



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ADMINISTRATIVE BOARD**

**WEDNESDAY, JUNE 18, 1986  
4:00 PM - 6:00 PM  
INDEPENDENCE ROOM**

**THURSDAY, JUNE 19, 1986  
8:00 AM - 12:00 PM  
INDEPENDENCE ROOM**

**WASHINGTON HILTON HOTEL  
WASHINGTON, DC**

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

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**COUNCIL OF DEANS  
ADMINISTRATIVE BOARD MEETING**

Washington Hilton Hotel  
Washington, DC

AGENDA

**Wednesday, June 18, 1986**

4:00 pm - 6:00 pm

Independence Room

Page

I. Reporting of NBME Scores . . . . . 1

6:00 pm - 7:00 pm

Lincoln & Monroe Rooms

Joint Administrative Boards Reception & Dinner

Thursday, June 19, 1986  
8:00 am - 12:00 pm

- I. Call to Order
- II. Report of the Chairman
- III. Approval of Minutes . . . . . 11
- IV. Action Items
  - A. Revision of the General Requirements Section of the Essentials of Accredited Residencies (Executive Council Agenda-----p.18)
  - B. Report of the Ad Hoc MCAT Review Committee (Executive Council Agenda-----p. 20)
  - C. GME Transition Committee Report (separate attachment)
  - D. Designation of Federal Liaison Function . . . . . 18
- V. Discussion Items
  - A. Role of the AAMC in Promotion of Academic Medical Centers to the Public (Executive Council Agenda-----p. 27)
  - B. Trends in Medical School Applicants (Executive Council Agenda-----p. 29)
  - C. Follow-up on COD Spring Meeting Resolutions (Executive Council Agenda-----p. 45)
  - D. 1986 COD Annual Meeting Program . . . . . 19
- VI. Information Items
  - A. MEDLOANS (Executive Council Agenda-----p. 57)
  - B. COD Nominating Committee Report . . . . . 28
  - C. Response to the "Dear Colleague" Letter . . . . . 30
- VII. OSR Report
- VIII. Old Business
- IX. New Business
- X. Adjourn

## REPORTING OF NBME SCORES

Issue: Should the AAMC take a position favoring the reporting of NBME examination scores solely on a pass-fail basis?

### Background

Discussion and debate concerning the effect of NBME examinations on medical student education has centered on the score reporting system, particularly for Part I. The OSR has requested that the Board consider the question proposed above and has submitted the attached background piece for the discussion. The issue has been discussed in various reports (including GPEP) and forums over the past several years and may be well known to Board members. Here we only sketch the basic arguments.

Proponents for a pass-fail only scoring system assert the following:

- 1) The historical purpose and chief value of the NBME examinations is the licensure of physicians. Scale scores make no contribution to this decision.
- 2) The reporting of scale scores tends to have various detrimental effects on medical education.
  - a) It reinforces the tendency for the examination to drive the curriculum. For example, it focuses the faculty's attention on the competencies and skills measured by the exam at the expense of other competencies of equal or greater importance. Also, the examination format tends to promote an emphasis on memorization and information recall.
  - b) The need to make distinctions among a very able group of medical students invariably results in questions focusing on knowledge of minutia having only very indirect clinical implications.
  - c) Internal pressures to produce high scores stifle curriculum innovations.
  - d) It encourages faculties to abrogate their evaluation responsibilities to an external agency.
- 3) Scale scores are too easily abused. By the NBME's own assessment, the examinations evaluate only 25 percent of the competencies expected of graduating students. Yet these scores are viewed by the LCME as evidence of institutional effectiveness. Also, at times political bodies such as state legislatures request score information as a way of evaluating the institutions they support. Under such pressures it is difficult to decrease the emphasis placed on maximizing performance on the examination.

The counter-arguments presented include the following:

- 1) While licensure is the NBME's primary purpose, the examinations can serve other purposes, e.g., student evaluation, program (curriculum) evaluation, and institutional self-study.
- 2) Whatever disagreements exist about the importance of the material tested, the questions are written by medical school faculty members. Thus, it is not an external agency but our own faculties which are making judgments about the relevance of the material.
- 3) If abuses occur in the uses of the scores, the proper remedy is improved education on appropriate and inappropriate uses.
- 4) NBME scores are the single dependable numerical measure of competence and achievement available to program directors who must assess a large number of applicants to residency positions.
- 5) In the final analysis, each medical school faculty has the prerogative to determine institutional policy regarding the use of NBME scores. The information provided by scale scores should not be denied them.

Recently the National Board has embarked on a change in policy regarding the NBME examinations, to improve their value and, no doubt, to respond to the criticisms which have been levelled against them. In the proposed changes, individual discipline scale scores are no longer provided. However, the National Board stopped short of eliminating the reporting of an overall scale score.

Questions for Discussion:

- 1) Does the reporting of an overall scale score on the NBME examinations have such a deleterious effect on medical education that any benefits are outweighed by negative consequences?
- 2) Do internal and external pressures to achieve high NBME scores at the departmental or institutional level substantially undermine faculty freedom to decide the examination's use and value?
- 3) Does the LCME overemphasize institutional mean scores on the NBME examinations in its accreditation review? Is there a perception that it does so?
- 4) Are there alternatives to program directors' reliance on NBME scores to assess applicants to residency positions?
- 5) Is the proposition that NBME scores should be reported only on a pass-fail basis one on which the AAMC can achieve a consensus among its members?
- 6) If AAMC advocacy for eliminating the reporting of scale scores is not advised, are there other steps the AAMC can take to eliminate abuses in the use of the examination, improve its value to students and schools, and mitigate any adverse effects on medical education?

SCORE REPORTING FOR NATIONAL BOARD EXAMINATIONS  
OSR ADDENDUM

The Administrative Board of the Council of Deans has requested discussion of Pass/Fail score reporting for National Board Part I and Part II examinations. Interest in exclusive Pass/Fail score reporting was highlighted by a COD Plenary discussion on the National Boards at the 1985 AAMC National Meeting, and by the publication of the Report of the Panel on the General Professional Education of the Physician (GPEP) and College Preparation for Medicine (AAMC, 1984) and new Liaison Committee on Medical Education (LCME) standards for accreditation Functions and Structure of a Medical School (LCME, 1985). The GPEP Report is critical of an overreliance on multiple choice examination techniques in the evaluation of medical student performance, and the new LCME standards were written so as to exclude any direct reference to, or reliance upon, the National Board Examination Scores in the accreditation process.

When founded in 1915, the original purpose of the National Board of Medical Examiners (NBME) was to produce a voluntary certification process of such high quality that an NBME certificate would become acceptable as evidence of proficiency to all state jurisdictions responsible for physician licensure. The NBME achieved that goal initially with the development of comprehensive essay examinations and then with development during the 1950's of multiple choice examinations (Hubbard, 1978). Further refinement and development is currently underway by the NBME towards development of new examinations that are interactively directed towards accessing decision making skills. The NBME has consistently maintained that its examinations are principally for licensure. It has long recognized and facilitated the use of its examinations for other than licensure, but has formally provided recommendations and cautions to medical schools regarding the use of NBME examination scores. Individual schools can and do use the examinations for purposes of individual student evaluation or curriculum evaluation. The responsibility for that use currently rests with each school.

Under the current scoring system for National Board examinations, subscores are provided to the test subjects and their institutions for each discipline covered using a 200-800 scale with five point score intervals. Actual passing standards are referenced to the performance of a selected group of examinees from the previous four years. Under this system it is theoretically possible for all examinees, in any given year, to pass Part I or II, although this has not occurred. Pass/fail rates on Parts I and II have remained relatively constant.

Currently, 47 percent of U.S. medical schools require students to achieve a passing total score on Part I for promotion and/or graduation, while 38 percent require a passing grade on Part II (Table 1). These figures have been stable over the past five years. Only 11-12 percent of medical schools use scores from Parts I or II in the determination of final course grades. This is a significant reduction from the number four years previously for Part I but reflects stability for Part II. Results of the NBME examinations are currently used by half of the medical schools in the U.S. for educational program evaluation, with no substantive change in this frequency of use over the past five years.

Table 1

USE OF NBME EXAMINATIONS BY  
U.S. MEDICAL SCHOOLS - 1980-81 to 1984-85

	1980-81*		1981-82		1982-83		1983-84+		1984-85	
	No.	Percent (N=125)	No.	Percent (N=126)	No.	Percent (N=126)	No.	Percent (N=127)	No.	Percent (N=127)
<b>STUDENT EVALUATION</b>										
Use of the NBME exam, Part I										
Exam optional . . . . .	31	24.8	32	25.4	31	24.6	29	22.8	29	22.8
Student must record score . . . . .	35	28.0	33	26.2	34	27.0	35	27.6	35	27.6
Student must record total passing score . . .	58	46.4	59	46.8	57	45.2	59	46.5	59	46.5
Student must record passing score in each section . . . . .			3	2.4	4	3.2	3	2.4	3	2.4
Scores used to determine final course grades	31	24.8	29	23.0	11	8.7	18	14.2	14	11.0
Use of selected sections of NBME exam, Part I, by departments to evaluate students										
Anatomy . . . . .	12	9.6	10	7.9	8	6.3	8	6.3	4	3.2
Behavioral sciences . . . . .	7	5.6	5	4.0	5	4.0	2	1.6	2	1.6
Biochemistry . . . . .	14	11.2	12	9.5	10	7.9	9	7.1	9	7.1
Microbiology . . . . .	23	18.4	20	15.9	15	11.9	12	9.5	9	7.1
Pathology . . . . .	21	16.8	17	13.5	12	9.5	11	8.7	10	7.9
Pharmacology . . . . .	19	15.2	16	12.7	10	7.9	9	7.1	6	4.7
Physiology . . . . .	18	14.4	15	11.9	11	8.7	8	6.3	4	3.2
Use of NBME exam, Part II										
Exam optional . . . . .	36	28.8	39	31.0	38	30.2	36	28.4	35	27.6
Student must record score . . . . .	37	30.4	36	28.6	42	33.3	41	32.3	41	32.3
Student must record passing score to graduate . . . . .	47	37.6	46	36.5	44	34.9	48	37.8	48	37.8
Scores used to determine final course grades	16	12.8	17	13.5	14	11.1	16	12.6	15	11.8
<b>CURRICULUM EVALUATION</b>										
Based in part on										
Results of the NBME exams . . . . .	65	52.0	67	53.2	61	48.4	62	48.8	63	49.6

\* This compilation includes 1978-79 data for Louisiana State-Shreveport and 1979-80 data for California-Los Angeles (UCLA)

+ This compilation includes 1982-83 data for Georgetown.

Critics argue that these uses by the schools of the NBME examinations have a deleterious effect on medical education in two ways. First, a focus on the competencies assessed by the NBME examinations may devalue other competencies of equal or greater importance. Second, the adoption of the NBME examinations as a national standard for achievement in various disciplines, may induce faculties to abandon their responsibility to exercise independent judgement in the design of the curriculum and the identification and evaluation of important learning objectives.

The first concern can be viewed in the context of the range of competencies that comprise the goal of undergraduate medical education. In the planning and development of enhanced Part I and II examinations, the NBME identified five characteristics important in student evaluation: knowledge and understanding, problem-solving and judgement, technical skills, interpersonal skills, and work habits and attitudes. By applying these five characteristics to ten identified physician tasks, the NBME produced a 50 cell matrix that correlates with competence expected of MD graduates entering graduate medical education (Figure 1). Implicit adoption of this analytical framework by the AAMC is indicated by its appearance in an AAMC position paper on external examinations (AAMC, 1981). Only 12 of these 50 cells represent areas amenable to assessment by current NBME test questions. The argument is made that focus by the school on NBME results tends to overemphasize the areas of competence that NBME examinations cover, at the expense of other competencies. The evaluation method also has a concomitant effect on the teaching methods used. Information recall methods of evaluation tend to promote information transfer methods of teaching. These problems stem in part from the lack of objective measures available to assess the 'other' areas of competence. NBME scores are thought to fill a vacuum created by an absence of other methods of assessment.

Even within the sphere of competencies that the NBME examinations purport to address, a second concern has been expressed about its influence on the content of what is taught in the medical school curriculum. Decisions about the content of the curriculum have always been regarded, within very broad limits, as the prerogative of the medical school faculty. Critics have charged that in seeking the approbation that NBME scores have come to represent, faculties have in effect delegated that authority to the NBME. 'Teaching to the Boards' may have become more commonplace, resulting in a greater emphasis on the transfer of information useful for test performance. This has come at the expense of learning care concepts together with the development of problem-solving and self directed learning skills. The dynamics of test construction itself may, in fact, lead away from core concepts because of the inclusion of more difficult questions designed to produce the desired spread of scores. Medical school proponents of the examinations have countered that the detailed information provided by the NBME on student performance has been useful in identifying gaps in the medical school curriculum. Relatively poor performance by students on one or another segment of the examination may highlight subject matter not learned or inadequately taught.

The use of National Board mean scores and failure rates by the LCME in the accreditation process of U.S. medical schools was actively discussed during the drafting of new accreditation guidelines last year (Jones and Keyes, 1985). By LCME consensus, and in actual fact during the review process, the LCME's principal focus is on a given school's failure rate. A relatively high failure rate signifies a potential problem for a school to produce licensable graduates. It also indicates that a number of students do



FIGURE 1

PROPOSED MATRIX OF PHYSICIAN COMPETENCIES \*

ABILITIES TASKS	A Knowledge & Understanding	B Problem-Solving & Judgment	C Technical Skills	D Interpersonal Skills	E Work Habits & Attitudes
1. Taking a History	NBME	NBME			
2. Performing a Physical Examination	NBME	NBME			
3. Using Diagnostic Aids	NBME	NBME			
4. Defining Problems	NBME	NBME			
5. Managing Therapy	NBME	NBME			
6. Keeping Records					
7. Employing Special Sources of Information					
8. Monitoring & Maintaining Health	NBME	NBME			
9. Assuming Community & Professional Responsibilities					
10. Maintaining Professional Competence					

\* Cells filled by NBME represent those areas currently assessed by NBME multiple-choice test questions.

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not possess a minimal fund of basic and clinical science information deemed relevant by the community of accredited medical schools. Mean scores on NBME examinations currently receive a secondary focus.

Another use of NBME scores that has drawn the ire of some medical educators is the use by residency program directors in the selection of house officers. The perception that this use is on the rise stems from two factors: a 'buyers' market created by the increasing number of graduates competing for quality residency positions; and, the use of pass/fail grading systems by a number of schools which make it difficult for program directors to discriminate among applicants by some simple measure of academic performance. Concern is expressed that this is contributing to the replication in medical students of a set of behaviors in pre-medical students described as 'pre-med syndrome.' This 'syndrome' is seen as a highly competitive and inappropriate focus on the acquisition of a database of extremely detailed information at the expense of mastery of more fundamental understanding, knowledge, skills and attitudes.

A recent national survey of residency program directors sheds some light on this issue (Wagoner and Suriano, 1984). Preliminary results of this survey are shown in Figure 2. NBME Part I scores are seen to rank eighth in importance in a list of ten academic criteria, with Part II scores ranking fifth, although generally not available in time for the application review process. It is noted that 86 percent of program directors would not rank an applicant who has failed Part I, but 75 percent would rank a candidate who had an Part I score in the 380-450 range, which is the lowest ten percent of passing scores.

State licensure boards require a passing score on NBME Parts I, II and III, but do not look at individual subject or total scores. At the COD Plenary session at the 1985 AAMC national meeting it was noted that the state licensure boards consider the NBME scores only a fraction of the actual criteria for licensure. The principal criteria are the possession of a valid MD degree and the successful completion of an accredited PGY-1 year of clinical training.

The charge that medical education has become a process of information transfer at the expense of skill development should not obscure the fact that medical students need to learn and understand core concepts in biomedical science and bring to patient care a basic fund of clinical information. While no absolute agreement may ever exist on the parameters of this core material, the NBME examination content specifications, designed by test committees composed of medical school faculty members, are presumed to approximate well the topics covered in the curricula of U.S. medical schools. Passing the NBME examinations reflects therefore some minimum level of knowledge of basic and clinical science information and skills in applying this knowledge deemed relevant by U.S. medical schools. In addition, passage of NBME examinations is still a major pathway to licensure.

Against this background, discussion by the Councils within the AAMC is requested by the OSR Administrative Board concerning the implications and feasibility of requesting a change in score reporting by the NBME limited to a PASS/FAIL designation only.

FIGURE 2A

RESIDENT SELECTION: PROCESS AND FACTORS \*

Norma E. Wagoner, Ph.D., and J. Robert Suriano, Ph.D.  
October 31, 1984

A national survey of residency program directors was conducted in order to determine the degree of importance which cognitive factors, letters of recommendation, and interview criteria played in the selection of candidates by each specialty. A stratified random sample of programs was selected and 405 questionnaires were mailed to program directors. A return rate of 59% was achieved for an N of 237. Some of the results are detailed below:

PERFORMANCE: THE ACADEMIC RECORD

The program directors were asked to select the degree of importance for ten cognitive criteria using a five point rating scale: (1) = unimportant; (2) = some importance; (3) = important; (4) = very important and (5) = critical. The mean ratings are rank ordered below:

	$\bar{X}$	s.d.
1. Grades in clerkships of program's specialty	3.9	0.9
2. Grades in elective of program's specialty	3.6	0.9
3. Grades in other clerkships	3.5	0.7
4. Rank order in class	3.5	0.9
5. NBME II scores (assuming availability)	3.2	1.0
6. Membership in AOA	3.2	1.2
7. Grades in other electives	3.1	0.8
8. NBME I scores	3.1	1.0
9. Grades in preclinical courses	3.0	0.8
10. Research activities	2.7	0.9

The program directors were also asked to respond in a yes/no manner to a series of questions relating to cognitive criteria. These responses are rank ordered below by magnitude of agreement:

1. 86% give preference in ranking to students who have done well in an elective in the program director's specialty and hospital.
2. 86% would not rank an applicant who has failed NBME I.
3. 75% would rank a candidate with an NBME I score in the 380-450 range.
4. 55% select applicants to interview primarily on academic records.
5. 55% think that HONORS grades in preclinical courses are more important than NBME Part I scores.
6. 54% would favor an applicant who had taken and passed Part II of NBME by the time the candidates are ranked.

\*Preliminary results of a survey conducted of program directors in specialties of: Internal Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, Psychiatry, Emergency Medicine, Family Medicine, Otolaryngology, Orthopedic Surgery. Survey date: 9/84

FIGURE 26

LETTERS OF RECOMMENDATION: DEGREE OF IMPORTANCE OF VARIOUS TYPES OF LETTERS

Program Directors were asked to choose the type of letters which were most often found useful in the selection and ranking of candidates. Using the rating scale listed on the previous page, the choices are listed in rank order:

	$\bar{X}$	s.d.
1. Chairman's letter	3.9	0.8
2. Clinical letter/your hospital/your specialty	3.9	0.8
3. Clinical letter/your specialty	3.6	0.8
4. Dean's letters	3.6	1.0
5. Clinical letters/other specialties	2.9	0.7

DEAN'S LETTERS: CONTENT AND POLICY/STYLE

Program Directors were asked to rate a number of specifics which could be included in the Dean's letters using the same rating scale listed on the first page. The results are listed in rank order below:

	$\bar{X}$	s.d.
1. Hints of underlying problems	4.0	0.9
2. Consistency of performance	3.9	0.7
3. Negative comments	3.8	0.9
4. Highly laudatory comments from members of your specialty	3.7	0.9
5. Overall "bottom line" rating based on all students in the class.	3.7	1.0
6. Personal comments about candidate from Dean's letter writer	3.4	0.9
7. Narrative description of academic performance in each clinical rotation	3.4	0.9
8. Delineated rank order of candidate	3.4	1.0
9. Completion of curriculum in prescribed time	3.3	1.0
10. A signed waiver indicating student has not viewed the letter	2.3	1.3

INTERVIEW CRITERIA

Program Directors were asked to rate the importance of a series of individual criterion in the areas of Interpersonal Relationships, Communication Skills, and Work Performance on the one to five scale noted previously. The results are rank ordered below:

	$\bar{X}$	s.d.
1. Compatability with your program	4.5	0.6
2. Ability to grow in knowledge	4.4	0.6
3. Maturity	4.3	0.6
4. Commitment to hard work	4.3	0.7
5. Fund of Knowledge	4.1	0.6
6. Ability to solve problems well	4.1	0.7
7. Willingness to seek help from others	4.0	0.7
8. Ability to articulate thoughts	4.0	0.7
9. Sensitivity to other's psychosocial needs	3.9	0.8
10. Realistic self appraisal	3.8	0.8
11. Ability to listen	3.8	0.8

## REFERENCES

Association of American Medical Colleges. Physicians for the Twenty-first Century: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine. Washington, D.C.: AAMC, 1984.

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Hubbard, John P., Measuring Medical Education. Lee and Febiger, Philadelphia, Pennsylvania, 1978.

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Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. LCME, 1985.

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

MINUTES

April 10, 1986

7:45 a.m. - 11:45 a.m.

Farragut Room

Washington Hilton Hotel

Washington, D.C.

PRESENT

(Board Members)

William Butler, M.D.  
D. Kay Clawson, M.D., Chairman  
Robert Daniels, M.D.  
William B. Deal, M.D.  
John W. Eckstein, M.D.  
Fairfield Goodale, M.D.  
Louis J. Kettel, M.D.  
Walter F. Leavell, M.D.  
Richard H. Moy, M.D.  
John Naughton, M.D.  
Richard Ross, M.D.

(Guests)

Vicki Darrow  
Richard Janeway, M.D.\*  
Richard Peters  
Robert G. Petersdorf, M.D.\*  
Edward J. Stemmler, M.D.\*  
Virginia Weldon, M.D.\*

ABSENT

Arnold L. Brown, M.D.

(Staff)

Brownie Anderson  
Melissa Brown  
John A.D. Cooper, M.D., Ph.D.  
Debra Day  
John Deufel\*  
Paul Jolly, Ph.D.  
Thomas J. Kennedy, M.D.  
Joseph A. Keyes, Jr.  
Richard M. Knapp, Ph.D.\*  
James R. Schofield, M.D.  
Nancy Seline\*  
John Sherman, Ph.D.  
Elizabeth Short, M.D.\*  
August Swanson, M.D.\*  
Kathleen Turner\*

\*Present for part of meeting

## I. CALL TO ORDER

Dr. Kettel called the meeting to order at 7:45 a.m. in the absence of Dr. Clawson who was delayed at a meeting of the Executive Committee.

## II. DISCUSSION OF COD MEETINGS

### A. Spring Meeting

Board members reviewed the recent COD spring meeting. There was a general consensus that the change in format to small group discussions was well-received. The topics chosen for the discussion were attractive to the participants and the background papers provided a useful point of departure for the discussions. The discussion at the business meeting and resolutions adopted produced an unprecedented sense of exhilaration among the deans. Suggestions for improvement included shortening the time for each discussion to one hour, limiting the topics to three, permitting the speakers at least 10 more minutes to develop their topics and including at least one formal presentation, perhaps a keynote speech.

The Board discussed how to continue the momentum created by the meeting. It was agreed that the recommendations which emerged should be sent to Council members as an addendum to Dr. Clawson's Dear Colleague letter. These recommendations were viewed as general instructions to the Board which, after receiving further comments, the Board would distill and refine and move as action items through the AAMC governance.

### B. Annual Meeting

The Board also discussed the general outline of this year's annual meeting events for the Council of Deans. They supported the continuation of the Sunday afternoon program and Sunday evening social event. The issues of cost and subsidy were also addressed. The Board concluded that the appropriate strategy should be to design an evening of high quality irrespective of cost. From the discussion that emerged, the preferred social event would be an evening on a river boat which would include a reception, a dinner, a jazz band, and dancing. If such a program could be offered, the deans were of the view that a cost in the neighborhood of \$70-\$80 per person would be reasonable.

## III. APPROVAL OF MINUTES

The minutes from the January 22-23, 1986 meeting of the Council of Deans Administrative Board were approved without change.

## IV. CHAIRMAN'S REPORT

Dr. Clawson reported that the Executive Committee had approved Dr. Petersdorf's contract as President of the AAMC. The contract was similar in substance to contracts of other CEO's of major educational and hospital associations.

The AAMC was purchasing a house within walking distance of One Dupont Circle to serve as the AAMC President's residence.

V. ACTION ITEMS

A. Interpreting the AAMC Policy in the Treatment of Irregularities in Medical School Admissions

At the September Executive Council Meeting a revised policy for treatment of irregularities was approved. The Board considered two questions which had arisen regarding its interpretation.

1. Whether the AAMC should forward irregularity reports to non-member institutions or organizations dealing with non-MCAT related irregularities?
2. Whether the AAMC should honor the request of the Federation of State Medical Boards that it be forwarded certain categories of irregularity reports?

Under current procedures, MCAT related irregularities are routinely sent to all schools to which MCAT scores have been sent. AAMC policy appeared to authorize the transmission of non-MCAT irregularities to the same schools, but in only one instance had this been done. The request by the FSMB was based on its desire to improve its screening for licensure of U.S. graduates of foreign medical schools. Those supporting the transmission of irregularity information to non-member institutions expressed the view that the AAMC bore a social responsibility to uphold the high ethical standards of the medical profession which was particularly visible at the present because of criticisms that current procedures for policing abuses were inadequate. Weighing against this view were concerns about the AAMC's legal liability in transmitting such information, the drain on Association resources that litigation would involve, and the potential for difficulty in disputing what constitutes a "legitimate interest" in the information. Also discussed was the question of whether information should be automatically sent or only upon request.

Action: On motion, seconded and passed, the Board approved the routine transmission of non-MCAT related irregularity reports to non-member schools or their agencies in cases where there was reason to believe the subject of the report may be an applicant and the transmission upon specific request of the same information to licensure boards.

B. Revision of the General Requirement Sections of the Essentials of Accredited Residencies

The ACGME adopted two revisions of the General Requirements which had to be ratified by ACGME sponsors. The first was the insertion of a sentence which read "[F]urther, adequate financial support for residents' stipends is an essential component of graduate medical education." A second sentence was revised to read "[I]nstruction in medical ethics, in the socioeconomics of health care, and in the importance of cost containment should be part of all programs." The discussion focused on the first of these changes which was viewed as an effort to establish control over residency programs that do not offer stipends or have such little stipend support that they depend heavily upon the self-support of residents. The change was seen as an effort to provide



protection for students and was interpreted not to preclude an occasional opportunity for someone to engage in residency training as a way of sub-specializing or changing specialty and who was able to provide their own support.

Action: On motion, seconded and passed, the Board approved both revisions of the General Requirements.

#### C. Tax Report Update

The Board discussed Senator Packwood's detailed tax reform proposals, which had eliminated many of the items appearing in H.R. 3838 which had drawn the Association's concern, particularly provisions regarding tax exempt bonding authority. Nevertheless, the caps on the 403(b) elective deferrals and limitations on IRA's that were part of the House bill and the Packwood proposal continued to be worrisome, and were seen as making academic medical center pensions less competitive and providing incentives for practice plans to be organized outside medical school structures. The Board agreed on the importance of medical schools continuing to press on these provisions and discussed ways to continue an effort to get faculty members involved in letter writing to their Senate representatives. Staff was asked to provide another draft form letter, such as one provided previously by the AAMC to the deans, as well as a readable description of the impact of provisions which the AAMC found objectionable.

#### D. Report of the Ad Hoc Committee on Federal Research Policy

Dr. Elizabeth Short, Director of the AAMC's Division of Biomedical Research and Faculty Development, presented the report of the ad hoc Committee on Federal Research Policy. She indicated that as result of discussions by the Council of Academic Societies a few modest changes had been introduced into the draft report. These included giving greater priority to support for research training and elimination of any statement critical of the "payback" provision of the National Research Service Awards. The latter was based on the perceived need for more data on the impact of this provision on research manpower. Discussion of the report by Board members centered on the call for a 15-20 percent annual increase in NIH and ADAMHA budgets for each of the next five years. That request was feared to appear excessive. Board members suggested that the derivation of these figures be explained more fully in the report and that the extended rationale that appeared in the body of the report be included in the executive summary.

Action: On motion, seconded and passed with these recommendations, the Board endorsed the draft report of the ad hoc Committee on Federal Research Policy.

#### E. AAMC Finance Committee Report

Drs. Weldon and Stemmler reported on the progress of the AAMC Finance Committee. The committee had hoped to draw up a plan for assuring a continued balanced budget prior to the start of Dr. Petersdorf's term as President. Upon further reflection, the committee decided to slow down the process to allow Dr. Petersdorf to contribute to the planning. The committee had concluded that the Association's finances had been

extraordinarily well-managed during Dr. Cooper's tenure. The committee was proposing several principles to meet future needs: 1) that the operating budget should fully fund depreciation, build reserves as necessary, and have an operational margin of 4-5 percent; 2) that a methodology for adding a portion of the income from the endowment to the operating revenues be developed. If necessary, member dues should be increased to meet the first goal. Dr. Petersdorf expressed his appreciation to the committee for allowing him to participate in further discussions.

#### F. Report of the Committee on Financing Graduate Medical Education

Dr. Knapp presented the final report of the Committee on Financing Graduate Medical Education for endorsement by the Board. Generation of the report had proved to be extremely difficult and specific provisions of it continued to be controversial. However, Dr. Knapp believed that the committee members' willingness to call for something less than a continued open-ended commitment was a significant advance, particularly in light of the sentiment of and actions taken by Congressional bodies. The report concluded among other things that funding should be continued for residents up to primary board eligibility plus one year, up to a maximum of six years.

Board members expressed their appreciation of the difficulties in getting consensus on these issues. They noted that the AAMC will need to confront additional issues in the future, including the role of faculty practice income in the support of residency programs and sources of support for residency training in out-patient settings.

Action: On motion, seconded and passed, the Board endorsed the final report of the Committee on Financing Graduate Medical Education.

#### G. Proposed Medicare Regulations on Payments for Medical Education

The Board was set to discuss a series of proposed Medicare regulations for reimbursing the direct costs of graduate medical education, which would have eliminated reimbursement for nursing and allied health training and faculty supervision. However, the Executive Committee in a meeting with Secretary Bowen the previous day had learned that these regulations were effectively mooted by the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Dr. Knapp explained the provisions of COBRA which include reimbursement of the direct costs of GME up to first board eligibility plus one year to a maximum of five years. Subsequent year trainees are to be funded at 50 percent of costs, 75 percent during a transition year. The indirect medical education adjustment is set at 8.1 percent per .1 residents per bed, by a formula which increases the percentage in a non-linear fashion for higher ratios. Dr. Knapp commented that a number of procedural and definitional issues in implementing the law remained to be resolved. He noted the variability among academic medical centers in current hospital support of fellows. Thus, the law was likely to have a differential impact on hospital revenues.

#### H. Changes in GME Training Requirements

At the February 1986 ACGME meeting the RRC in Anesthesiology requested approval of changes in its special requirements that would have the effect of lengthening the training period by one year for many house officers. Board members discussed past and current strategies to secure ABMS member approval of any such changes that impinge on the resources of teaching hospitals providing graduate training. The ABMS had rejected an amendment to its by-laws to that effect, but introduced an "open forum" procedure prior to the implementation of any changes.

Action: On motion, seconded and passed, the Board decided to take no further action until the "open forum" procedure proposed by ABMS for securing comments on any proposed specialty training requirements had been tried. The Board agreed that such forums should occur as early in the process as possible, to make it at least possible that the forum might influence the decision.

## VI. DISCUSSION ITEMS

### A. Marketing and Advertising: The Role of the AAMC

The Barton-Gillet Company had proposed to the AAMC and AAHC the development of a joint marketing program for academic medical centers, to preserve its patient base for teaching and research. Board members agreed that responding to this specific proposal was premature. Further efforts should be made by staff to define the problem which a joint marketing or image-building program would appropriately address, then to determine what resources internal to our member institutions could be drawn upon. If external expertise were needed, the appropriate approach would be to solicit several proposals via an RFP.

### B. Current Proposals on Reimbursement of Indirect Costs

The Administrative Board noted the Administration's plan to publish a revision to OMB's Circular A-21, "Cost Principles for Educational Institutions." The proposal would seriously affect a number of medical schools. The Board noted with approval the Association's efforts to support alternative proposals which had been recommended by the Council on Governmental Relations to reduce costs and to control departmental administration costs.

## VII. OSR REPORT

Mr. Peters reported the decision of the Association not to publish the OSR Critical Issues Paper as an OSR report. While the students were resigned to this outcome, they were nevertheless interested in carrying out a dialogue with the COD Administrative Board regarding student concerns, and learning, with somewhat greater precision, what the deans' concerns and criticisms of the critical issues paper were. Several members of the Administrative Board responded to Mr. Peters request for a reaction to the paper. These responses were directed to the general premise and tone of the paper rather than specific issues discussed in it. One comment was that the reader felt as though he were coming into the middle of a discussion, seeing criticisms and solutions to problems that had not been described. Another suggested that reading the report made him feel that he was reading a series of answers to questions that had not been identified.

The OSR chairman reported that the document had pretty much served its purpose, having been the basis for a series of discussions at the OSR meeting in the fall and having been distributed to each OSR representative subsequently. He expressed the desire to work collaboratively with the deans on specific issues identified in the paper.

**VIII. INFORMATION ITEM**

The Board noted with approval the application of Pfizer Pharmaceutical's efforts on behalf of biomedical and behavioral research which were manifest in their ad entitled, "Medical Research--Building a Healthier Future."

**IX. ADJOURNMENT**

The meeting was adjourned at 11:45 a.m.

## DESIGNATION OF FEDERAL LIAISON FUNCTION

From time to time the Association must contact responsible officials at member institutions for the purpose of informing them of an urgent legislative matter requiring the institution's attention. Frequently the dean or CEO is unavailable. In other instances the deans' institutional responsibilities require that he inform another official either directly cognizant or in a decision-making line outside the medical school. These situations suggest that it would be both useful and efficient for the Association to develop a continuing relationship with a designated person, an office, a function, an executive secretariat--you name it--to whom (or which) the Association could provide background on legislative/regulatory issues on a continuous basis and who (or which) would be: knowledgeable about the institutions decision making processes; would be empowered to develop a tentative plan, for review by higher authorities, for an institutional response; and dependably available on short notice. Thus, the Boards are asked to consider the advisability of requesting that each medical school and teaching hospital designate--in addition to current addressees--a focal point: to receive and triage AAMC memoranda dealing with legislative, regulatory or other matters warranting urgent attention; and to initiate appropriate institutional response processes.

**RECOMMENDATION:** That the Administrative Board consider the advantages and disadvantages of creating an institutional federal liaison focal point that would: 1) be copied on all Association mailings relating to federal legislative matters, and 2) be responsible for managing the institutions initial response to Association alerts.

## THE COD ANNUAL MEETING PROGRAM

Dr. Clawson has appointed an Annual Meeting Planning Committee consisting of: William T. Butler, M.D., Phillip M. Forman, M.D., David S. Greer, M.D., Louis J. Kettel, M.D., Walter F. Leavell, M.D., Thomas H. Meikle, M.D., and Robert H. Waldman, M.D. The committee has not yet had an opportunity to meet.

The Committee on Graduate Medical Education and the Transition of Residency Programs recommended that a joint meeting of the CAS, COD and COTH should be held to discuss the Committee's recommendations at the Annual Meeting. Such a program has been tentatively scheduled for 4:00 pm - 5:30 pm on Sunday afternoon.

Attached are a series of proposals for the Sunday evening social event. Additional proposals were offered by other catering services but were not price competitive. The proposal coming closest to meeting the requirements set out by the previous meeting of the Board is set out on the first page of the attachment. It would involve the private charter of the Creole Queen Riverboat. The price of \$82 or \$86 is dependent upon the menu chosen. While this cost is at the outer range of reasonableness as expressed by the Board's previous meeting, there is a possibility that this cost could be reduced by a subsidy by or via the Louisiana schools. Dr. James Hamlin, dean at Tulane, is exploring the possibility of picking up all or part of the cost of this event. We hope to have further information on the results of his efforts at the time of the Board meeting.



ASSOCIATION OF AMERICAN COLLEGES  
DEAN'S DINNER  
Sunday, October 26, 1986

COCKTAILS, DINNER AND "ALL THAT JAZZ"  
ON THE CREOLE QUEEN RIVERBOAT

A trip to New Orleans is not complete without taking a Mississippi Cruise! For the enjoyment of the AAMC Dean's Dinner guests, Crescent City Consultants has exclusively chartered New Orleans' newest and most exciting Riverboat, the CREOLE QUEEN.

The site of your dinner party is a luxurious paddlewheeler, reminiscent of a bygone era. As you approach the deck, a delightful Jazz Band will greet you, and Crescent City Consultants' hostesses will be on hand to assist you with boarding.\*

Open bars serving premium brands will be available and the following hors d'oeuvres will be served:

MENU I

Baked Brie en Croute  
with Apple and Pear Slices  
(Garnished with Seasonal Fruit)

French Cut Crudite Vegetable Platter  
with Curry Dip

Gourmet Assortment of Pates and Galantines  
with Crusty French Bread

Passed:

Shrimp and Oyster Patties

Canapes of Smoked Irish Salmon  
on Pumpnickel Points

Muffalatta Pinwheel Canapes  
on Melba Toast Rounds

Tiger Shrimp with Sweet and Sour Dip

MENU II

Fresh Fruit Platter  
with Strawberry Cream  
and Poppy Seed Dressings

Fresh Vegetable Platter  
with Dill Curry Dip

Assorted Gourmet Cheeses  
Garnished with Fruits of the Season

Passed:

Petite Spanikopita:  
Phyllo Triangles with Spinach and Feta

Shrimp Vinaigrette  
Wrapped in Snow Peas

Assorted Pinwheel Canapes:  
Smoked Salmon and Cream Cheese  
Baked Ham and Dijon  
Roast Beef and Horseradish  
Turkey Breast and Curry  
Muffalatta Pinwheels

\*We recommend having the hostesses walk people from the Hilton to the dock. If transportation is required, please advise.



ASSOCIATION OF AMERICAN COLLEGES  
DEAN'S DINNER (cont.)  
Sunday, October 26, 1986

During cocktails as well as dinner, the Jazz Band will play for your listening and dancing pleasure.

The formal seated dinner will be served by white-gloved waiters. We recommend one of the following menus:

MENU I

Oysters en Brochette

Creole Gumbo

Caesar Salad

Red Fish Filets Sauce Mueniere

Fresh Vegetable Saute'

Creme Caramel

Garnished with Chocolate Covered Strawberries

Wine, Coffee and Tea

MENU II

Duet of Pates:

Oyster and Artichoke Pate  
Pate de Canard

Chilled Vichysoisse

Bibb Lettuce with Seedless Grapes  
in Cognac Mayonnaise

Filet St. George  
(Tenderloin of Beef Sliced  
and Served with Sauce  
Espagnole with Mushrooms)

Fresh Seasonal Vegetable Maison

Praline Mousse in a Chocolate Cup

Wine, Coffee and Tea

Truly, an "only in New Orleans" evening--certain to be a highlight of the Association of American Medical Colleges Convention!

MINIMUM: 130 persons

MAXIMUM: 250 persons

TIME: 6:30 p.m. to 9:30 p.m.

COST: MENU I - \$86.00 per person

MENU II - \$82.00 per person

NOTE: Cost is inclusive of exclusive charter of the boat, menus as outlined, open bars (premium brands), wine with dinner, fresh flower centerpieces, Jazz Band for 2½ hours, Crescent City Consultants' coordination and hostess staffing, all rental, service, tax and gratuity.

Other menus are available upon request.





ASSOCIATION OF AMERICAN MEDICAL COLLEGES

DEANS' DINNER

One of New Orleans most historic buildings, the New Orleans Board of Trade, will be the site of your Medical College Deans' Dinner. Erected in 1883, the New Orleans Board of Trade features a beautifully painted domed ceiling, cast iron appointments, balconies and lovely formal garden and patio. It is here on the patio that your evening will begin with cocktails\* and hors d'oeuvres. The sounds of a creole jazz trio will set a festive mood for your party.

After your guests have all arrived, you will be escorted into the Board of Trade building. Here elegantly set tables, candles and flowers await you. Your seated dinner will be served by white gloved waiters and wine will be offered. See attached suggested wine list and menus. The jazz trio will continue to entertain you with their lively local sound.

After dinner you may wish to walk the short distance to the French Quarter where you may continue the evening on your own.

MINIMUM: 130 persons  
MAXIMUM: 200 persons

TIME: 7:00 p.m. to 10:00 p.m.  
COST: \$60.00 per person

NOTE: The cost is inclusive of facility rental, security, entertainment, fresh flowers, food, Crescent City Consultants staffing and coordination fee all taxes and gratuities.

\*Liquor and wine will be billed as per consumption.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
Sunday, October 26, 1986

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MENU FOR AAMC DEAN'S DINNER  
AT THE  
NEW ORLEANS BOARD OF TRADE

COCKTAILS & HORS D'OEUVRES

PETITE SPANIKOPITA  
(Phyllo Triangles with Spinach & Feta Cheese)

SHRIMP VINAIGRETTE WRAPPED IN SNOW PEAS

ASSORTED PINWHEEL CANAPES  
(Smoked Salmon and Cream Cheese, Baked Ham and Dijon  
Roast Beef and Horseradish, Turkey Breast and Curry  
Muffaletta Pinwheels)

FRESH FRUIT PLATTER WITH STRAWBERRY CREAM AND POPPY SEED DRESSINGS

FRESH VEGETABLE PLATTER WITH DILL CURRY DIP

ASSORTED GOURMET CHEESES GARNISHED WITH FRUITS

DINNER MENU

APPETIZER

(Duet of Pates; Pate de Canard, Oyster and Artichoke Pate  
Garnished with Cornichon Olive and Apple)

CHILLED VICHYSOISSE

BIB LETTUCE WITH SEEDLESS WHITE GRAPES  
IN COGNAC MAYONNAISE

ENTREE (Choice of:)

A. FILET ST. GEORGE

(Tenderloin of Beef Sliced and Served with  
Sauce Espagnole with Mushrooms)

B. JUMBO SHRIMP SAUTE' WITH ANGEL HAIR PASTA

FRESH SEASONAL VEGETABLE MAISON

PRALINE MOUSSE IN A CHOCOLATE CUP

COFFEE, DECAFF, HOT TEA



COCKTAIL BUFFET IN A FRENCH QUARTER RESIDENCE

A cocktail buffet in a private French Quarter residence will certainly answer any questions you may have about why so many people fall in love with New Orleans!

As you relax in the lush fragrance of this private courtyard hidden from the Vieux Carre' streets by heavy antique gates and illumined by flickering candles, you'll begin to absorb the wonderfully mysterious atmosphere which prevades this romantic city.

Your private cobblestoned patio adjoins an historic residence, an architectural jewel dating back to the 18th century, which provides a uniquely beautiful setting. This magnificent home and its fine appointments will certainly be enjoyed by all.

Amid this historic and elegant atmosphere, New Orleans cocktail buffet will be served while a Creole Jazz trio plays for your listening pleasure. Fresh flowers, open bars, security and Crescent City Consultants' staffing and coordination will further insure a perfect evening in the French Quarter\*.

MINIMUM: 150 persons

TIME: 7:00 p.m. to 9:00 p.m.

MAXIMUM: 200 persons

COST: \$40.00 per person

SUGGESTED MENU

Fresh Fruit Platter with Strawberry Cream and Poppy Seed Dressings  
Fresh Vegetable Platter with Dill Curry Dip  
Assorted Gourmet Cheese Platter  
Rumacki  
Shrimp and Oyster Patties  
Assorted Pinwheel Canapes  
Smoked Salmon and Cream Cheese  
Roast Beef and Horseradish  
Turkey with Curry  
Ham and Dijon  
Assorted Stuffed Vegetables:  
Snow Peas with Lobster and Jalapeno Cheese Apperail  
Cherry Tomatoes with Sour Cream and Red Caviar  
Zucchini with Crawfish Apperail  
Summer Squash with Blue Cheese  
Crawfish Etouffée with Rice  
Creole Gumbo with Rice  
Jambalaya



Oyster, Tasso and Fettucine  
Tortellini with Basil Marinara  
Crawfish with Angel Hair Pasta  
Steamship Round of Beef  
Roast Turkey  
Baked Ham

Pistolette Rolls, Sliced Cheeses and Condiments for Sandwiches  
or Sauces, Gravies and Rice

Pies: Selection of Pecan, Apple and Sweet Potato  
Cheese Cakes, Chocolate Mousse, Various Petit Fours and More  
Pure Coffee

Coffee and Chicory  
Decaffeinated Coffee  
Hot Tea

Cream, Sugar & Sweet n'Lo, & Lemons

Black Tie Waiters, White Frocked Chefs  
Hors d'oeuvres passed butler style  
Individual stations manned

\*Subject to availability



## THE ELMS MANSION

Welcome to the Elms Mansion\*, purchased by Mr. and Mrs. John Elms, Sr. in 1950 (his dream come true home). As a young man, Mr. Elms delivered french bread up and down St. Charles Avenue for Leidenheimer Bakery. John Elms vowed that one day he would own and live in one of these homes. Consequently, a young man's dream became a reality.

This home was built in 1869 by Watson Van Benthuyson, who came from New York when he was twenty years old. He was the president of the first Bell Telephone Company. He was the president of the New Orleans, Carrollton and Crescent City Railroad; and, he built the Coliseum line. He later disposed of his interest in this respect and became president of the Poughkeepsie Bridge Company and was foremost among those concerned in the spanning of the Hudson River at Poughkeepsie. During the Civil War, Mr. Van Benthuyson was in charge of the Tax Department of the Confederate Army, and later commanded the famous wagon train of Jefferson Davis that traveled all the way from Virginia to Florida. On October 13, 1858, Watson Benthuyson married Cornelia Elizabeth Scott of New Orleans, to whom were born three children. Katie died at age four, Edgar died before his parents. Mr. Van Benthuyson passed away on March 30, 1901, at age sixty-eight. After his death his fortune dwindled, necessitating his wife, Cornelia, to auction off a million dollars of antiques from this house. The auction took place in the grand ballroom. Cornelia then moved to the carriage house at the rear of this building, and rented the home to the German Consulate. When World War II started, it is remembered by many citizens the burning of documents that went on for days in the driveway. The Consulate was also a captain and navigator. With this knowledge he accomplished an unusual fete of navigating a German Submarine up the Mississippi River past Baton Rouge.

And now for the history and tour of this home.

This home is Italian Romanesque and was designed by Henry Howard.

Entrance Hall: 16' X 19' - Transition period - woodwork mahogany with cast bronze metal work by Guerin and Company of New York. Sconces are 24K gold Dore'. Verde antique marble mantle and hearth. Side walls original canvas handstenciled with Bonaparte Bee. This room was designed and decorated by Sturdy and Company of Chicago, Illinois.

Dining Room: 18' X 26' - Jacobean English design in oak. Deep beamed ceiling in a design. Elaborate mantle to ceiling height with carved panels and caryatid and columns and carved caps over all doorways. All woodwork finished in Flemish oak. Mantle has Verde antique marble facing and hearth. Notice the beautiful leaded glass designs in color with figured transoms. Imported chandelier of crystal, a duplicate from Napoleon's room in the Grand Trianon.



Drawing Room: 16' X 23' - Louis XVI design imported mantle of Carara marble, hand-carved with undercut sections. The columns on either side of the room are imported from Europe. And do notice the beautiful Sevres vases. Notice the parquet floors in all rooms are of different designs. Floors were installed by Wood Mosaic Company of New Albany, Indiana. This room was designed and decorated by Study and Company of Chicago, Illinois.

Notice the stairway window has a beautiful central painted figure design, bordered with painted leaded glass to harmonize with the center. Notice the ceiling dome with leaded glass sash in color. This was designed by Favrot and Livaudais Architects of New Orleans.

We are now entering the Grand Ballroom which measures 18' X 49'. The ceiling is a reproduction of the town hall in Brussels, Belgium. Notice the beautiful built-in book cases, the circular alcove which was used for the chaperones. Notice the raised platform where you could entertain or have music recitals. This mantle is Italian sandstone. All walls are imported linen tapestry, which tells an Irish love story. The bar was built by Mr. Elms in a motif that was in keeping with the room.

Your reception will take place in this lovely mansion as you enjoy the sumptuous New Orleans hors d'oeuvres listed below. The music of a 3 piece jazz band will play for your listening and dancing pleasure throughout the reception. Transportation will be provided to and from the predesignated hotel and Crescent City Consultants' hostesses will accompany you.

MINIMUM: 150 persons

TIME: 7:00 p.m. to 9:00 p.m.

MAXIMUM: 250 persons

COST: \$42.00 per person

#### SUGGESTED MENU

Fresh Vegetable Platter with Curry Dill Dip

Assorted Gourmet Cheese Platter

Assorted Stuffed Vegetables of:

Snow Peas with Lobster and Jalapeno Cheese Apperail

Cherry Tomatoes with Sour Cream and Red Caviar

Zucchini Squash with Blue Cheese

Pasta Salad

Creole Gumbo with Rice

Steamship Round of Beef/Roast Turkey

Pistolettes and Condiments/Sauces, Gravies & Rice

Stir Fry Mixed Vegetables

Dessert Bar with Chocolate Covered Strawberries  
and Various Petit Fours - Coffee & Hot Tea

\*Subject to availability

The University of Texas Medical Branch at Galveston

Medical School  
Graduate School of Biomedical Sciences  
School of Allied Health Sciences  
School of Nursing

Marine Biomedical Institute  
Institute for the Medical History  
UTMB Hospitals at Galveston



RECEIVED

Executive Vice Chancellor KUMC

Office of the Dean of Medicine  
(409) 761-2671

APR 21 1986

AM PM  
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April 15, 1986

D. Kay Clawson, M.D.  
Executive Vice Chancellor  
University of Kansas School of Medicine  
39th Street at Rainbow Blvd.  
Kansas City, KS 66103

Dear Kay:

Enclosed is the official letter. I have one suggestion for change in the nominating process for subsequent years. Each member of the Nominating Committee should agree to forego a personal nomination as a condition of appointment. Things were a bit touchy this year, but it all worked out well. I think you would find considerable support for this suggestion among our colleagues, but I have discussed it with no one.

Again my thanks for this opportunity to participate.

With best personal regards,

Sincerely yours,

Handwritten signature of George T. Bryan in cursive script.

GEORGE T. BRYAN, M.D.  
Dean of Medicine

GTB:pt

cc: Louis J. Kettel, M.D.  
Chairman Elect.

The University of Texas Medical Branch at Galveston

Medical School  
Graduate School of Biomedical Sciences  
School of Allied Health Sciences  
School of Nursing

Marine Biomedical Institute  
Institute for the Medical Humanities  
UTMB Hospitals at Galveston



April 15, 1986

Office of the Dean of Medicine  
(409) 761-2671

D. Kay Clawson, M.D.  
Executive Vice Chancellor  
University of Kansas School of Medicine  
39th Street at Rainbow Blvd.  
Kansas City, KS 66103

Dear Kay:

On behalf of the Nominating Committee, I submit herewith our unanimous recommendations:

For Chairman Elect, Council of Dean: William T. Butler.

For Executive Council: Walter F. Leavell and John Naughton.

For Members at Large, Administrative Board: L. Thompson  
Bowles, Henry P. Russe and W. Donald Weston.

Since Dr. Butler will leave an unexpired term on the Executive Council when he becomes Chairman Elect, we nominate Hibbard E. Williams for that position.

Thank you for this opportunity to be of service to the Council.

Sincerely yours,

A handwritten signature in cursive script that reads "George T. Bryan".

GEORGE T. BRYAN, M.D.

GTB:pt

cc: Henry H. Banks, M.D.  
Robert L. Friedlander, M.D.  
Tom M. Johnson, M.D.  
Joseph W. St. Geme, Jr., M.D.





**THE UNIVERSITY OF KANSAS**

Office of the Executive Vice Chancellor  
College of Health Sciences and Hospital  
39th and Rainbow Blvd., Kansas City, Kansas 66103  
(913) 588-1207

May 12, 1986

Hibbard E. Williams, M.D.  
Dean  
University of California, Davis  
School of Medicine  
Davis, CA 95616

Dear Hibbard:

Thank you for your response to my "Dear Colleague" letter and minutes. I will take both of your comments on; one to the Administrative Board and the other as your delegate to the ACGME.

Most sincerely,

D. Kay Clawson, M.D.  
Executive Vice Chancellor  
Executive Dean

DKC/pgw

cc: Mr. Joseph A. Keyes, Jr. ✓  
August G. Swanson, M.D.

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DEAN

SCHOOL OF MEDICINE  
DAVIS, CALIFORNIA 95616

April 30, 1986

RECEIVED  
EXECUTIVE

D. Kay Clawson, M.D.  
Chairman of the Council of Deans  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20036

MAY 9 1986  
AM 7,8,9,10,11,12,1,2,3,4,5,6 PM

Dear Kay:

Thank you for sending out the very complete summary of the Spring Meeting of the Council of Deans. I think the summaries of the four discussion groups were particularly well recorded.

I have two issues on which I would like to make some comments. The first of these relates to the issue on page two of your letter concerning a change in the general requirement section of the essentials of accredited residencies. Personally, I am opposed to making the proposed change concerning adequate financial support for resident stipends. I am well aware of the issue of some residents working without salary, but I believe this should be a local issue and not one controlled by ACGME. The proposed statement, "further, adequate financial support for resident stipends as an essential component of graduate medical education" is relatively innocuous, but I do not think the ACGME should be getting into the issue of funding of resident positions. That potentially opens a Pandora's box which I would hate to see opened.

Secondly, I want to comment on the topic discussed at the Spring Meeting entitled: "Transition to Residency Education." I confess, I was part of the discussion group which came up with the proposed resolution and, therefore, I confess a strong bias in favor of the resolution. I strongly urge the Administrative Board to take a very positive position on this issue. It is a statement which needs to be made to counteract the progressive intrusion of the specialty boards on our medical student curricula. For the resolution to be effective, it will require adherence by all Deans and all Medical Schools, but I sensed very strong support at the Spring Meeting, and a strong statement by the Administrative Board and the AAMC will clearly make it more likely that unanimity of action among the Deans will follow.

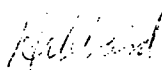
I have already addressed this issue with my own department chairs, and as expected, there were concerns expressed by the specialties of Ophthalmology, Orthopaedics and Neurology. However, the large number of department chairs present at our meeting clearly favored this approach. The one substantive concern that I will transmit to you from our Chair of Ophthalmology is the concern of implementation of this program. He argued strongly for implementation in 1988 or 1989 so as to allow the specialties adequate time in which to adapt, a point of view that I can understand and support.

Document from the collections of the AAMC. Not to be reproduced without permission.

D. Kay Clawson, M.D.  
April 30, 1986  
Page Two

Thank you for sending out the very complete minutes of the Spring Meeting. As I told you at the meeting, it was one of the best Council of Deans meetings I have attended, and as a Dean in my sixth year, I do have some experience from other meetings. My congratulations to you on putting together such a fine program.

Sincerely,



Hibbard E. Williams, M.D.  
Dean

HEW/bjk



PONCE SCHOOL OF MEDICINE  
P. O. BOX 7004  
PONCE, PUERTO RICO 00732

OFFICE OF THE DEAN

(809) 843-8288

May 13, 1986

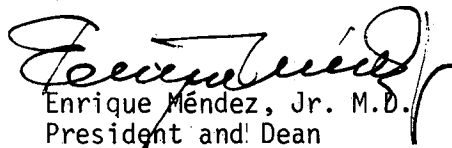
Dr. D. Kay Clawson  
Chairman  
Council of Deans  
Association of American Medical Colleges  
One Dupont Circle, NW  
Washington, DC 20036

Dear Dr. Clawson:

In response to your letter of April 24 I reviewed all of the material that you sent.

In item IV (transition to Residency Education) I recall that specific mention was made of the need for an earlier time frame than October 1 to fill the needs of military training programs for the availability of Dean's letters and transcripts. I see no mention of that in the proposed resolution under item IV and wonder if the matter is being pursued or clarified.

Sincerely,

  
Enrique Méndez, Jr. M.D.  
President and Dean

# Mayo Foundation

Rochester, Minnesota 55905 Telephone 507 284-2511

Mayo Clinic Mayo Medical School  
Mayo Graduate School of Medicine  
Mayo School of Health-Related Sciences

Franklyn G. Knox, M.D., Ph.D.  
Director for Education  
Dean, Mayo Medical School

May 28, 1986

D. Kay Clawson, M.D.  
Chairman  
Council of Deans  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Dr. <sup>Kay</sup> Clawson:

Your recent memorandum with summaries of the four major topics discussed at the spring COD meeting was greatly appreciated. I've shared these summaries with our two associate deans and, for whatever value they might be to you and the Administrative Board, here are our observations.

## I. Attractiveness of Medicine as a Profession:

Among the strategies developed regarding premedical advising we should be sure that accurate information portraying the schools is made available to undergraduate advisers. Some premed advisers use reports such as the "hoax" perpetrated by Jack Gorman in his "Gorman Report" on graduate schools. It might be worthwhile considering an official condemnation of the report as biased, opinionated, and inaccurate.

Demographically stratified opinion surveys of high school and undergraduate college students would be helpful to obtain a perception of how the medical profession and medical school is perceived by potential enrollees.

Item 6 states:

All medical schools should analyze individual applicant pool data seeking negative factors that can be corrected and positive factors that can be emphasized in their local areas. The item seems a bit vague, and we're not clear as to its intent. We pole our applicants who have not accepted appointment asking their perception of our school. Perhaps that is the sort of information that is being sought.

Your memo continues with the general theme and under "motions," we view the suggestion that schools analyze their class size in reference to the quality of its applicant pool and ability to maintain high internal standards of education as very important. It may even imply a move toward restricting admission to medical school and perhaps limiting admissions to medical schools to those able to demonstrate a high quality in their applicant pool.

## II. Institutional Responsibility for Medical Education:

We endorse the statement concerning the dean being the key person in the implementation of institutional responsibility. The suggestion that the dean establish out of his office a central resource unit to provide technical support for education has been instituted here. Some years ago we added an office for providing services and coordinating instructional resources. It's a small unit but has been appreciated by our course directors. More recently an Instructional Resources Committee, including service providers from throughout the institution and others with a contribution to make in this area, was established.

We are also supportive of the call for more self-directed, problem-based learning, particularly in interdisciplining courses, because of the potential for increasing faculty interaction across departmental lines. A fairly large component of our curriculum is organized in this fashion, and we are pleased with the results.

To the suggestion that the primary responsibility for teaching be rotated among fewer faculty and that the "parade of stars" be avoided we say, "Amen."

The call for more shared accountability across departmental lines, especially clinical and basic sciences, is laudatory. We try to work at this by bringing our course and clerkship chairs together on a regular basis at meetings of the First, Second, Third, and Fourth Year Curriculum Committees.

We enthusiastically endorse the action step which calls for the AAMC staff to identify and collect valid criteria for measuring excellence in teaching by faculty members. The whole question of how we can better recognize good teaching and show appreciation for it has been a major theme for us this past year.

## III. Institutional Responsibility for Graduate Medical Education:

With regard to Graduate Medical Education we certainly support efforts toward improving better communication with the RRC's and the ACGME and toward developing mechanisms to provide institutional input to the decision-making process. The memo points out that decisions by these groups often impact on the utilization of scarce resources. My office is responsible for allocation of these resources at Mayo, but we are frequently not informed of changes until they have been finalized. Given our budgetary responsibilities for our programs and the responsibility for program integrity, it seems reasonable to expect that we should have a voice in the decision-making process. Effective AAMC representation and good communication through the AAMC representatives, with the assistance of the AAMC offices, could improve this situation.

IV. Transition to Residency Education:

We are supportive of the concept of an "earlier date" before which dean's letters and transcripts can be sent to residency programs. October 1 might be a bit late, perhaps September 15 would be more realistic. There may be some conflicts with programs not providing adequate G11 preparation and requiring a transitional year. It will be a bit difficult to limit distribution of transcripts since they can be released by the student. Dean's letters and letters of recommendation, however, could be restricted quite easily. Obviously, all schools would have to agree on a set date, as will residency programs, but movement in this direction seems appropriate.

We're of the opinion that a variety of fourth year experiences should be encouraged particularly in students applying to highly competitive residencies who feel a need to take several electives in one particular specialty area. This practice is frowned upon not only by the administrations of medical schools but by directors of residency training programs.

Efforts to make the match uniform would certainly reduce pressure on the students as well as Student Affairs offices.

I hope these comments are of some assistance to you as you prepare for the June meeting. We found it a worthwhile exercise to discuss each of the four questions from our perspective and experience.

Sincerely yours,



Franklyn G. Knox, M.D., Ph.D.

FGK:jr

FUTURE MEETING DATES

1986 Meeting Dates:

*Executive Council/COD Admin. Board -*

September 10-11

*AAMC Annual Meeting -*

New Orleans Hilton  
New Orleans, Louisiana  
October 25-30

1987 Meeting Dates:

*Executive Council/COD Admin. Board -*

January 21-22  
April 15-16  
June 17-18  
September 9-10

*AAMC Annual Meeting -*

November 7-12  
Washington Hilton Hotel  
Washington, DC

*COD Spring Meeting -*

April 4-8  
Stouffer Wailea Beach Resort  
Maui, Hawaii