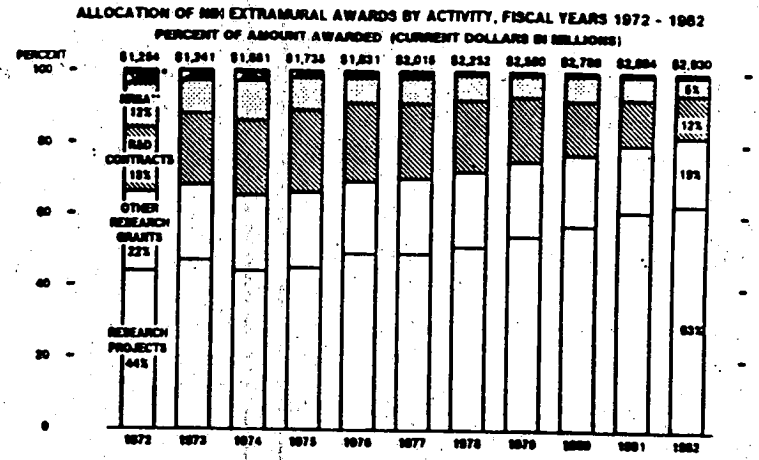

Figure 2

policy with regard to RO1 grants also must take into consideration the implications of these decisions on the other budget mechanisms, such as research training grants, R&D contracts, and the intramural program.

Our discussion Wednesday evening with Dr. Mansfield will include the actual projected costs of a sustained increase in the number of competing project grants and the implications of such costs for the NIH budget as a whole.

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

MINUTES

June 20, 1985
8:00 a.m. - 12:30 p.m.
Hamilton Room
Washington Hilton Hotel
Washington, D.C.

Present

(Board Members)

L. Thompson Bowles, M.D.
Arnold L. Brown, M.D., Chairman
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.
John Naughton, M.D.
Henry Russe, M.D.
Edward Stemmler, M.D.*

(Staff)

Robert Beran, Ph.D.*
Janet Bickel
John A.D. Cooper, M.D.*
Debra Day
John Deufel*
Paul Elliott, Ph.D.
James B. Erdmann, Ph.D.*
Charles Fentress*
Robert F. Jones, Ph.D.*
Joseph A. Keyes, Jr.
Thomas J. Kennedy, M.D.*
Mary Littlemeyer*
James R. Schofield, M.D.
August G. Swanson, M.D.
Xenia Tonesk, Ph.D.
Kathleen Turner*

(Guests)

Robert Buchanan, M.D.*
David H. Cohen, Ph.D.
Robert Heyssel, M.D.*
Richard Janeway, M.D.*
Rick Peters
Ricardo Sanchez
Charles Sprague, M.D.

*Present for part of meeting

I. CALL TO ORDER

The meeting was called to order at 8:00 a.m.

II. REPORT OF THE CHAIRMAN

Dr. Brown reported on the meeting of the Executive Committee. The annual budget for the next fiscal year was considered and forwarded to the Executive Council with a recommendation that it be approved. Because of the declining revenues from MCAT and AMCAS programs, the budgetary situation was constrained. However, the budget did include a $300,000 reserve and monies set aside for legal contingencies. Funds were also made available to the Friends of Research.

Annual meeting fees were also discussed. In the past the AAMC has subsidized the annual meeting out of other revenues. The Executive Committee felt that this should no longer be the case and approved an increase in the fees to $75 in 1986 and $100 in 1987. This increase would allow the AAMC to meet the expenses of the annual meeting solely from registration fees. The program for the annual meeting will include special recognition given to Alex McMahon, who is retiring from the American Hospital Association, and Ed Brandt for his service as Assistant Secretary of HHS.

The Executive Committee also decided that the AAMC should join the AMA in filing an amicus brief in a case before the Supreme Court. The case emerged from laws passed in Pennsylvania and Illinois regulating certain aspects of the physician-patient relationship, the practice of medicine and establishing reporting requirements in the context of abortion. AAMC's interest in the issue does not relate to abortion but rather to the issue of state control of the practice of medicine.

III. APPROVAL OF MINUTES

The minutes from the April 4, 1985 COD Administrative Board Meeting were approved without change.

IV. ACTION ITEMS

A. Proposed Charge for the AAMC Research Policy Committee

The Board considered a charge developed by staff for the AAMC Ad Hoc Research Policy Committee to develop or reaffirm Association positions in four key policy areas: research training and research manpower needs, federal support for research institutions, research funding mechanisms and levels of funding, and the goals of federal research and the role of Congress in setting science policy.

Action: On motion, seconded and carried, the Board voted to approve the charge as written.

B. Report of the AAMC Ad Hoc Committee on the IOM Study of the Structure of NIH

The Board considered a document prepared by an ad hoc AAMC committee providing a critical review of the recent publication by the Institute of Medicine of a study entitled "Responding to the Health Needs and Scientific Opportunity: The Organizational Structure of the National Institute of Health". Dr. Tom Kennedy indicated that, in general, the committee was disappointed with the study, particularly with regard to the absence of any concern about Congressional micro-management of NIH. Still the committee agreed that it should take as supportive a tone as possible to the study, while emphasizing the AAMC's continuing concerns. The Board discussed a strategy of ignoring the IOM study and not publishing the AAMC review. However, it was believed that the report might be helpful in pressing the AAMC's views on the organizational and management structure of NIH.

Action: On motion, seconded and carried, the Board endorsed publication and dissemination of the AAMC review of the IOM report.

At the request of Dr. Brown, Dr. Kennedy also gave a brief update on NIH reauthorization legislation. The Administration has recently produced its version of an NIH reauthorization bill that the AAMC could support enthusiastically. However, whether the Administration is successful in getting its bill introduced in Congress will depend upon the fate of existing bills. The House recenty passed the Waxman bill which is essentially the same as that passed last year but vetoed by the President.

C. Health Planning

The Board considered the existing AAMC position on health planning, adopted on April 13, 1982, to determine whether the position should be modified or reaffirmed. The questions for consideration were: should mandated state Certificate of Need Laws continued to be supported and if so, should the dollar thresholds for review be raised and should all providers including non-hospital providers be subject to review? Several Board members noted the changes in the practice environment that have taken place since the initial development of health planning laws. There is a growing conflict between the pressures to respond to competition and the regulatory environment defined by health planning legislation. It became clear that members experienced great difficulty in adopting a specific position on these issues because of concern that any position would create problems for some institutions. Several members felt that the Board did not know enough about local situations to either abandon the position or develop a new one at this time. Dr. Clawson therefore introduced a motion to table the issue, pending a review by staff.The effect of this motion would have been to leave the current policy intact, but have staff involved in federal liaison advise others, as appropriate, that the AAMC position is under review. Some members questioned whether we could afford waiting and suggested that at least the Board could agree on an increase in the dollar

thresholds and the inclusion of all providers in Certificate of Need review.

Action: On motion, seconded and carried, the Board recommended that for the present AAMC policy should be left intact but that a review should be initiated by staff and a position paper developed that could be discussed by the Board at its September meeting. The review should include a state-by-state analysis of the health planning/CON laws. In addition, staff should attempt to ascertain the position of the membership on these issues.

D. 1987 COD Spring Meeting

AAMC staff recommended that the 1987 COD Spring Meeting be held at the Stouffer's Waillea Beach Resort on the Island of Maui, Hawaii, April 4-8.

Action: On motion, seconded and carried, the Board approved the staff recommendation.

V. DISCUSSION ITEMS

A. AAMC Faculty Practice Survey

Dr. Jones introduced the discussion of the summary report of the AAMC Faculty Practice Survey by noting that many of the issues raised seem to be problems that required ongoing management rather than resolution through a national initiative. However, he hoped that the report might suggest to the Board members AAMC programs of an educational or informational nature to help member institutions in dealing with these issues. The discussion began with several Board members commenting specifically on their impressions of the survey results. Most of these found the data to be interesting and informative, particularly with regard to the close agreement on important issues by the various groups of respondents. The dominance of issues regarding the apportionment of the faculty time, threats to the patient base and need for changes in modes of practice was noted. Mr. Keyes expressed his belief that among the issues mentioned there seems to be three specific areas that deserve further attention. These are the effects of changes in reimbursement policies which divide the faculty from the hospital at the same time purchasers of health care are seeking neither physician services nor hospital services as such, but systems of care requiring close faculty hospital cooperation. The second area was the expressed need for organizing the faculty practice into organized group practices that would respond better to the changing environment. Third was the concern that in devising methods for securing patients and dollars, the academic mission is not lost in the process. Drs. Moy and Leavell both shared their local experiences which reinforced the importance of these issues and expressed some interest in the AAMC becoming active in helping schools deal with these needs. It became clear to many Board members that the need was not in terms of collecting more information on the structure of faculty practice plans but of finding a mechanism for learning from one another how to deal with the changing health care system. The

motivation for faculty hospital partnerships in this regard was addressed by Dr. Naughton, who saw the binding force being a mutual need for patients. Board members had difficulty defining more specifically what activities would be appropriate to assist schools, but one suggestion was made by Dr. Clawson who felt that a conference involving faculty, hospital and deans around these issues would be an appropriate first step. The idea of conferences was also reinforced by Dr. Meikle, who indicated that the fast changing environment required ongoing discussion forums, not snap shot approaches. There was an interest expressed in activities of the Medical Group Management Association Academic Practice Assembly who have as members many of the medical school faculty practice plan managers. Dr. Jones reported that this group, while concerned about the changing practice environment, was primarily a forum for dealing with operational matters of practice plan management and an organization devoted to professional development of its members. The Board concluded that further discussion of specific activities should continue at the Executive Council meeting.

B. Investor-Owned Hospital Participation in COTH

The Administrative Board of the Council of Teaching Hospital had recommended that the AAMC by-laws be amended to permit individual for-profit hospitals to become members provided that they meet membership requirements that apply to all other hospitals. A motion was made to approve this recommendation. Dr. Tom Bowles indicated that while his current situation may cause him to have a conflict of interest on this matter, he hoped the AAMC would approve this change. He views the for-profit hospital chains as in the business "to stay," and that in limited numbers they will be interested in acquiring major teaching hospitals. He therefore viewed it as important that we include these hospitals in the AAMC structure. Dr. Moy, speaking against the motion, agreed that investor-owned chains would be interested in acquiring major teaching hospitals as "loss leaders," but argued that inclusion in the AAMC structure ignores the fact that the individual hospitals are part of larger corporate entities. In his experience, these parent corporations have no sympathy for the values of academic medicine and that money and profit will become the driving force of their activities. He foresaw that some of these hospitals would be able to provide a complete range of tertiary care services at significantly less than the cost of comparable teaching hospitals, because they will have no commitment to teaching. Dr. Kettel noted that within COTH presently there are hospitals with adversary relationships and that it would be valuable to get investor-owned hospitals in the COTH structure regardless of the differing views they might hold. Mr. Keyes noted that our need to get an I.R.S. ruling on this change as it affects the non-profit status of the Association was one reason for delaying formal Executive Council action of this item until the September Board meeting. A motion to table the motion on the floor was not seconded.

Action: On motion, seconded and carried by a vote of six to four, the Board approved the COTH recommendation that individual for-profit hospitals be permitted to join COTH.

C. National Board of Medical Examiners Change to Comprehensive Part I and Part II Examinations

The Board was provided with additional descriptions of the changes in NBME policy regarding Part I and Part II Examinations, including a letter from Edith J. Levitt, M.D., President of the NBME. Dr. Levitt is interested in suggestions and recommendations from the Council of Deans as the NBME prepares to implement these changes. The changes include development of Part I and Part II into comprehensive examinations with less restrictive content specifications, abandoning the reporting of individual discipline scores to students, but retaining the reporting of overall scores and pass-fail status to students and mean disciplinary scores to institutions. Two opposing views were expressed as to the significance of the changes. On one side were those who felt that the National Board examinations exert an undue influence on the content of the undergraduate medical education curriculum and who see the retention of overall scores and mean disciplinary scores to institutions as preserving the status quo. Dr. Swanson and Dr. Meikle spoke forcefully with this view, with Dr. Swanson suggesting that the Administrative Board recommend to the NBME that scores be reported to students only on a pass-fail basis. Dr. Bowles defended the NBME's actions. While acknowledging the abuses which sometimes take place with the information provided, he saw the score information as valuable when used appropriately and supporting the view that it needed to be preserved. Dr. Bowles also speculated that the NBME examinations are likely in the future to be used less commonly by state licensing boards.

Mr. Sanchez, speaking for the OSR, supported Dr. Swanson's recommendation. He viewed the NBME examinations as being very limited in what they are able to measure and described them generally as having a deleterious effect on students' education. Mr. Sanchez admitted that, if polled, many students would favor retention of NBME scores, but emphasized that their views must be considered in the context of the present system in which NBME scores are needed to secure desirable residencies. For Dr. Moy the problem was with faculty who regard the scores as sufficient to certify the competence of students. Dr. Schofield was called upon to explain the LCME's use of National Board scores. He reminded the Board of the LCME's global responsibility for attesting to the adequacy of education conducted in the nation's medical schools and the need for the LCME at times to have some external reference point for evaluating the learning which takes place. This need is particularly felt when evaluating newer schools whose resources in a developmental period may not match LCME's expectations. The LCME standards do not specifically identify the NBME examinations as the external examinations required. Dr. Schofield has written to a number of organizations representing basic science and clinical disciplines, inquiring of their interest in developing examinations within their disciplines that

might be used for this purpose. He cautioned the Board not to do away with the quantitative information provided by NBME scores until such time as there are other measures to replace it. No consensus emerged on the suggestion by Dr. Swanson that the Administrative Board go on record as favoring only pass-fail reporting of NBME results. Dr. Brown concluded the discussion by indicating that this topic will be the focus of a program session on Sunday afternoon at the annual meeting.

D. Review of the AAMC MCAT Program

Dr. Brown noted that various concerns have been raised about the MCAT in recent years, including its emphasis on science, the use of scores by schools, the effect of coaching courses, and the presumed conflict of interest the AAMC has regarding the test. Dr. Erdmann indicated that staff in addressing these concerns wished to be responsive to the governance structure of the AAMC. He suggested that staff would benefit from a study group drawn from the constituency to deliberate about these matters. In the discussion several Board members noted that there are a plethora of views on the MCAT which may never converge and that the important point was for the AAMC to encourage institutional responsibility in their use of MCAT score information. Dr. Naughton questioned whether or not a review of the MCAT program can be truly objective given its role in the AAMC financial structure. However, Board members seem to agree that it was timely for an AAMC review of the MCAT program given these concerns and that the committee formed might consider mechanisms for ongoing review.

Action: On motion, seconded and carried, the Board recommended that a task force be appointed to conduct a broad-based evaluation of the MCAT program.

E. Financing Graduate Medical Education

Dr. Janeway joined the Board to discuss a recent Executive Committee decision to comment on a graduate medical education bill introduced by Senator Robert Dole. Hearings on the Dole-Durenberger bill were held quickly, preventing the normal discussion of such an important issue by the Executive Council. The Executive Committee decided to support the proposal for payment for graduate medical education up to and including Board eligibility or five years, whichever is less. This position has drawn the ire of those in internal medicine and its sub-specialties, but it was the sense of the Executive Committee that such a position was consonant with the general views of the AAMC constituency. Dr. Buchanan, Chairman of the Committee on Financing Graduating Medical Education, indicated that such a decision was not seen as intrusive on that Committee's activities. The position was consistent with the views of the majority of the committee members. Dr. Janeway indicated that while the position may be seen as negative for medical sub-specialties, open to them are options that may in the long run save money and get training periods reduced. The Association of Professors of Medicine (APM) and the American College of Physicians (ACP) testified at hearings but did not coordinate with the AAMC on this issue.

The Reagan administration was reported to be interested primarily in limiting the amount of money for medical education and not in engineering specialty manpower. They see the exclusion of USFMG's and FMG's with permanent visas from funding as raising serious constitutional and political issues and appeared unlikely to support such an exclusion. Dr. Butler noted that Congress may be more willing to tackle this issue. Senator Bentsen's staff members have contacted the Texas deans to solicit their support of such an exclusion as a way of saving money.

A technical point was raised to assure general understanding that the AAMC's recommendation was not intended to support billing by residents, but rather that bills could be rendered on behalf of residents by institutions and organizations. The question was raised whether or not the Administration would save money by limiting the time period for medical education payments. The outcome may likely be greater expenditures for the government, since care for patients by advanced residents would be billed by somebody.

F. Commentary on the GPEP Report

The Board reviewed a commentary prepared by CAS and COD administrative Board members on the GPEP report. Dr. Kelly, who represented CAS, indicated that he and Dr. Stemmler had agreed the commentary needed editing to improve its flow. A particular section discussed was a line in the report which indicated that all faculty members who teach medical students must be engaged in scholarly endeavors that are intellectually challenging. This raised questions about what constitutes a scholarly endeavor and whether or not voluntary faculty members are included in this charge. Dr. Kelly noted that the term scholarly endeavor was considered to be more inclusive than use of the term research, and that this section had already been earmarked for changes that would respond to these points. Also, a section indicating the need for improved quality and sophistication in undergraduate science education, "particularly in biology," raised concerns about a potential danger in steering undergraduate students to become biology majors. Dr. Kelly stated that the group considered it important to upgrade undergraduate science education but that he would consider a rewriting of this section that would satisfy this concern. The CAS had recommended that this document undergo approval by the Executive Council as an AAMC commentary on the GPEP report, to be distributed no later than October 1, as a companion document to GPEP. The Board agreed to this process and decided to review a modified copy at its next meeting.

G. Howard Hughes Medical Institute

Dr. Brown reported that he had met with Dr. Donald Frederickson, president of the Howard Hughes Medical Institute to discuss their plans for distributing monies obtained from the settlement of the Hughes estate. The Institute would likely change its legal structure to a foundation over the next couple of years, to provide greater flexibility in the projects funded. Approximately one-third of the deans responded to Dr. Frederickson's request

for suggestions with various ideas. Dr. Russe noted the precedent of the Ford Foundation which, when faced with a revenue windfall, provided a "air share" istribution to schools. Dr. Brown stated that the Institution's focus was more directly on research and expressed doubts that the Institute would be favorably disposed to need a proposal. However, the idea of a prorated distribution to the nation's medical schools and/or hospitals received general support from the group. It was noted that this would satisfy the schools' principal need for flexible money.

Action: On motion, seconded and carried, the Board recommended that Dr. Brown write to Dr. Frederickson urging him to consider a distribution of the money to all medical schools. Such a distribution should include the provision that it be used to enhance the research environment of the medical school but would otherwise be discretionary. Dr. Brown was advised to reference the Ford Foundation action as a precedent for this proposal.

H. Report of the Group on Student Affairs

As part of the Board's continuing efforts to develop closer ties with the various Groups in the Association, Dr. Norma Wagoner, chairperson of the Group on Student Affairs (GSA) was present to describe that Group's activities. Dr. Wagoner expressed her pleasure at seeing on the Board's agenda many of the issues that student affairs officers are involved with, specifically the MCAT, NBME examination, residency problems and GPEP. Dr. Wagoner proceeded to highlight a few of the many areas of interest of the Group on Student Affairs. These included the development of traffic rules in admissions which, while long-standing, seemed particularly important in the face of the declining applicant pool. The experience of one school, which lost 27 entering students two weeks before the start of the school term, highlighted the need for effective cooperation among schools in admissions.

The intrusion of financial constraints into the admissions process was another area of concern. The growing cost of medical education and the increased indebtedness of medical students poses a challenge to the medical schools in educating students who will go into less lucrative careers such as academic medicine. The complexity of the financial aid picture is reflected in the increased paperwork required. Its growing importance is illustrated by the institution at the University of Cincinnati of a program of debt management counselling.

The special problems of non-traditional students entering medical school was another area discussed by GSA. GSA has always had an interest in the problems of minority students in medical education and, under the leadership of Dr. Leavell, instituted in the late 1970's a Minority Affairs Section to the GSA.

The recent problems discussed by the deans surrounding residency application was of immediate concern. These include the problems of premature residency selection demanded by certain specialties

and required clerkships at hospitals offering residency positions. The GSA continues to offer programs for the professional development of its members.

In the discussion it was suggested that the financial aid problems might be helped by development of work study models, which are used in engineering schools. Dr. Russe asked if the GSA might consider confirming or disputing the current wisdom in Congress that loans to medical schools presently constitute a 27 percent return on investment once the students enter practice. Dr. Clawson indicated that the figures are difficult to dispute if current physician incomes are used. The problem which the Congressional analysis fails to address is the projection of incomes for physicians in the new practice environment which was seen as considerably different. Dr. Bowles concluded the discussion by urging the COD to involve GSA more in their meetings on topics of joint interest, for example, the NBME examinations and the residency application and selection process.

VI. INFORMATION ITEMS

A. COD Nominating Committee Report

Dr. Brown announced that the nominating committee had recommended Dr. Edward Stemmler for the position of Chairman-Elect of the Assembly, Dr. Louis Kettel for chairman-elect of the Council of Deans and Drs. William Deal and Richard Ross for representatives from the Council of Deans to the Executive Council. Also for positions of members at-large of the Administrative Board of the Council of Deans, the committee recommended the nominations of Drs. Walter Leavell, John Epstein and Fairfield Goodale.

B. 1986 AAMC Annual Meeting

Dr. Brown reported that the COD program at the annual meeting will feature a session devoted to NBME examinations and one devoted to the problems surrounding residency selection. He also indicated that a Sunday night dinner would be held. The most likely location was the Cosmos Club, where a cocktail hour and dinner will cost approximately $40.00 per person.

C. Residency Application Fee

Dr. Swanson distributed a memorandum describing the institution of an application fee by one hospital for residency programs. As far as he knew, this was an isolated instance but a practice which may grow as monies supporting graduate medical education become constrained.

VII. OSR REPORT

Mr. Sanchez reported that the OSR program at the annual meeting will include a plenary session devoted to the effects on education of the changes in the health care environment, followed by small group discussions dealing with evaluation methods, problems with clinical education, curricular integration of health care

cost awareness and ethics, preventive medicine, legislative affairs, computer-based medical education and financing medical education. The OSR has made progress on its issues paper and is preparing a report on working relationships with nurses and ancillary personnel. The OSR is also making a concerted effort to improve the attendance of members at the annual meeting. Last year 27 medical schools did not send officially designated representatives to the meeting. Problems identified included lack of funding, and a lack of willingness of clerkship directors to allow time off to attend the meeting. Mr. Sanchez indicated that the deans were in a prime position to help with both of these problems.

VIII. NEW BUSINESS

Dr. Brown suggested that the Board might recommend to the Executive Council the formation of a task force that would look into various problems surrounding the transition to graduate medical education, including premature matches by certain specialties, required electives by certain programs, and the role of medical schools in graduate medical education. A motion to that effect was made and seconded but later withdrawn as it was felt unnecessary. Such a task force would need a specific charge before being constituted. Board members therefore asked staff to formulate a charge for such a committee to be discussed at the next Administrative Board meeting.

IX. ADJOURNMENT

The meeting adjourned at 12:34 p.m.

TRANSITION TO GRADUATE MEDICAL EDUCATION
ISSUES AND SUGGESTIONS

The attached issues paper was developed from an analysis by Dr. Norma E. Wagoner with the assistance of Drs. Jack Gardner, Jon Levine, and Paula Stillman at the request of theCOD Administrative Board following a discussion of problems in the transition to graduate medical education at the June Board meeting. It represents an attempt by the leadership of the Group on Student Affairs (GSA) and the Group on Medical Education (GME) to assist the Association by more specifically identifying and describing the myriad of problems which have tended to be lumped together under the generic label of "the problem with residency selection" in many previous discussions of this issue (see Attachment I, pp.). The GSA-GME paper explicitly identifies issues in three key phases of the transition to graduate medical education. It attempts to clearly acknowledge the complexity and interrelatedness of the many facets of this process. It also suggests possible and partial solutions to some of the specific concerns identified.

The COD Board should review this document and discuss whether it might serve as an agenda of issues for the Association consideration. Does the Board feel that these are the key issues? Are there others? Does this analysis help to provide a focus for further actions?

The CAS Board is also discussing this paper, and is considering whether to follow the lead of the COD and use it as a basis for a discussion by the entire Council at the Annual Meeting.

TRANSITION TO GRADUATE MEDICAL EDUCATION: ISSUES AND SUGGESTIONS

A Report to the
Administrative Boards
Association of American Medical Colleges
September 11-12, 1985

Developed from an Analysis by:
Norma E. Wagoner, Ph.D.

With the Assistance of:
Jack C. Gardner, M.D.
Jon H. Levine, M.D.
Paula L. Stillman, M.D.

TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

I. Graduate Medical Education and the Selection Process

A. Issues

A number of recurring questions and concerns center around the selection process and the associated matches:

- o With the limitation in positions, do program directors need to begin to define the population to whom they will give major consideration in the selection process?

- o We have yet to see the impact of the for profit hospital corporations on the recruitment and selection of medical students for positions funded by those corporations in certain medical centers.

- o Does any organization have the right to prevent, restrict or constrain any groups of individuals from establishing their own match process? Will the for profit hospital corporations move in that direction?

- o The NRMP has been in continual evolution since the late 1950's; does the system need further revision to accommodate contemporary needs?

Consideration of these questions and concerns have led to the identification of the following problem list for the graduate medical education selection process:

1. Too much splintering of specialty interest groups into their own match processes: Colenbrander matches, military matches, Urology match, and individual hospital or specialties which operate outside the boundaries of any match process (the no-match group).

2. No uniformity of applications. Some programs use the uniform application, while others use one that has been developed by their own hospitals. This creates enormous pressures on students who may need to submit 30 to 50 applications to one, two, or more specialties.

3. Points of entry into graduate training are many and varied, leading to massive communication problems for all participants.

4. The algorithm and terminology of the NRMP are complex and not easily understood even by the most experienced.

5. In the competitive specialty programs, selection committees are insisting that candidates come for interviews (without any assurances) in order to be given consideration.

6. There is no composite information on available options through all forms of selection processes. This leads to difficulties in communication about entry points for postgraduate training. Each entity administering a match carries out its own form of advertising.

B. Suggestions

Short Term Changes

1. Request that NRMP review and evaluate current information that is being disseminated to program directors and students, including descriptions of the match algorithm and the types of positions offered.

2. There is a definite need for some entity (perhaps the AAMC) to develop comprehensive materials on the residency selection process. A prototype example might be the Medical School Admission Requirements handbook. Explore how this information can or should be communicated.

Long Term Changes

3. Consider a thorough examination and evaluation of the current NRMP process and staffing needs. The NRMP Board of Directors is the group with this responsibility. Perhaps the recently created advisory board could work with the NRMP to provide input from each specialty.

4. Consider development of centralized application service. While there is a uniform application, there is no agreed upon useage. If the program directors could be furnished a reduced administrative workload through such a service (e.g. AMCAS), the system could become sufficiently widely used to furnish a basis for the development of "traffic rules" (e.g. uniform dates).

5. Develop materials by specialty (including details of specific programs within each specialty) which could be sold at cost to students. Such materials should include the following types of information:

   a. Types of candidates that each program seeks. If possible, a greater specificity about the range of backgrounds sought: LCME graduates only, East coast schools only, AOA, National Board Part I scores of 550 or better, etc. This could reduce the "shot-gun" approach to program selection which currently exists and could markedly reduce the work-load of all parties concerned. If a book of this type is to be developed,

program directors must be convinced that it helps them cut their own costs of communicaton, and reduces their work load.

b. Range of stipend. This may become increasingly important as students amass high debts. Students will need to know if they can afford particular programs.

c. Range of benefits - malpractice insurance, health benefits, etc.

d. Expected background -- "desirable to have electives in....."

e. How the interview process is administered.

f. Whether they have special programs: primary care track, research track, and other special features of the program.

6. Have teaching hospital directors assume authority over the recruitment and selection procedures of the programs sponsored by their institutions. The diversity of specialties and the sheer number of programs (over 5,000) makes the achievement of uniform policies and procedures almost impossible. In addition, the development of useful information about institutions' programs for students would be simplified if reliable communications were estabished with the institutions that sponsor programs rather than with each program director. The AAMC has pressed for greater institutional responsibility for graduate medical education since the late 1960s. The assumption of authority over recruitment and selection policies and procedures by the directors of COTH member hospitals, which provide more than 60 percent of residency positions, could set a precedent that other hospitals would follow.

II. Graduate Medical Education and the Clinical Curriculum

A. Issues

Another major dimension of the transition process is its impact on the clinical education of the medical student, as is evidenced by the following questions and concerns:

- o Do residency directors unduly influence the medical school curriculum now that students are being recruited and selected as early as the third year?
- o Are program directors suggesting (or even stating) to students that unless they take an elective in their hospital, they will not be interviewed or fully considered for a position?
- o Has the use of external examination scores (NBME Parts I and II) become a major selection factor, when it is known that

these scores measure only a small fraction of the attributes necessary for the practice of quality medicine?

A careful review of these and related questions lead us to the following delineation of problems in the clinical education of medical students:

1. Students seeking positions in the very competitive specialties (particularly the surgical specialties, but also, ophthalmology and emergency medicine) are reported to be taking three and four identical electives in the specialty area of choice at various hospitals in the hope of bettering their selection chances. This compromises the general professional education of the physician.

2. A good portion of the fall of the senior year is devoted to completing multiple applications and seeking interviews. There appears to be little interest in assisting the students by grouping interviews for traveling to a particular region of the country. Often times students must make multiple trips back to an area because of the inflexibility of the interview process.

3. The cost of travel associated with the selection process discriminates against less affluent students and, if incorporated in the approved educational costs, increases their indebtedness.

4. The focus on education and learning is being lost in the increasing emphasis on preparing for the residency selection process.

5. Schools are being forced to change their third year curricular structures to accommodate pressures on their students for early exposure to various specialties. Similar pressures in the fourth year are acting to distort elective programs as students undertake earlier specialization.

6. Earlier selection and preparation for selection are forcing premature decisions about career choices upon students.

7. Because low or average NBME scores may preclude a student from being interviewed, schools now need to furnish considerable time for students to prepare for and/or to provide support services to assist them in preparation for these examinations.

8. The pressure upon schools to place their graduates is causing a grade inflation problem, thus lessening the credibility of grades as a measure of competence.

B. Suggestions

Short Term Changes

1. Ask the program directors to work with the AAMC to facilitate communication with medical schools: traffic rules, general guidelines, uniform applications, interview time frames.

2. Undertake research to determine which selection factors provide the best residents. This may increase the quality of selection factors beyond those now currently being used.

Long Term Changes

3. Reduce the number of medical students commensurate with the reduction in residency positions.

4. Development of an examination of clinical skills which is both more comprehensive and more oriented to problem solving. Such an examinaton might well include a "hands on" performance evaluation.

5. Consider a fifth year of medical school. By the fifth year, students would have narrowed their specialty interest to three and would spend three months in each area. The three remaining months of that year would be devoted to a Match process with high quality evaluation techniques being utilized to provide maximum information about the students' skills, abilities and suitability for a particular professional area.

6. Consider extending medical school through four years of clinical education, incorporating residency training into the fourth, fifth, and sixth years of a pre M.D. program.

III. Graduate Medical Education and the Counseling Process

A. Issues

A third series of questions and concerns exemplify another area affected by the transition: the role of Deans of Student Affairs and the problems of counseling in residency selection.

- o In transmitting information to program directors, should Deans of Student Affairs be a student advocate or a factual reporter? Do they have an obligation to see that all medical students have a graduate medical education position?

- o In times of more limited resources, Deans of Student Affairs are being asked to take on greater responsibilities in the residency placement process, including working with graduates who are one, two, or more years out of medical school. How far in time does institutional responsibility extend?

- o What responsibility does an institution have to develop a comprehensive advising system? Should such a system include financial planning and debt counseling since graduates may

have debts which are excessive in relation to residency salaries?

- o Advising is a demanding job and advisors need to have broad knowledge of programs, hospitals, specialties, understanding of selection factors and knowledge of financial matters. Is it realistic to expect our medical schools to expand the staffing for these advising functions?

These questions suggest the following problem areas which might be addressed:

1. In the past, medical students have usually been able to obtain a position in the specialty they wanted. Now, with fewer positions available, Deans of Student Affairs are being placed increasingly in the position of encouraging students to apply for two or three specialties. This emphasis on getting students placed, comes at the expense of the "career fit" counseling process.

2. A related problem with yet to be determined consequences is the possible effect of reduced funding for graduate medical education on the remuneration available and the possibility of significant variation in compensation levels.

3. Early Deans' letters for special matches often require supplemental letters for subsequent matches, compounding the administrative load.

4. Training new and or part-time Deans of Student Affairs in the development of counseling systems and in keeping up with changes in the selection process.

5. Advising the students who find themselves in difficult ethical dilemmnas regarding match situations. The ethics of the marketplace appears to be prevailing, and the sense that anything goes is creating major problems with agreements about current procedural guidelines. This is particularly true for the unmatched student who is seeking a competitive specialty. When very few places are available, the temptation to cheat increases.

6. Helping students reduce the anxieties involved in a competitive selection process where their years of work may not achieve a result supportive of their career goals. This may contribute to a loss of idealism about the practice of medicine and about themselves as practicing physicians.

B. <u>Suggestions</u>

1. Offer a national institute where program directors, Student Affairs Deans, and selected students can meet to develop some strategies and goals for increasing the effectiveness of the selection process.

2. Develop a network of Deans of Student Affairs (computer bulletin board?) to provide a means for updating certain kinds of information. Such a network has been proposed by the NRMP for listing unfilled places throughout the year. This type of network might be extended more fully to provide a greater array of services through the NRMP office.

THE PRERESIDENCY SYNDROME: A RECENT CHRONOLOGY

1983

A. A presentation by Jack Graettinger (NRMP) at the Northeast GSA, Spring Meeting - 1983, was instrumental in beginning the most recent round of discussions regarding this set of interrelated problems.

B. Howard Levitin (Yale) took the concerns of the NEGSA to the Thirteen School Consortium who through Dean Robert Berliner (Yale) wrote to Dr. Cooper requesting that the AAMC undertake a major initiative to develop solutions.

C. The Council of Deans discussed this as an agenda item at their Scottsdale meeting (Spring 1983).

*D. The AAMC decided to study the problem from the perspective of the program directors. Dr. Cooper (AAMC) wrote to the clinical societies within CAS asking of each society whether it had an established position on the matter of the selection of applicants into residency training programs.

*E. A plan of action was discussed by The Executive Council (June, 1983). The GSA Steering Committee was charged with the preparation of a "White Paper."

*F. As requested by the Executive Council, Joe Keyes wrote an analysis of the CAS responses for the Executive Council agenda, September, 1983. The Executive Council concluded that the Executive Committee of the AAMC should meet with officials of those clinical disciplines using early match dates. (See H, Below)

*G. This problem area was the major topic of the CAS agenda at the AAMC Annual Meeting, Fall, 1983.

H. Dec. 7, 1983; AAMC Executive Committee met with specialties operating outside NRMP. Libby Short (AAMC) designed for this special meeting a flow chart showing how the NRMP match could meet all of the objectives of those disciplines currently operating outside the match. Minutes of this meeting were circulated to all participants who were, in turn, asked to comment.

* Reference documents; See ATTACHMENT II

1984

*I. The minutes of the Dec. 7, 1983 meeting were adjusted for these comments and were mailed to the Executive Council with the agenda for the January, 1984 meeting.

J. The proposal developed by the Executive Council (September 1983) for an advisory committee to NRMP was vetoed by the AMA representative to the NRMP board. In late Spring, 1984, the advisory committee was approved, although it did not meet until Spring, 1985.

K. Spring and Summer of 1984, Dr. Cooper and Dr. Graettinger appeared before the Boards of some of the specialties which operate outside the match with the request that they participate in NRMP; little response.

*L. June, 1984, the CAS Administrative Board adopted a resolution supporting the position of a single match.

*M. September, 1984, the AAMC Executive Council approved a modified form of that resolution.

N. At the AAMC Annual Meeting, Fall, 1984, the Council of Academic Societies and the Council of Deans approved the Executive Council resolution.

1985

O. At the Spring, 1985, CAS meeting, a planned discussion on GPEP developed into a discussion of early match problems.

P. April, 1985, the Specialty Advisory Committee to the NRMP Board held its first meeting with Dr. Swanson representing the AAMC.

Q. April, 1985, new LCME guidelines approved; "Functions and Structure of a Medical School" (See R., below).

*R. Dean Arnold Brown (Wisconsin) requested further discussion at the Summer Meeting of the COD Administrative Board. The Board requested that AAMC Staff, GME officers, and GSA officers develop an Action Agenda for the September, 1985, meeting.

*Reference Documents; See ATTACHMENT II

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