COUNCIL OF DEANS

ADMINISTRATIVE BOARD MEETING

Washington Hilton Hotel
Washington, DC

AGENDA

Wednesday, September 7, 1988

Joint Boards Session
6:00 p.m. - 7:00 p.m.
Conservatory

Guest speaker: Dr. Donald Ian MacDonald
Special Assistant to the President
for Drug Abuse Policy
Former Administrator, ADAMHA

Reception & Dinner with OSR Board
7:00 p.m. - 9:30 p.m.
Map

Topic: Indigent Care
(See page 25 in the COD Agenda)

Thursday, September 8, 1988

COD Administrative Board Meeting
8:00 a.m. - 12:30 p.m.
Map

Joint Boards Lunch
12:30 p.m. - 1:30 p.m.
Conservatory

VI. Information Items

A. Report of Nominating Committee (Butler)

B. Annual Meeting Plans (Kettel)

C. CoGME Report
(See Executive Council Agenda, page 78)

D. Spring Meeting 1989 Planning Committee

VII. OSR Report

VIII. Old Business

IX. New Business

X. Adjourn

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

June 23, 1988
8:00 a.m. - 12:30 p.m.
Map Room

Washington Hilton & Tower Hotel
Washington, D.C.

PRESENT:

(Board Members)

William T. Butler, M.D., Chairman
William B. Deal, M.D., Chairman-elect

Executive Council Representatives

L. Thompson Bowles, M.D., Ph.D.
Richard S. Ross, M.D.
Henry P. Russe, M.D.
Robert E. Tranquada, M.D.

Members-at-Large

George T. Bryan, M.D.
Robert L. Friedlander, M.D.

(Guests)

Clayton Ballantine
John W. Colloton*
Kimberly Dunn
Robert L. Volle, Ph.D.*

(AAMC Staff)

Robert Beran, Ph.D.*
Sarah Carr
Edwin Crocker*
Joan Hartman-Moore
Paul H. Jolly, Ph.D.
Thomas J. Kennedy, M.D.*
Louis J. Kettel, M.D.
Joseph A. Keyes, Jr., Esq.
Jack Krakower*
David Moore*
Wendy Pechacek
Gladys V. Peters
Robert C. Petersdorf, M.D.*
John F. Sherman, Ph.D.*
August G. Swanson, M.D.
Kathleen Turner*

***Present for part of the meeting**

ABSENT:

(Board Members)

Executive Council Representatives

John Naughton, M.D.
W. Donald Weston, M.D.

Member-at-Large

Phillip M. Forman, M.D.

I. CALL TO ORDER

The meeting was called to order at 8:06 a.m. by William T. Butler, M.D., Chairman.

II. REPORT OF THE CHAIRMAN

Dr. Butler deferred his report to other areas of the Board's agenda.

III. APPROVAL OF MINUTES

The Administrative Board Minutes of February 25 and March 22, 1988 were approved as distributed.

IV. DISCUSSION ITEMS

A. Uniform Examination Pathway to Licensure

Dr. Bowles recalled for the Board earlier informal discussion of a possible uniform examination pathway to licensure and the controversies of the past.

About two years ago, the New York State legislature made clear its intent to move to a single examination to licensure. California and other states have followed. Drs. Volle, Bowles and other colleagues, including the Federation of State Medical Boards, discussed the pros and cons of the uniform examination pathway to licensure. From these discussions came a Task Force to explore moving toward a single path. The study group recognized the complexities but found the issue worthy of exploration.

Dr. Robert L. Volle, President of the National Board of Medical Examiners (NBME) reported that the NBME started meeting with the Task Force for the Study of Pathways to Licensure in January, 1988. The Task Force consists of representatives from the Association of American Medical Colleges; American Medical Association; Federation of State Medical Boards; Educational Commission on Foreign Medical Graduates; Health and Human Services; Medical Board of Osteopathic Medical Consultants; and National Board of Medical Examiners. A subcommittee is developing a challenge paper for the Task Force meeting in late August. This subcommittee, stated Dr. Volle, favors a uniform examination sequence for those eligible to be considered for the initial license to practice medicine.

ACTION: By consensus, the Board agreed the subject of an uniform pathway to licensure needs further and continued discussion.

B. **NBME Liaison Person in Medical Schools**

ACTION: A program to provide a direct link between LCME accredited medical schools and the National Board of Medical Examiners was approved. (A background paper is available from the NBME.)

C. **1988 Spring Meeting, Follow-up**

Dr. Kettel reported the following actions taken based on the recommendations at the Spring Meeting:

- A Declining Applicant Pool Workshop, Washington, D.C., June 13-14, 1988. The workshop was well attended. Strategies for action will be monitored by annual or every other year follow-up workshops.

  The AAMC Division of Communications is developing a video tape and backup items for high school and other advisors. Dr. Robert Beran is working with medical school admission officers to develop materials.

  Dr. Paul Jolly is working with individual school specific problems and providing data.

- The recruiting for the AAMC Vice President for Minority Affairs is started. There is foundation interest in minority programs. Dr. Russell Miller has been very involved and will be reporting to the Southern Deans in September.

  Dario Prieto received a grant to bring minority faculty to executive management workshops.

- A well attended Women in Medicine workshop occurred in May. Among the strategies for the women was a proposal from the Macy Foundation to study the problems in academia; what can be done; and what additional steps out to be taken.

- The International Medical Scholars Program is incorporated. The Board has met once and will meet again in early Fall. Dr. Swanson reported

that the AAMC with the Educational Commission on Foreign Medical Graduates is surveying institutions to update current activities. A directory of programs and projects of international medical education will be available this summer.

- In CME two things are happening:

  1) The Society of Medical College Directors of Continuing Medical Education has requested membership in CAS.

  2) A consensus conference for early 1989 may occur to develop strategies for the remediation of recertification/ relicensing problems.

- A joint meeting with the COD and the VA Directors/Chiefs of Staff at the AAMC Annual Meeting will be Tuesday afternoon. Drs. Butler, Petersdorf and Kettel will join some VA people on a panel reacting to a keynote by Dr. Sherman Mellinkoff. The COD is invited. The 2-3 hour session will focus on issues of affiliations. Joseph A. Keyes is convening a meeting with Dr. Peter Regan and VA staff to develop workshops to better relate Directors and Chiefs of Staff and deans. The particular emphasis will be on new deans to develop the greatest potential VA relations available.

Dr. Kettel called for topics to be considered for the Santa Barbara Spring Meeting. Dr. Deal favored the format of our last meeting. The Program Committee, chaired by Dr. Deal, will meet in the Fall.

Issues to take into account in planning the Spring Meeting

- Business Meeting Attendance.

  IDEA: Put the Business Meeting in the middle of the program instead of at the end. There should be no final morning meeting, end with a full day.

- In the breakout groups comments are too long--often longer than the speaker's presentation. The group leader is charged with authority to assure everyone has a chance to speak.

- The Program Committee should decide upon a theme dinner. Would it be better to have a reception every night?

D. **1990 Spring Meeting Plans**

Dr. Kettel reported the Spring Meeting will be held at the Fess Parker Red Lion Resort, Santa Barbara, California.

ACTION: The 1990 Spring Meeting will be at the Breakers, Palm Beach, Florida, April 7-10.

E. **RRC and Specialty Board Standards (Dr. Moy's letter)**

Dr. Kettel reported that the problem of inappropriate RRC accreditation demands seems mostly in community based schools. He asked if this should be put on the deans' agenda to create pressure on the ACGME? Dr. Swanson asked for more data, e.g. how many experiences? Dr. Kettel suggested surveying the deans asking how many have had this kind of problem. Dr. Swanson will look at ACGME requirements for written problems.

ACTION: This would be a good Spring Meeting topic.

V. **ACTION ITEMS**

A. **Endorsement of Accreditation Decisions** (Based upon the Executive Council Agenda)

The Board unanimously approved the Executive Council endorsement of the accreditation of the following list of schools for the terms stated.

University of Nevada — Sept. 27-Oct. 1, 1987
Columbia School of Medicine
College of Human Medicine

(Continuing full accreditation for a seven year term with a progress report due September 1, 1988 concerning seven items. Next visit in 1994-95 with self-study.)

University of Hawaii — January 11-14, 1988
School of Medicine

(Continuing full accreditation for a seven year term with a progress report due March 1, 1990 concerning two items. A self-study conducted jointly by the faculty and administration in accordance with the LCME format within 18 months of the new dean's arrival. A report on the progress in recruitment of a new dean should be submitted by January 15, 1989.)

B. **AAMC Mission Statement and Goals**

The motion to approve the proposed Executive Council amended mission statement was seconded and accepted.

C. **Fraud in Research**

Responding to the request for other efforts that the staff should initiate in representations or negotiations regarding fraud in research, the following suggestions were made:

1) Be positive and stay ahead of the Congressional people;
2) External monitoring mechanism;
3) National Institutes of Health should provide guidelines;
4) Rather than to provide oversight of everything, some spot checks would be a good idea;
5) Randomly select an article published in Journals;
6) Incorporate ethical scientific training in graduate curriculum;
7) Scientists not involved in medical schools and non-scientists should participate in the data book review process;
8) Be more pro-active;
9) The Board supports the Harvard Paper which limits the number of publications in support of scholar work.

D. **Physician Recredentialing**

Responding to the three questions for discussion and action, Question 1 was not accepted as written; Questions 2 and 3 were rejected. The following is the proposed language change for Question 1:

- **Should the AAMC support assessment of all physicians through periodic evaluation of competence?**

E. **Intramural Research at NIH**

The motion to support the recommendations as written was seconded and accepted.

F. **Institutional Policies Regarding Student Participation in Education Experiences Involving the Use of Animals**

Dr. Tranquada stated that a student who uses an ethical reason for not being involved in animal usage in that students' education comes very close to disqualifying himself/herself from a M.D. degree. Dr. Swanson asked if anyone had considered or promulgated in their catalogues or bulletins any institutional policies regarding this issue. The response was affirmative. There was a consensus that the faculty should have the right to make the decision as to whether or not to use animals.

G. **Recommendations Concerning Medical School Acceptance Procedures for First-Year Entering Students**

Upon motion, seconded and carried, the Board recommended that the AAMC Recommendations Concerning Medical School Acceptance Procedures for First Year Entering Students be approved by the Executive Council after the editorial change was made:

Page 34, Question 5:

> "Only after April 15 are schools free to apply appropriate rules for dealing with accepted applicants..."

Dr. Butler ordered an executive session and the following occurred:

Dr. Petersdorf discussed two items:

1. Dues Increase

   The dues increase was again approved.

2. Commentary on the issue of the Registered Care Techologist proposed by the AMA

   It was the general consensus of the Board that the proposal required further study.

The executive session ended and the Board resumed discussion of its agenda items.

I. **Distinguished Service Member Nominations**

The Committee submitted its nominations report via telephone and recommended Drs. Harry Jonas and Louis Kettel for Distinguished Service Membership. **(Dr. Kettel left the room.)** Kathleen Turner reported the Association's policy, ...staff members are not allowed to be designated in this category. On motion the Committee's recommendation of Dr. Harry Jonas was endorsed and consideration of Dr. Louis Kettel was deferred. Dr. Marjorie Wilson was nominated and approved for Distinguished Service Membership. Dr. Kettel rejoined the meeting.

VI. Information Items

A. **Report of Nominating Committee**

Dr. Butler reported for the Nominating Committee (Dr. Alton I. Sutnik, Chair and members Drs. Peter Kohler, Kenneth I. Shine, Harry Beaty, and Eugene M. Sigman). The proposed slate is:

Members-At-Large, Administrative Board:

David S. Greer, M.D.
Leon E. Rosenberg, M.D.
Hibbard E. Williams, M.D.

Three year term representatives to the Executive Council:

George T. Bryan, M.D.
Phillip M. Forman, M.D.

To complete two years of Dr. Bowles' unexpired term as representative to the Executive Council:

W. Donald Weston, M.D.

Chairman-Elect of the Council:

L. Thompson Bowles, M.D., Ph.D.

Dr. Kettel reported the Nominating Committee had concerns about the nominating process. These concerns are:

- There is inadequate constituent input.
- Should more than one person be nominated for each position?
- Should eligibility consider length of service as dean?
- Should the Council develop guidelines for qualifications of people to be nominated?

Dr. Bowles stated the need to assure that the Nominating Committee understand the basic principles of the organization structure and how representations come together. Dr. Butler requested setting up a conference call between the past three to four year Nominating Committee chairs to discuss the issues and report back to the Board through Dr. Kettel at the September meeting.

B. November 1 Deans Letters

Dr. Kettel reported no new concerns since the recent memo from Dr. Petersdorf. Dr. Butler received a letter from the Baylor Ophthalmology Department Chairman thanking him for a copy of the memo and noting things were working out well.

C. Annual Meeting Plans

1. Sunday Afternoon Joint Session with CAS/COTH

Dr. Kettel reported that Dr. Elizabeth Short worked very hard with CAS to set up this session. He agreed the COD should attend and COTH saw enough involvement in their hospitals to warrant participation.

2. Welcoming Breakfast for New Deans

Dr. Kettel reported that Dr. Butler would host an AAMC breakfast to welcome new permanent deans. Board members are invited. The breakfast will be informal on Monday morning. The formal orientation with AAMC staff will be set at the Spring Meeting.

3. **Deans' Dinner**

Dr. Kettel reported the dinner is scheduled for Monday night, tentatively at the Art Institute. The Illinois Deans will contribute $3,500 to defray the cost of the dinner.

4. **Joint Session with VA Management**

Dr. Kettel reported the VA Directors and Chiefs of Staff joint session will be Tuesday afternoon. This is a good chance to continue the dialogue started with Dr. John Gronvall at the Spring Meeting. The session will focus on affiliation relationships and GME problems. There will be a panel presentation and open discussion.

5. **AMA/AHA/AAMC Next Conference**

Dr. Kettel reported this conference succeeds the February, 1988 conference on Competence. The planning group met a month ago. The next conference will focus on supervision in clinical medical education. Ira Singer, Ph.D. of the AMA has scheduled a Florida hotel for the last week in January, 1989. Drs. Henry Russe and Thomas King will represent the AAMC at the next Planning Committee, June 27, 1988, during the Chicago AMA meeting.

VII. **OSR Report**

Kimberly Dunn, Chair of the Administrative Board of OSR, reported. The Board met on June 22, 1988 and finalized their annual meeting program. Points of interest are:

- 100 residents will be invited for an overview weekend session. The Board will submit names of invitees who will provide their own expenses.
- The Saturday plenary session is titled "Society and Ethics, Public Health and Science." Either Alfred Gellhorn, M.D. or Bertrand Bell, M.D. will speak.

Other topics on the program are:

- AIDS and the Medical Student: Responsibilities and Opportunities.
- Medical Education in the Ambulatory Care Setting.

- Legislative Updates.
- Medical Language and the Changing Social Climate.
- Computers in Medical Education.
- International Health.
- Demographics of change in medical practice. George Engel, M.D. will be speaking.

On other items Ms. Dunn listed the following as activities of the Board:

- The contents for the next issue of the Progress Notes.
- Consideration of adding Graduating Student Questionnaire analyses to the LCME Site Visits data base.
- A survey of students concerning issues of women in medical schools.
- The issues of access to health care.
- The status of regulations on resident hours and supervision.

VIII. **Old Business**

There was no old business.

IX. **New Business**

1. **How should the AAMC Administrative Board relate to the AMA Section on Medical Schools' Governing Council?**

   Drs. Butler and Kettel have had discussion with their counterparts. The need for communication is apparent. Dr. Butler asked for comments and suggested a person might be designated by the Administrative Board to meet with the Governing Council and someone be designated by the Governing Council to sit with the COD Administrative Board. The Board approved exploring some mechanism. Dr. Butler will notify Dr. William Stoneman who will present this to the AMA Governing Council on June 24, 1988.

2. **Management Education Program**

Mr. Keyes updated the Management Education Program directions and recent seminar. Seminars are scheduled for next month in Aspen on "Information Technology" and in the fall on "Instituting Problem-Based Learning" as part of the curriculum. There will be an executive development seminar in the fall for associate deans and department chairs. Invitations are sent out by starting with a waiting list from one program. A second executive development seminar is being explored for the Spring. A Kellogg grant will permit planning on training and education workshops in the ambulatory setting for a year or so hence. A committee has been appointed to help design this program. Finally, for the future there are plans to re-offer our program on the evaluation of students.

The MEP Advisory Committee met in early June and recommended reinstitution of the executive development seminar program for members of the Council of Teaching Hospitals, using this device as a means of communication among deans, department heads and teaching hospital directors.

3. Mr. Keyes reported that Dr. William Sawyer, President of the China Medical Board, recently toured the nine medical schools they support. Dr. Sawyer concluded they would benefit from more focus on management. Some version of the AAMC management program will be offered between September 15-25, 1988 or next Spring.

4. Dr. Butler asked whether the Board was aware of Dr. Harry Beaty's perception of a growing gap between VA hospital directors and Dr. John Gronvall, Chief Medical Director? The issue is funding. Last month Sonny Montgomery, Chair of the House Committee on Veterans Affairs, sent a team out to 16 VA medical centers and found 1,771 hospital beds closed because of inadequate staffing. The directors implied VA Central Office has not argued persuasively for Congressional funds. General Turnage, Administrator, and Dr. Gronvall appear to have made the decision, in order to save money, not aggressively to seek the staffing to operate the beds. The House Committee is concerned that all of the mandated 90,000 beds are not open. They found in the field a need for the beds. Dr. Petersdorf received a letter from a mid-western medical school

dean detailing the VA budgetary constraints explicitly diverting service for patients to purchase of material. Dr. Petersdorf described a coalition for which AAMC is in part responsible. These Washington people are concerned with the level of VA support. Discussants confirmed examples of budgetary stress at affiliated VA Medical Centers. Dr. Gronvall has many supporters. A sense of a rift was not felt by the Administrative Board. The Board will monitor this issue.

5. Dr. Bryan reported that women faculty in the School of Medicine at Galveston periodically raise the question about the sixty seven cent dollar--sixty seven cents is a dollar in women wages. To deal with such salary questions it would be appropriate to put gender in the faculty data base. Dr. Paul Jolly reported there are some pros and cons to publishing such selective reports since other factors affect salary besides gender; for example, time in rank. Collection of time in rank data is a substantial increase in the respondent's burden. Dr. Tranquada spoke against publishing national data, but noted the concerns are there and need to be faced institutionally. Dr. Russe noted the need for faculty consent to identify gender just as race and religion. Dr. Bowles noted present data is collected from the Business Office, not the faculty. Dr. Bryan stated if data were collected, it would be much easier to get individual or group studies for institutions, even if not collected for national publication. Dr. Jolly suggested as an immediate step, AAMC would work with individual schools to study their own faculty. This would allow collection of gender specific school-by-school data optionally and use it only for local study until we understand it better. At some point it might be ready to be a normal part of the survey for publishing. An AAMC memo two months ago encouraged schools to do salary equity studies with AAMC help. A few schools responded.

6. Dr. Butler reported that Dr. Francis M. James is pleased that Dr. Kettel contacted deans of medical schools with anesthesia departments not participating in their matching program.

X. ADJOURNMENT

STRATEGIC GOALS

1. To attract the most talented and broadly representative persons into medicine.

2. To promote medical education and training of high quality consistent with the future practice of medicine

3. To ensure an environment in which biomedical research can flourish

4. To promote the organizational and financial vitality of medical schools and teaching hospitals

5. To create a community of interest in academic medicine among all professionals

6. To promote a broader understanding of the contributions of academic medicine

7. To maintain the Association's intellectual and financial resources needed to achieve these goals

8. To provide representation about the Association's purposes, capabilities, and positions to its constituents, the public and their elected and appointed representatives

THE 1988 MEDICAL SCHOOL APPLICANT POOL: A STATUS REPORT

Although the AAMC does not complete its files for the 1988 entering class until October, the data available as of the first of August should be relatively close to the final figures. The information concerning the entering class of 1988 is based on approximately 99.3% of all applicants and is derived from reports provided by the Section for Student Services.

As of August 5, the total number of applicants for the 1988 first year entering class was 26,614. This number represents a 4.7% decrease when compared to the 1987 applicant group. The decrease between 1986 and 1987 was 10.2%. While the number of actual matriculants will not be available for about a month, the schools projected the size of the 1988 entering class to be 16,000. This will most likely result in being an overestimate, since last year's first year entering class was 15,927. It is probable that the size of the 1988 first year class will be in the area of 15,650 students.

A comparision of the 1987 and 1988 national groups of applicants indicates the following:

- Underrepresented minority applicants have decreased by 2.8%
- White female applicants have decreased by 4.5%
- White male applicants have decreased by 8.3%
- Black female applicants have increased by 2.8%
- Black male applicants have decreased by 7.2%
- American Indian/Alaskan female applicants have increased by 11.3%
- American Indian/Alaskan male applicants have decreased by 17.6%
- Asian/Pacific Islander applicants have increased by 5.5%
- The science and total GPA's for 1988 applicants were slightly lower than 1987 applicants (Table 1)
- The MCAT scores for 1988 applicants were lower than 1987 applicants in **all MCAT areas of assessment** (Table 2)
- Differences between the 1987 and 1988 GPA's and MCAT scores for underrepresented minority applicants were less than similar qualifications for the non-minority applicants (Table 3 and 4)
- 60.6% of the national group of applicants have been offered at least one acceptance in comparison to 56.3% a year ago.

An examination of performance of examinees on the recent 1988 spring MCAT administration suggests that further declines in MCAT scores will become evident for the applicants to the 1989 entering class. The spring 1988 mean scores for all six MCAT areas of assessment dropped from their 1987 levels (Table 5).

TABLE 1

GRADE POINT AVERAGES
ALL APPLICANTS

	1986	1987	1988
Biology, Chemistry, Physics, Math (Science)	3.21	3.2	3.18
Total GPA	3.30	3.30	3.28

TABLE 2

MEAN MCAT SCORES
ALL APPLICANTS

	1986	1987	1988
Biology	8.9	9.1	8.8
Chemistry	8.7	8.7	8.5
Physics	8.8	8.7	8.6
Science Problems	8.7	8.7	8.5
Skills Analysis: Reading	8.2	8.2	8.0
Skills Analysis: Quantitative	8.1	8.1	8.0

TABLE 3

GRADE POINT AVERAGES
ALL UNDERREPRESENTED MINORITY APPLICANTS

	1986	1987	1988
Biology, Chemistry, Physics, Math (Science)	2.68	2.7	2.67
Total GPA	2.88	2.89	2.87

TABLE 4

MEAN MCAT SCORES
ALL UNDERREPRESENTED MINORITY APPLICANTS

	1986	1987	1988
Biology	6.9	7.0	7.0
Chemistry	6.6	6.6	6.5
Physics	6.4	6.4	6.4
Science Problems	6.4	6.5	6.4
Skills Analysis: Reading	6.0	6.1	5.9
Skills Analysis: Quantitative	5.5	5.6	5.7

TABLE 5

SPRING MCAT ADMINISTRATION MEAN SCORES FOR ALL EXAMINEES

		Spring 1986	Spring 1987	Spring 1988
Biology		8.4	8.3	8.2
Chemistry		8.2	8.1	7.9
Physics		8.3	8.1	8.0
Science Problems		8.1	8.0	7.9
Skills Analysis:	Reading	7.7	7.8	7.7
Skills Analysis:	Quantitative	7.7	7.8	7.5

APPLICANTS BY LEGAL STATE OF RESIDENCE
(Selected States)

	1981	1986	1987	1988	% Change 1981-88
Illinois	1,892	1,528	1,350	1,299	- 31
Kansas	403	281	262	251	- 38
Minnesota	857	538	489	463	- 46
Wisconsin	675	473	434	434	- 36
Michigan	1,599	1,198	1,074	987	- 38
Alabama	550	409	387	349	- 37
Florida	1,213	1,093	939	805	- 34
Texas	1,913	1,928	1.793	1,646	- 14
Virginia	956	730	643	589	- 38
Connecticut	503	425	329	332	- 34
Maryland	878	788	749	676	- 23
New York	3,901	3,164	2,863	2,766	- 29
Pennsylvania	1,990	1,564	1,434	1,334	- 33
Arizona	340	298	285	230	- 32
California	3,459	3,410	3,097	3,104	- 10
Oregon	298	233	206	233	- 22
Colorado	533	416	413	364	- 32

REQUIREMENTS FOR OTHER SPONSORED PROGRAMS FOR ACGME ACCREDITATION

Earlier this year, one of the deans reported that he had been told that in order to sponsor one subspecialty program in internal medicine, it was essential that two other subspecialty programs also be sponsored by the institution. Given the concerns about an excessive number of subspecialists being trained, it seemed illogical that such a requirement should be an official position of the internal medicine RRC and ACGME.

John Gienapp, Secretary of the ACGME, was asked to review the requirements for other sponsored programs, set forth in the Special Requirements of the several RRCs. Attached is the analysis produced by one of Dr. Gienapp's staff members. Note that internal medicine has a statement in its Special Requirements as follows:

> "Moreover, it is essential that the sponsoring institution participate meaningfully in a minimum of three accredited subspecialty programs."

The analysis makes clear that there is great variation among the RRCs regarding other program sponsorship. Should the Council pursue this matter further?

REFERENCES IN SPECIAL REQUIREMENTS TO OTHER ACCREDITED PROGRAMS

Allergy and Immunology (Section V. A.)
Allergy and immunology programs should be conducted principally in institutions with accredited graduate medical education programs in pediatrics and internal medicine.

Anesthesiology - none

Colon and Rectal Surgery - none

Dermatology - none

Dermatopathology - none

Emergency Medicine (Section II. C.)
The parent institution for emergency medicine training must have a major educational commitment as evidenced by training programs in other major specialties.

Family Practice - none

Geriatric Medicine (Introduction)
In order to qualify for initial accreditation, a geriatrics program must function in conjunction with a fully accredited family practice program.

General Surgery (Section I.)
Since interaction with peers from other disciplines contributes to the quality of the learning experience and provides the framework upon which future patterns of practice are based, it is important that there be accredited residency programs in other medical specialties in the teaching institution(s). While the minimum requirement is only for an accredited residency in internal medicine, pediatrics, or family practice in the institution, it is desirable that there be a better balance, as provided by residencies in several primary care disciplines, and in obstetrics and gynecology, pathology, and radiology. Residencies in other surgical specialties, while not specifically required, contribute to quality and a balanced educational atmosphere

Special Areas of General Surgery (Section I. A,)
Post graduate fellowship programs in the subspecialties of general surgery may be accredited only in institutions which sponsor accredited residency programs in general surgery, or which are related by formal agreement to such institutions and programs.

Hand Surgery (Section 2. b.)
A training program should be conducted in a facility in which there is accredited training in surgery, plastic surgery, and orthopaedic surgery as well as other medical and surgical specialties and subspecialties.

Pediatric Surgery (Section I. B.)
To provide the necessary breadth of experience, an accredited training program in pediatrics is essential. Residency training programs in other surgical and pediatric specialties, radiology, and pathology, either within or affiliated with the institution, are highly desirable.

General Vascular Surgery (Section IV. C.)

The objectives of a general vascular surgery training program can only be achieved when the program is based within an institution approved for graduate education in general surgery and/or thoracic surgery and also in the disciplines particularly related to surgery, namely internal medicine, radiology and pathology. Programs in general vascular surgery are approved only as an integrated part of and administratively attached to the approved core program in general surgery or thoracic surgery.

Internal Medicine (Section V.)

Additional accredited residency programs should be sponsored by the hospital because such programs permit increased peer interchange and augment the breadth of the educational experience.

Subspecialties of Internal Medicine (Section A.)

To be eligible for accreditation, a subspecialty program must function as an integral part of an accredited residency program in internal medicine and the discipline must be one for which a certificate of special qualifications or a certificate of added qualifications is offered by the American Board of Internal Medicine.

(Section F.)

Moreover, it is essential that the sponsoring institution participate meaningfully in a minimum of three accredited subspecialty programs.

Neurological Surgery (Section III. C. 1.)

Recognizing the nature of the specialty of neurological surgery, it is unlikely that a program can mount an adequate educational experience for neurological surgery trainees without approved training programs in related fields. Clinically oriented training programs in the participating institutions of the neurological surgery program shall include accredited training programs in neurology, general surgery, internal medicine, pediatrics and radiology.

Neurology - none

Child Neurology - (Section V. A.)

The three years of training in child neurology must take place in a center in which there are accredited residency programs in both pediatrics and neurology, and with the approval and support of the program directors of both of these departments.

Nuclear Medicine (Section VII. A.)

The institution or institutions should have other residency programs to provide an opportunity for interaction among residents in the various medical disciplines.

Obstetrics-Gynecology

The program must exist in an educational environment which includes other relevant graduate medical education programs in the institution(s), such as internal medicine, pediatrics and surgery.

Ophthalmology - none

Orthopaedic Surgery (Section V. G.)

In order to provide an adequate interdisciplinary educational experience, the institution should have accredited training programs in general surgery, internal medicine and pediatrics.

Subspecialties of Orthopaedic Surgery (Section A.)

Postgraduate fellowship programs in the subspecialties of orthopaedic surgery may be accredited only in institutions which sponsor accredited residency programs in orthopaedic surgery, or which are related by formal agreement to such institutions and programs.

Hand Surgery (Section 2. b.)

It is desirable that the educational program be affiliated with a facility in which there are additional accredited programs in surgery, plastic surgery, and orthopaedic surgery as well as other medical and surgical specialties and subspecialties.

Musculoskeletal Oncology - See above

Orthopaedic Sports Medicine - See above

Pediatric Orthopaedics - See above

Otolaryngology - none

Pathology - none

Pathology subspecialties - none

Pediatrics - none

Subspecialties of Pediatrics (Introduction)

In order to qualify for initial accreditation, a subspecialty program must function in conjunction with an accredited core program which is in good standing.

Pediatric Cardiology - See above

Neonatal-Perinatal Medicine (Introduction)

Training programs in neonatal-perinatal medicine must exist in conjunction with an accredited three-year pediatric residency program and an accredited obstetrical residency program.

Pediatric Hematology/Oncology - See above

Pediatric Endocrinology - See above

Pediatric Nephrology - See above

Physical Medicine and Rehabilitation - none

Plastic Surgery - none

Subspecialties of Plastic Surgery (Section A.)

Postgraduate fellowship programs of graduate education on the subspecialties of plastic surgery may by accredited only in institutions which sponsor accredited residency programs in plastic surgery, or which are related by formal agreement to such institutions or programs.

Hand Surgery (Section 2. b.)

It is desirable that the educational program be affiliated with a facility in which there is additional accredited training in surgery, plastic surgery, and orthopaedic surgery as well as other medical and surgical specialties and subspecialties.

Preventive Medicine - all areas - none

Psychiatry (Section 3. d.)

The general academic level of the teaching environment of the institution as reflected by interaction with training programs in related fields (e.g., neurology, internal medicine, pediatrics, psychology) is another measure of program quality.

Child Psychiatry (Section II. C.)

Each program accredited for child psychiatry must be an integral part of a psychiatry residency program which is accredited for three years of training, or must have a formal educational affiliation agreement with such a program.

Diagnostic Radiology (Section IX.)

The education in diagnostic radiology should occur in an environment which encourages the interchange of knowledge and experience among residents in the program, and with residents in other major clinical specialties located in those institutions participating in the program.

Nuclear Radiology (Section IV.)

The institution offering a residency in diagnostic radiology with special competence in nuclear radiology must also be approved to offer training in diagnostic radiology.

Radiation Oncology (Section III. L.)

The educationin radiation oncology must occur in an environment which encourages exchange of knowledge and experience among residents in the program and with residents in other oncology specialties located in the same institution participating in the program. Other residency training programs, including medicine and surgery, must be ongoing in the institution.

Thoracic Surgery (Section II. B. 3. a.)

Recognizing the nature of the specialty of thoracic surgery, it is unlikely that a program can provide an adequate educational experience for its residents without approved residencies in related fields. It is important that thoracic surgery residents have the opportunity to interact with residents in other specialties.

Urology (Section IV.)

The activities of these disciplines should be supported by residency training programs, particularly in the areas of internal medicine, general surgery, pediatrics, obstetrics and gynecology, pathology, and radiology, in order to facilitate the rapid interchange of up-to-date information so essential to a proper educational environment.

INDIGENT CARE DISCUSSION

The issues surrounding indigent health care are numerous, ranging from moral and ethical to economic and political. Together they occupy a seemingly overwhelming challenge to our societal values, institutions, and, in some respects, current structure for redress. The immense scope of the problem has contributed to an attitude of helplessness textured by such comments as "the need for a broad societal address". Increasingly, recognition of the enormity of the problem has served as a convenient scapegoat for inactivity without first discerning what each individual and institution could contribute singly and, through unity of effort, collectively.

For two very different reasons, it is difficult to fully understand the AAMC's reluctance to become an effective contributor to resolving, where possible, certain aspects of the problem. First, the AAMC is involved in (or has plans for) analyzing the contributions that academic medicine can make in such socially pervasive areas as AIDS, minority recruitment issues, development of women faculty, and international medical education. All of these areas represent tough problem areas laden with cultural values and difficult institutional barriers. Second, many teaching hospitals and medical education institutions are currently supplying a great deal of indigent patient care and, in

some, rely on the indigent for the teaching of medical students and residents.

During the past year some discussion has arisen within various quarters within the AAMC, particularly the OSR-Ad Board about the scope of the problem and areas in which the AAMC could potentially contribute in confronting the indigent care problem if the decision was made to devote some effort. In September, 1986 a proposal was drafted by the deans of the Central Region for consideration by the AAMC. (See attachment A). At the January, 1987 meeting there was extensive discussion of the paper and no resolution for activity. In fact, the concensus was for deliberate inactivity.

Dr. Jim Bentley at the 1987 April OSR Ad Board meeting gave an overview of the questions facing leaders concerned about the care of indigent patients during a time of shrinking resources for health care overall. He described the distribution of indigent patients as heavily skewed, with most of these patients in public general hospitals, and teaching hospitals as the next major source of care. Dr. Bentley divided his description of indigent patients into several categories: the long-term chronically ill, young mothers and children with no insurance, alcoholics and drug addicts, and those who are

simply poor. He also discussed the avenues currently being examined to address problems with indigent care including:

a) national health insurance

b) improving the health care delivery system in general (e.g., projects at the U. of Penn and Johns Hopkins are examing the effects of patients with no primary provider)

c) legislative efforts to make health care benefits a requirement of employment

d) a large variety of state efforts.

Dr. Bentley concluded with thoughts about how many tiers Americans will allow in their health care system and about medical educators' examining their dependence on poor patients to teach.

At the 1987 June OSR meeting Mr. David Moore reviewed the current legislation for health benefits for the uninsured. There was consensus that all persons should have access to health care.

During the 1987 September OSR meeting, a proposal for stimulating activity within the AAMC was considered. There was a feeling that a problem exists and that the status quo within the AAMC has been goodwill characterized by little activity.

The OSR Program at the Annual Meeting focused on service and to a great extent on many of the issues surrounding indigent care. Additionally, to either confirm or negate our suspicion and bias that a problem exists,

information was collected through a very informal questionnaire and informal discussions about medical students' and residents' experience with two issues relating to indigent care in teaching hospitals. The first suspicion we held was discrepancies in supervision by faculty exist between indigent and non-indigent patients. The second related to our perceptions on discrepancies in the "quality of care" delivered between the two groups. Listed for your perusal in Appendix B is a summation of comments from the survey we used at the Annual Meeting. This was intended solely as a way to get a broader perspective of medical students' views and experiences. It is not intended as anything even approaching a valid representation of the indigent care problem from student perspectives. However, it did confirm our suspicion that the problem is widespread and cement our resolve to keep it before us an agenda item. We feel that Medical Academia occupies a privileged position in our society and concomitant with that trust comes an obligation to serve society. One, we do not feel, we are currently addressing to our full capacity even within the bounds of our own institutions.

The growing seriousness of the problem both in an ethical and moral context and in every substantive context together with the danger of political over-reaction (particularly given the recent events in New York and California) requires prompt, comprehensive and thoughtful assessment by each of our societal institutions (e.g.,

professional societies, educational institutions) as to the possibility of new or enhanced roles that they might undertake for the public good. Unquestionably, academic medical centers carry a major reponsibility for such analysis and possible actions. Furthermore, the unique and ethical character of the problems posed by the growing inequities in medical care suggests that the Association should thoroughly explore every possibility for appropriate collective activities.

Therefore the following question is posed for discussion:

> How could the Association respond to the growing problems for our society posed by the increasing discrepancies in health care delivery, i.e. indigent care?

As a springboard for discussion a few ideas are listed below.

1. Valid assessment of the problem in academic medical institutions. A valid questionnaire could better delineate the scope and magnitude of the problem and highlight approaches for improving the situation. At present there are some efforts to do this. For instance the IOM is currently involved in such an effort. How could we contribute? This might be an area in which certain foundations might wish to

contribute money for an assessment of the problems and possible soulutions.

2. Legislative efforts- The AAMC has been supportive of initiatives such as the Medicaid and the National Health Service Corps Reauthorization. But, what else could be done? Why not take a pro-active approach? For example, given that this is the year for re-authorization of Title VII, why not advocate for support of training of future experts in attacking the problem, e.g. MD/MPH funding.

3. Clearing house of activities- Why not devote some resources to developing and/or expanding the AAMC's ability to serve as a clearing house of activities to include, specifically, initiatives in dealing with indigent care? For instance, this could include educational projects, health service innovations, and state initiatives and activities.

4. Interfacing with other groups- Why not join forces with other organizations that have had a long history of active involvement with issues related to indigent care. In particular perhaps we could interact intimately with groups concerned with health services research and prevention-related activities e.g., the American Public Health Association and the Centers for Disease Control?

5. Medical Education: supervision and attitude. An example from the survey will illustrate this point. One student reported an attending asking a group of students after 20 minute chart rounds (one of three per week) "Are there any up-town patients that I need to stop and see on my way out". In this we all recognize the need for improved supervision of students and housestaff to be more than sitting around a table chatting about all the patients for twenty minutes a day. Also important is the subliminal message that is transmitted to students that it is alright to treat patients differently based on their economic circumstances rather than their medical situation. As a third year student I had the pleasure of working in an ambulatory pediatric clinic specifically set up for indigent patients and effective teaching of medical students. The program is structured such that there is excellent supervision of six medical students by a

full-time faculty member and a senior resident. The goals of the program are to provide quality care and solid teaching in an ambulatory setting. This program costs money. Just as a library is considered a necessary part of an educational institution so should the quality of teaching in an educational setting. Neither make money.

5. Institutional commitment- Many students have initiated a variety of student-run programs for indigent patients with the quality ebbing with the flow of commitment of a changing student body. Therefore, we well recognize the need for an institutional committment in order for there to be long-lasting quality care. One example can serve to illustrate the beginning of an institution's committment. Recently at the University of Texas Health Science Center at Houston a Vice-President for Indigent Care was created to analyze in what concrete ways the institution can contribute.

6. Task Force on Physician Supply- Until the question of need or demand is addressed, it will not be possible to adequately predict future supply of physicians.

7. Annual Meeting Theme- Academic medical institutions will continue to be in the midst of issues associated with the indigent care question. Therefore, it might behoove us to take some time to address it over the course of a few days when all of the constituents of the AAMC could discuss what aspects of the problem impact them and what they are doing to address the problem and how they feel the AAMC could contribute.

The above is merely a brief outline meant to sharpen focus, heighten dialogue and, hopefully, spark activity. The problem is broad and will require community of minds and efforts to solve. I hope that, though we have a packed agenda, we will be able to plan an approach to keeping this issue before us.

AAMC FUTURE MEETING DATES

1988

September 7-8	Executive Council Meeting/COD Admin. Board Washington, D.C.
November 11-17	Annual Meeting Chicago, Illinois
December 11-13	Officers & Staff Retreat

1989

February 22-23	Executive Council/COD Admin. Board Washington, D.C.
April 11-16	COD Spring Meeting Fess Parker's Red Lion Resort Santa Barbara, California
June 14-15	Executive Council/COD Admin. Board Washington, D.C.
September 27-28	Executive Council/COD Admin. Board Washington, D.C.
October 27-Nov. 2	AAMC Annual Meeting Washington, D.C.
December 11-13	Officers Retreat