association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

ADMINISTRATIVE BOARD

WEDNESDAY, SEPTEMBER 10, 1986
5:00 PM - 6:30 PM
GEORGETOWN EAST

THURSDAY, SEPTEMBER 11, 1986
8:00 AM - 12:00 PM
EDISON ROOM

WASHINGTON HILTON HOTEL
WASHINGTON, DC

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

COUNCIL OF DEANS
ADMINISTRATIVE BOARD MEETING

Washington Hilton Hotel
Washington, DC

AGENDA

Wednesday, September 10, 1986

5:00 pm - 6:30 pm

Georgetown East Room

I. AIDS - Institutional Policies

6:30 pm - 9:00 pm

Caucus Room

Reception & Dinner

Thursday, September 11, 1986
8:00 am - 12:00 pm

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

June 18, 1986

4:00 p.m. - 6:00 p.m.

June 19, 1986

8:00 a.m. - 12:00 p.m.

Independence Room

Washington Hilton Hotel

Washington, D.C.

PRESENT

(Board Members)

Arnold L. Brown, M.D.
William Butler, M.D.,
D. Kay Clawson, M.D., Chairman
Robert Daniels, 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.

(Guests)

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

(Staff)

Janet Bickel
John A.D. Cooper, M.D., Ph.D.*
Debra Day
John Deufel*
James B. Erdmann, Ph.D.*
Paul Jolly, Ph.D.
Robert F. Jones, Ph.D.
Thomas J. Kennedy, M.D.
Joseph A. Keyes, Jr.
Karen Mitchell, Ph.D.*
James R. Schofield, M.D
Nancy Seline*
John Sherman, Ph.D.
August Swanson, M.D.*
James Terwilliger
Kathleen Turner*

ABSENT

William B. Deal, M.D.
Richard Ross, M.D.

*Present for part of meeting

I. CALL TO ORDER

Dr. Clawson called the meeting to order at 4:05 p.m. The order of agenda items was modified to accommodate AAMC staff members who were scheduled to brief the Board on various issues.

II. APPROVAL OF MINUTES

The minutes from the April 10, 1986 meeting of the COD Administrative Board were approved without change.

III. CHAIRMAN'S REPORT

Dr. Clawson reported on the Executive Committee meeting held earlier that day:

- The Committee met with Drs. Neal Vanselow and Edward Brandt of the AAHC. Dr. Vanselow chairs and Brandt is a member of an AAHC committee charged with deliberating on future directions for that organization. The discussion centered on ways in which the AAMC and AAHC could work more effectively together, avoid duplication of effort and prevent conflicting calendars. A key concern was how the two organizations should present themselves on Capitol Hill. No final conclusions were reached but it was agreed that consideration of this matter should continue both at staff and Board level.

- The Committee gave further consideration to the proposed general funds budget which now included projected revenues and expenses for the MEDLOANS program. It was noted that the AAMC continues to operate without liability insurance coverage except at an umbrella level.

- The Committee re-affirmed AAMC policy that participation in joint conferences required that the AAMC should be a party to initial planning. The AAMC would join with the AMA and AHA in sponsoring a conference in February-March, 1987 on the attractiveness of medicine as a profession.

- Special awards for the 1986 Annual Meeting were discussed. Dr. James Wyngaarden would be present to accept an award on behalf of the 100 year centennial for the NIH. It was suggested that the AAMC honor Senator Russell Long for his work on behalf of teaching hospitals as chairman of the Senate Finance Committee. The appropriateness of this was to be explored further.

- A delegation to the PAMFAMS meeting would include Drs. Stemmler, Weldon, Petersdorf, and Cooper.

Dr. Stemmler indicated that he had been invited to attend in August a meeting of the Assocation of Medical Deans of Europe. He expressed support for developing closer ties to that group, perhaps through a reciprocal invitation to the COD spring meeting. The Board suggested that Dr. Stemmler provide a report on the European meeting at its September meeting.

IV. ACTION ITEMS

A. Revision of the General Requirements Section of the Essentials of Accredited Residences

The Board addressed a proposed revision to the General Requirements regarding the financial support of residents. Action on this issue had been tabled at the April, 1986 Executive Council meeting as a result of COTH objection. In the COTH view, it was inappropriate for an accreditation document to stipulate that financial support for resident stipends is essential. Dr. Peters stated the categorical opposition of OSR and other student and resident groups to unpaid residencies. He expressed reservations with an alternative revision suggested by AAMC staff in response to COTH's concerns in terms of the strength of the wording and its placement in the document. It was estimated that there were approximately 400 unpaid residency positions currently. The Board discussed various modifications to both the proposed revision and the alternative revision. It sought language that would support its belief that approved residency positions should be paid and assuage COTH's concern about the propriety of such language in an accreditation document. Dr. Clawson agreed to take the sense of the discussion to the Executive Council meeting in the hope that appropriate language could be negotiated.

B. Report of the Committee on the Transition to GME

Dr. Spencer Foreman, committee chairman, and Dr. Swanson highlighted the major points in the report of this committee which reviewed the AAMC position on institutional responsibility for graduate medical education and discussed problems at the transition between medical school and residency. A key recommendation was for the ACGME to establish a separate RRC-like committee to review institutional programs in terms of their compliance with the General Requirements. Dr. Foreman conceded that it would be difficult to get the ACGME to implement this recommendation but suggested that it would be valuable as a statement of the AAMC's continued concern with the realization of the principles embodied in the General Requirements. Dr. Kettel noted that the ambiguity in defining the sponsoring institution could be used to subvert the goals of those requirements. This problem aside, the Board expressed optimism that the committee's strong advocacy for the principles of institutional responsibility embodied in the General Requirements might at least have a beneficial effect on RRC review of progams.

Dr. Swanson indicated editorial changes suggested by the CAS and OSR in recommendations on the taking of electives and summarized the proposal for a later match (April 1), shortened match processing time (one month), and a recommended November 1 date for the transmission of deans' letters. He noted that the committee had agreed that separate matches were no longer required and recommended further negotiations with the specialties involved. A central application service, recommended by the deans, was not considered feasible but use of the universal application form was encouraged.

Action: On motion, seconded and passed unanimously, the Board voted to accept the report of the Committee on the Transition to Graduate Medical Education.

Dr. Foreman expressed his pleasure that the deans could feel satisfied that their recommendations at the COD spring meeting had been incorporated in the report.

C. Report of the Ad Hoc MCAT Review Committee

Dr. Swanson presented the final report of the MCAT Review Committee. Dr. Naughton questioned the committee's conclusion that the AAMC was not unduly dependent on income from the MCAT. Dr. Swanson responded that this conclusion was reached by the committee after reviewing financial data submitted by law to the state of California, which showed an appropriate balance of revenues and expenditures.

Action: On motion, seconded and passed unanimously, the Board voted to endorse the findings and recommendations contained in the ad hoc MCAT Review Committee Report as a guide to the conduct and further development of the MCAT program.

D. Designation of Federal Liaison Function

The Board considered a staff suggestion that deans designate a responsible person or group, to be copied on all AAMC mailings related to federal legislative matters and to be responsible for managing the institution's initial response to AAMC alerts. Board members expressed considerable reservations about the proposal. They noted that it raises sensitive institutional governance issues. They pressed for explicit recognition of the importance of their own role in such governance matters and wanted it to be clear that they were not approving an autonomous and separate decision-making or communications channel. Staff agreed to develop a survey instrument with sensitivity to these concerns.

Several Board members emphasized their need to be selective in pressing their senators and representatives on legislative matters, both from a strategic perspective and because of constraints imposed on them by university administration.

V. DISCUSSION ITEMS

A. Reporting of NBME Scores

At the OSR's request, the Board discussed whether the AAMC should advocate for a pass-fail only reporting of NBME scores. Presently, NBME results are reported as scale scores, overall and by discipline, in addition to pass-fail. In the proposed NBME comprehensive examination program, scheduled to go into effect in 1989, discipline scores would be eliminated but an overall scale score would be reported along with a pass-fail designation. The OSR felt that the reporting of scale scores has had various deleterious effects on the curriculum, causing departments and schools to focus on high scores at the expense of curriculum innovation. Also, the use of NBME scores in resident selection overemphasized for students the importance of performing well. The Board responded sympathetically to these concerns, while noting that the NBME's effect on curriculum was selective. While an AAMC position supporting pass-fail only scoring could not effect a change in policy, it could influence that policy.

Action: On motion, seconded and passed unanimously, the Board voted to support a "pass-fail only" score reporting for NBME Part I and Part II examinations, overall and by discipline.

The Board noted a GSA interest in this issue and its desire to be consulted. It also noted GSA contemplation of a survey on this question. The Board concluded that such a survey might muddle rather than clarify the issues. It agreed that its action should stand and that the Executive Council be asked to take up this matter at the June meeting rather than defer it to September.

B. Role of the AAMC in the Promotion of Academic Medical Centers to the Public

In response to a previous discussion of a proposal submitted by Barton-Gillet on a national marketing campaign for academic medical centers, the Group on Public Affairs conducted a survey on advertising by AAMC member institutions. Mr. Fentress reported the results of a survey. The data suggested that institutional advertising and marketing efforts were considerable and, in dollar terms, were comparable to that of the four largest for-profit chains. Dr. Cooper distinguished between advertising for patients and promoting and marketing the image of the academic medical center. He reported that COTH members were not interested in a national campaign directed toward the former purpose. However, there was some interest in discussing an AAMC effort directed to the latter purpose.

Action: On motion, seconded and passed unanimously, the Board endorsed the appointment of a task force to investigate in-depth whether or not the AAMC should seriously consider mounting an organized image enhancement campaign. If the recommendation should be positive, then the task force should make recommendations as to what level and how extensive this effort should be. It was further recommended that the task force membership include representation from the Group on Public Affairs.

C. Trends in Medical School Applicants

Dr. Paul Jolly reported data prepared by the AAMC's Division of Operational Studies that showed that academic qualifications of medical school applicants had thus far not declined. He also summarized the results of a survey of MCAT examinees who did not apply to medical school. The survey was prompted by a COD recommendation to initiate market research on the causes of a declining interest in the medical profession. The results suggested that graduate school in the biomedical sciences was the predominant alternative career path. Anecdotal information that the high cost of medical school, lessened autonomy of doctors, and active discouragement of MD's was contributing to student disaffection was supported. The Board decided to have the results sent to COD members along with a request for the identification of institutional research by parent universities that might cast further light on this question. These and other data collected by Dr. Jolly were expected to be available to the joint AMA/AAHC/AHA conference on the attractiveness of medicine as a profession.

D. Follow-Up on COD Spring Meeting Resolutions

Mr. Keyes noted several initiatives already taken as follow-up to the COD spring meetings. These included the analysis of data presented by Dr. Jolly on medical school applicants and plans for an AMA/AHA/AAMC joint conference on the attractiveness of medicine as a profession. The Graduate Medical Education transition committee had adopted many of the deans' recommendations in their final report. Finally, a group of curriculum deans within the Group on Medical Education had met with the Management Education Programs staff. This resulted in a proposal that a seminar series on enhancing the educational program be developed. Initial planning for such a series was underway.

E. 1986 COD Annual Meeting

Dr. Clawson reported that a planning committee for the annual meeting program had been appointed but had not yet met. Mr. Keyes presented various alternatives for a Sunday evening social event, including a riverboat party. The Board passed a motion to pursue the riverboat party if the projects costs could be negotiated down.

In futher discussion several Board members indicated serious reservations to the riverboat plan. It was left for Dr. Clawson and Mr. Keyes to pursue the various alternatives in conjunction with the deans of the medical schools in New Orleans.

F. Cardiac Surgery in the Veterans Administration

Dr. Clawson introduced discussion on a VA committee proposal to close cardiac surgical services in VA hospitals which had inadequate case loads and to review those services which exceeded a five percent operative mortality rate for bypass surgery. He noted that the study which prompted these recommendations was flawed in a number of respects, specifically in not looking at the total caseload achieved by the team in a given period, and by not considering the geographic impact of the closing of services. Dr. Butler, chairman of the VA's Special Medical Advisory Committee (SMAG), provided further background. He pointed out that the final decisions resulted from subsequent staff proposals based on considerations not in the committee report; these were almost entirely budgetary in nature. The Board expressed concern with the impact of these recommendations on residency programs and service availability but agreed that the quality of care considerations that may underlie these recommendations should be supported. Dr. Butler agreed to take the Board's concerns to the meeting of SMAG and Dr. Clawson indicated that he would mention the issue in his next Dear Colleague letter.

G. Legislative Report

Dr. Thomas Kennedy briefly reviewed legislative developments of interest to Board members. The budget resolution was in conference committee and overall was favorable to AAMC interests. A Senate tax reform bill that was more favorable to the AAMC, particularly with regard to tax-exempt bonding authority and the treatment of pension funds, was gaining considerable momentum.

Animal rights issues were a nagging concern. Emotion and sentiment were quite strong in favor of the release of 15 monkeys under federal custody. The AAMC was losing the public relations battle in this area.

A proposal in the Senate version of the Higher Education Act, restricting GSL loans to U.S. students in foreign medical schools, required active support for its retention by conference committee.

A total of 80 million dollars in research monies, earmarked for specific institutions, was first deleted from a Senate bill and then re-inserted in committee. The AAMC continued to oppose this by-pass of the peer review system.

Ms. Nancy Seline described a proposal by Rep. Pete Stark (D-CA) to incorporate payments for hospital-based physicians in DRG payment rates. He had asked his staff to obtain estimates of the cost savings under Part B of this proposal in anticipation of writing legislation. The Board's concern with this proposal was the potential impact on training programs if pathology labs and other services are driven outside the hospital.

Action: On motion, seconded and passed, the Board voted to oppose the Stark proposal for incorporating Part B payment for hospital-based physicians into DRG payments.

Ms. Seline and Dr. Bentley also decribed Congressional consideration of legislation dealing with the designation of organ transplant centers. The AAMC had previously supported giving the Secretary of HHS authority to specify medically relevant criteria to identify which centers and physicians were eligible under Medicare to be paid for transplantation services. In response to lobbying by the AMA and others, Congress deleted this controversial provision but was considering re-introducing it. The COTH and CAS Boards had concluded that the AAMC position should be modified; rather than authorizing the secretary to perform this function, the determination of such criteria should be reserved for the professional medical organizations with the requisite knowledge and expertise. Whether the determinations made by these groups would be adopted by the HHS Secretary for payment under Medicare would become a separate issue. The CAS was seen as being instrumental in identifying appropriate professional medical organizations to lead this effort.

Action: On motion, seconded and passed unanimously, the Board voted that the AAMC support, work with, and encourage the appropriate professional medical organizations to develop organ transplantation criteria and standards that would help ensure quality of care and provide guidance to the Secretary of HHS.

VI. INFORMATION ITEMS

Dr. Clawson noted for the Board's information a summary of AAMC progress in developing the MEDLOANS program. Marine Midland Bank in Wilmington, Delaware had been selected as the lender. Application materials were being prepared and sent to the schools.

The COD Nominating Committee would be nominating Dr. William T. Butler as COD chairman-elect, Drs. Walter F. Leavell and John Naughton as Executive Council members, and Drs. L. Thompson Bowles, Henry P. Russe, and W. Donald Weston as members-at-large of the Administrative Board. The Committee agreed to nominate Dr. Hibbard E. Williams to fill Dr. Butler's unexpired term on the Executive Council. Dr. Bryan, chairman of the nominating committee, suggested that in the future COD members should agree to foreswear any personal aspiration to be nominated as a condition of appointment to the nominating committee.

Dr. Clawson commended to the Board several responses to his Dear Colleague letter on the recommendations passed at the spring meeting. Included was correspondence between Dr. Brown and the chairman of the Department of Neurology at the University of Wisconsin regarding the independent match for that specialty.

VII. OSR REPORT

Dr. Peters reported that the OSR had completed its plans for an Annual Meeting program with the theme of access to medical education and health care. It also discussed a proposal to hold a symposium on problem-based learning. Dr. Peters asked the Board's advice on pursuing this project, particularly with regard to other AAMC's programs. Mr. Keyes provided background on several related seminars being planned under the Management Education Program (MEP), including one being developed with the Group on Medical Education (GME) on instituting curriculum change and adapting clinical education to the ambulatory care setting. Dr. Peters agreed that the proposed programs were consistent with the OSR's goals but elaborated further on its proposal. The Board saw merit in the OSR proposal and suggested that it be kept separate from the MEP/GME program. Dr. Peters agreed to discuss OSR plans further with Mr. Keyes to avoid duplication of effort.

Dr. Peters also noted that the OSR had some small concerns with the reports of MCAT Review Committee and Transition to GME Committee, and the changes proposed in the General Requirements section which he would discuss at the time they were considered.

In response to a proposed study mentioned by Mr. Keyes on teaching in the ambulatory care setting, Dr. Naughton questioned the appropriateness of it being conducted by the AAMC's Department of Teaching Hospitals (DOTH). Mr. Keyes indicated that DOTH's expertise on physician compensation issues had dictated that staffing but that his department and Dr. Swanson's department would be heavily involved in the conduct of the study.

VIII. NEW BUSINESS

Dr. Brown reported that NBME had organized a task force to consider the assessment of clinical competence. After several meetings, the task force is emerging with a process for developing a clinical assessment program that would expand the areas of physician competence currently covered by NBME examinations.

Dr. Moy announced that Judge Baker of the Federal court had accepted Southern Illinois University's request for summary judgment in its litigation with the Humana Corporation. The judgment was based on the principle of state action immunity.

Dr. Kettel requested that a no-smoking area be reserved at COD Administrative Board meetings.

Action: On motion, seconded and passed unanimously, the Board approved the designation of a no-smoking area.

IX. ADJOURNMENT

The meeting was adjourned at 12:11 p.m.

REPORTING OF NBME SCORES

The original discussion piece which appeared in COD and CAS agenda materials for the June 18-19, 1986 meetings is attached. Since there was some confusion at those meetings about current and proposed NBME score reporting policies, the following additional information is provided.

	Current	Proposal for the Comprehensive Exam
Individual student total scores for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student pass-fail status for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student discipline scores for Parts I and II	Yes, to students and schools	No, only group mean to schools
Individual student item keyword performance feedback	No	Yes, upon request to students and group performance to schools
Separate subject (shelf) examination program	Yes	Yes

Although there are various new features to the NBME's proposed "comprehensive" examination program, the major score reporting change is the abandonment of discipline scores for individual students. This is apparently a consequence of the content flexibility desired in the new examinations as well as the recommended reduction in number of questions. However, a school mean score by discipline may be derived and reported and item keyword performance feedback is introduced.

The NBME Study Committee for Parts I and II recommended the changes in score reporting for the comprehensive examination. At present the process for developing the comprehensive Parts I and II examinations are just under way. The committees selected to steer the development will meet in September. Thus far, the NBME has not made a firm policy decision on how the results of the examinations will be reported either to the examiness or the medical schools. We are informed that this decision will most likely occur in 1987.

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. (N=125)	Percent	No. (N=126)	Percent	No. (N=126)	Percent	No. (N=127)	Percent	No. (N=127)	Percent
STUDENT EVALUATION										
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
CURRICULUM EVALUATION										
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 perogative 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 desire 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 in 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.

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 accreditated 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

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

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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.

Wagoner, Norma E. and J.R. Suriano, Resident Selection: Process and Factors. Preliminary results of a national survey of residency program directors, 1984.

ELECTION OF DISTINGUISHED SERVICE MEMBERS

The Distinguished Service Member nominating committee consists of John W. Eckstein, M.D., Richard H. Moy, M.D., and Richard S. Ross, M.D. This committee solicited recommendations from the general membership of the Council of Deans. Recommendations have been received and the committee will have met prior to the Board meeting on September 11, 1986. Its report will be presented to the Board at this meeting.

1988 COD SPRING MEETING LOCATION

It is the staff recommendation based on site visits, contact with hotel staff and other meeting professionals, that the COD Administrative Board elect the Hotel Inter-Continental at Hilton Head, South Carolina.

The outstanding characteristics of the Hotel Inter-Continental at Hilton Head include: its relatively small size; its location on one of the smallest plantation resorts on Hilton Head; its elegant ambiance and friendly service oriented staff; its self-contained environment which offers a secluded beachfront, numerous recreational activities for sports and leisure, a variety of dining experiences along with a full health spa on property; its accessibility and convenience to nearby Savannah Airport and the Hilton Head commuter airport; its guest rooms have an elegant European flavor; and finally, its meeting facilities that are state-of-the-art in technology and comfort.

RECOMMENDATION: That the COD Administrative Board select a meeting site based on the relevant information provided by staff.

FEATURES	Innisbrook Tarpon Springs, Florida	Amelia Island Plantation Jacksonville, Florida	Mission Inn Howey-in-the-Hills, Florida
ACCESSIBILITY	A secluded thousand acre estate on Florida's Gulf of Mexico; located approx. 25 min. from Tampa Int'l Airport; minutes from the Gulf of Mexico beaches	Located 29 miles northeast of Jacksonville International Airport; private airport on Amelia Island for charter and private planes	Located in the foothills of Orlando approx. 50 min. from Orlando International Airport; Leesburg Airport provides for charter and private planes
LIMO SERVICE	Tampa Int'l Airport - $20/round-trip	Jacksonville Airport - $30/round-trip	Orlando Int'l Airport - $32/round-trip
ACCOMMODATIONS	1,000 guest rooms, organized in clusters of villas & condominiums; meeting facilities can accommodate up to 1,200 in two conference centers	550 inn/villa rooms--located on 900 acres with unspoiled beaches surrounded by lagoons and marshland; meeting facilities accommodate up to 1,000	160 guest rooms--located on 225 acres in setting of rolling hills, lakes and citrus groves; a spanish-themed resort w/ the ambiance of a plush country estate
AMENITIES	Spa facilities; three-18/hole golf courses; 19-tennis courts w/ night play; racquetball; biking; volleyball; basketball; full health fitness center; recreation & game room	Three/9-hole golf courses; 21 tennis courts w/ night play; four miles of beachfront; two pools; fishing; bicyling; paddle boats; sailing; volleyball; recreation & game room	One/18-hole golf course; 6 tennis courts w/ night play; resort marina located on Lake Harris featuring sailing, fishing, skiing, and cruises on a 1930 restored river yacht; fitness center; jogging trails, hydro-spa, bicycles
RESTAURANTS	Six - gourmet/casual Four - snack shops/cafe Three - lounges Room Service	Three - gourmet/casual Two - snack shops/cafe Two - lounges Room Service	Two - gourmet Two - casual One - snack shop One - lounge Room Service
COST	Single/dbl hotel rooms - $140/dy Club suites-single/dbl - $195/dy 1-bdrm suite " " - $210/dy 1-bdrom deluxes " " - $235/dy (1988 rates guaranteed)	Single/dbl hotel rooms - $135/dy Villas: 1-bdrm - $210/dy 2-bdrm - $245/dy Suites: 1-bdrm - $195/dy (1988 rates guaranteed)	Single/dbl hotel rooms - $125/dy Suites: 1-bdrm - $190/dy 2-bdrm - $290/dy Villas: 2-bdrm - $250/dy (1988 rates guaranteed)
LOCAL ACTIVITIES	Busch Gardens; Dali Art Museum; Jai-Alai; Sunken Gardens; horse and dog racing; Weeki Wachee; Sponge-o-rama; London Wax Museum	Downtown Jacksonville a 45 minute drive; St. Augustine--America's oldest city--90 minute drive; historical landmarks & boutiques for shopping	Orlando--DisneyWorld/EPCOT a 40 minute drive Tampa--approx. a 90 minute drive; resort boutiques for shopping
STATUS	Tentatively holding rooms for March 22-26	Tentatively holding rooms for March 22-26	Tentatively holding rooms for March 22-26

FEATURES	Hotel Inter-Continental Hilton Head, South Carolina	Mariner's Inn Hilton Head, South Carolina	March Beach Hilton Marco Island, Florida
ACCESSIBILITY	Located 45 min. from Savannah Airport on Hilton Head's prestigious Port Royal Resort Plantation; Hilton Head's private airport provides private and commuter planes access	Located 45 min. from Savannah Airport on Hilton Head Palmetto Dunes Resort Plantation; Hilton Head's private airport provides private and commuter plane access	Located 20 miles south of Naples Airport and 5 miles south of Ft. Myers Airport; Marco Island Airport provides private plan access
LIMO SERVICE	Savannah Airport - $32/round-trip	Savannah Airport - $32/round-trip	Naples Airport - complimentary Ft. Myers Airport - $35/round-trip
ACCOMMODATIONS	415 guest rooms--situated on a 24 acre beachfront site overlooking the Atlantic; lush green foliage surround the resort; meeting facilities can accommodate up to 800	324 guest rooms--located on a 13 acre beachfront site overlooking the Atlantic; sub-tropical landscape surround the resort; meeting facilities can accommodate up to 500	736 guest rooms--located on the southwest coast of Florida surrounded by beaches; meeting facilities can accommodate up to 1,000
AMENITIES	Three/18-hole golf courses; 16 tennis courts w/ night play; three swimming pools (one indoor); health spa and fitness center; lawn croquet; windsurfing, sailing, paddle boats; fishing; sand volleyball; water skiing; recreation & game room w/ billiards	Two/18-hole golf courses; 25 tennis courts w/ night play; one swimming pool; health spa; sailing; fishing; bicycles; paddle boats; water skiing; windsurfing; recreation & game room	Three swimming pools; 9-hole pitch & putt golf; 36-holes of golf off property; 16 tennis courts w/ night play; water skiing; windsurfing; parasailing; fishing; volleyball; bicycles
RESTAURANTS	Three - gourmet/casual Two - snack shops Three - Lounges 24-Hour Room Service	Two - gourmet/casual Two - snack shops One - lounge Room Service 7 am to 10 pm	Four - gourmet/casual Two - snack shops/deli Two - lounges
COST	Single/dbl hotel rooms - $118/dy Suites: 1-bdrm jr. exec- $190/dy 1-bdrm Exec. - $250/dy (1988 rates guaranteed)	Single/dbl hotel rooms - $115/dy Suites: 1-bdrm - $185/dy 2-bdrm - $260/dy (1987 rates w/ 10% increase anticipated for '88)	March / April Single/dbl tower rooms - $175/dy / $130/dy Suites: 1-bdrm - $330/dy / $250/dy 2-bdrm - $500/dy / $400/dy (1988 rates guaranteed)
LOCAL ACTIVITIES	Tours of antebellum homes--Rose Hill Plantation House; Baynard Plantation Ruins, Indian Shell Ring Preserve; Fort Mitchell; Newhall Audubon Preserve; Waddell Mariculture Center; entire month of March is celebration of Springfest	(see Hotel Inter-Continental)	Shopping in nearby Olde Naples; tour Thomas Edison's Winter Home and Museum; greyhound racing; antique auctions; cruises via airboat on the everglades;
STATUS	Tentatively holding rooms for March 19-23	Tentatively holding rooms for March 22-26	Released dates: April 28-May [illegible] too late March 22-26 [illegible] too high

1986 COD ANNUAL MEETING PROGRAM/SOCIAL EVENT

Since the last Board meeting, Dr. Clawson, Dr. Daniels, and Dr. Hamlin have worked with staff to conclude the arrangements for the Sunday evening reception and dinner at the Annual Meeting. We have settled on the Cresent City proposal for cocktails and dinner at the New Orleans Board of Trade more fully described on the following pages. Dr. Hamlin has been able to arrange for this event to be subsidized by funds received by Tulane University School of Medicine in an amount approximating $5,000. Additionally, he has arranged to conduct the arrangements through Tulane University, as a consequence, we are able to use their tax exempt status and save $925. This enables us to reduce the per person price from $76.00 to $46.00.

ASSOCIATION OF MEDICAL COLLEGES
DEANS DINNER
Sunday, October 26, 1986

COCKTAILS AND DINNER AT THE NEW ORLEANS BOARD OF TRADE

Crescent City Consultants' hostesses will meet you at the New Orleans Board of Trade for an elegant New Orleans evening. The Board of Trade, one of New Orleans' most historic buildings, erected in 1883, offers a magnificent atmosphere with its beautiful glass rotunda and historic murals.

Cocktails and delicious hors d'oeuvres will be served in the courtyard and Plaza, paved in pink Belgium flagstones, which provide a lovely setting amidst the crepe myrtles and sweet olive trees.

During cocktails, a three-piece Jazz Combo will perform. We suggest the following hors d'oeuvres:

PETITE SPANIKOPITA
(Phyllo Triangles with Spinach and Feta Cheese)

SHRIMP VINAIGRETTE WRAPPED IN SNOW PEAS

SMOKED SALMON ON PUMPERNICKEL

HAWAIIAN CHICKEN

GOURMET ASSORTMENT OF PATES AND GALANTINES
WITH CRUSTY FRENCH BREAD

OYSTER PATTIES

FRESH VEGETABLE PLATTER WITH DILL DIP

After hors d'oeuvres, the band will second line guests from the courtyard and Plaza into the Board of Trade dining area. For dinner, we suggest:

CRAWFISH CARDINAL

CAESAR SALAD

RASPBERRY SORBET WITH PERRIER WATER

TENDERLOIN OF BEEF ST. GEORGE
(Tenderloin of Beef Sliced and Served with
Sauce Espagnole with Mushrooms)

DUCHESS POTATOES WITH BABY CARROTS

CHEESES:
BRIE, PORT SALUT, MONTRACHET GOAT CHEESE WITH
APPLE SLICES AND WAFER CRACKERS

STRAWBERRIES ROMANOFF

COFFEE COGNAC

WINES:
CHATEAU OLIVER GRAVES WITH SOUP AND SALAD
CHATEAU TALBOT 1976 WITH ENTREE AND CHEESE

MINIMUM: 150 persons
MAXIMUM: 220 persons

TIME: 6:30 pm - 11:00 pm
COST: $76.00 per person

NOTE: Cost is inclusive of rental of the Board of Trade Building, security, the cocktail reception, the suggested menu, wine, entertainment, fresh flower arrangements, Crescent City Consultants' coordination, supervision and hostesses, all tax and gratuity.

FUTURE MEETING DATES

1986 Meeting Dates:

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