AGENDA
for the
Council of Deans Meeting

February 4, 1972

Monroe Ballroom
Palmer House
Chicago, Illinois

Program Session - Joint Meeting
with the
Council of Academic Societies
9:00 am - 12:30 pm

"Selection for Medicine - Are Current Policies Rational"

Chairman - Paul A. Marks, M.D.
Speaker - Sam L. Clark, Jr., M.D.
Panel - Mark Rosenberg, Harold J. Simon, M.D., Ph.D., Paul R. Elliott, Ph.D., Martin S. Begun, M.D., Roy K. Jarecky, Ed.D.

"Concepts of Three Year Curricula"

Chairman - Daniel C. Tosteson, M.D.
Speaker - Carleton B. Chapman, M.D.
Panel - L. Thompson Bowles, M.D., Ernst Knobil, Ph.D., Sherman M. Mellinkoff, M.D., Robert G. Page, M.D., Robert Sandstrom, M.D.

Business Session
2:00 pm - 4:00 pm

I. Minutes of Previous Meeting
II. Chairman's Report
III. Faculty Representation in the AAMC
IV. The "Fifth Pathway" for Americans Studying Medicine Abroad
V. Policy Statement on the Freestanding Internship
VI. The Admissions Process
VII. The Faculty Roster Study
VIII. Election of Provisional Institutional Members
IX. New Business

Break

Meeting with OSR Members
4:15 pm

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INFORMATION ITEM

I. Minutes of Previous Meeting

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
MINUTES
COUNCIL OF DEANS

Friday, October 29, 1971

1:30 pm - 5:00 pm
Washington Hilton Hotel
Washington, D.C.

## I. Roll Call

Attendance was taken by registration at the door; a quorum was determined to be present.

## II. Minutes of the Previous Meeting

The minutes of the May 20, 1971 meeting were approved as written.

## III. Chairman's Report

Dr. Chapman reported on the deliberations of the COD Administrative Board and its decision to take a more active role in the affairs of the COD. The Board has determined that the Bylaws of the AAMC and the Rules and Regulations of the COD mandate the Board to perform as an executive committee of the COD. Concerned that it had not fully fulfilled this mandate in the past, the Board determined that it would devote special attention to planning of future meetings, developing policy recommendations for the COD, and performing as liaison with AAMC staff to ensure that COD support requirements were communicated.

Dr. Chapman also traced the disposition of a proposal that a task force on COD goals and objectives be appointed to define the role of the COD and to clarify its relationships with the other constituent councils and units of the AAMC. At one point, the appointment of a blue ribbon committee seemed an appropriate next step to clarify these issues, especially as a concrete response to many of the concerns expressed at the previous COD meeting. Subsequent developments, however, including the Administrative Board decision to perform as an executive committee and the proposals for increased representation being advanced in the other councils, made the retreat of the Executive Committee appear the more appropriate place to

consider this matter of Association-wide significance. Therefore, the appointment of such a committee was deferred.

The Organization of Student Representatives Rules and Regulations were presented by the Chairman to the Council for approval. A Fourth Purpose clause was added by the students which read as follows: "to provide a vehicle for the student members' action on issues and ideas that affect the delivery of health care." In all other respects the document adopted by the OSR was identical with that provided in the COD agenda book. The Rules and Regulations as adopted by the OSR were approved by the COD. (Copy attached to these minutes - Appendix #I.)

Future meetings of the COD were then considered. Dr. Chapman reported that the February meeting will be held in Chicago in conjunction with the Congress on Medical Education; this may be the last meeting held in conjunction with the AMA Congress. The Administrative Board, he reported, had just considered the spring meeting in some detail. In outline, the proposal which the Board had endorsed involved holding a two to two and one-half day retreat in a resort environment with meetings held on an AAMC-Institute format, developing in some depth a topic of current interest and significance. The concept currently being considered as a theme around which to organize the meetings is an examination of alternative models which the medical school of the future might take and the implications of such models in terms of the resources and administrative framework requisite to their operation.

## IV. Remarks of the President

Dr. Cooper spoke briefly and focused his remarks on the interest and concern of the Association in developing the capability to respond effectively to the call for assistance in the areas of management skills and management tools development. He indicated that a major proposal is being prepared for submission to outside agencies for funding. This effort, which will hopefully be launched after the first of the year, will take top priority in the AAMC as a service to the Deans.

## V. Report of the Nominating Committee

The report of the COD Nominating Committee consisting of John W. Eckstein, Clifford Grobstein, Rulon Rawson, and Arthur P. Richardson was presented by its Chairman, Glenn W. Irwin.

The Council of Deans Nominating Committee met in Chicago on June 8, 1971. The Nominating Committee proposes the following

slate for 1971-72:

| | |
|---|---|
| Sherman M. Mellinkoff | - Chairman-Elect of the Council of Deans |
| Harold C. Wiggers | - Member-at-Large of the Council of Deans Administrative Board |

The COD Nominating Committee also recommends the following for consideration by the AAMC Nominating Committee:

| | |
|---|---|
| Charles C. Sprague | - Chairman-Elect of the Assembly |
| William D. Mayer | - COD Executive Council |
| J. Robert Buchanan | - COD Executive Council |
| E. M. Papper | - COD Executive Council |

In separate actions, the Council closed the nominations and elected the slate proposed by the Nominating Committee.*

## VI. Organization of Student Representatives

Actions relating to this topic were accomplished as a part of the Chairman's Report.

## VII. Regional Meetings

The Chairmen of the COD Regions reported on the most recent of their meetings.

WEST - Dr. Mellinkoff reported on a meeting of the Western Deans in San Francisco on September 24, 1971. The following actions were taken:

1. The Western Deans voted unanimously that the AAMC's Committee on Housestaff Affairs should consider housestaff matters as part of the total medical education program and not limit committee consideration to only financial considerations. The importance of con-

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* The Assembly elected the slate proposed by its Nominating Committee. The Administrative Board of the COD is thus constituted as follows:

Charleton B. Chapman, Chairman
William D. Mayer
Emanuel M. Papper
J. Robert Buchanan
Clifford G. Grulee, Jr.
Ralph J. Cazort
William F. Maloney
Sherman M. Mellinkoff
David E. Rogers
Harold Wiggers

tinued involvement by the AAMC in housestaff matters was stressed. It was suggested that the committee consider relating the housestaff salary structure to that of the faculty, i.e., the proposed University of California system, and that the University hospital should be considered the "index" hospital.

2. The Western Deans voted unanimously their opposition to additional faculty and staff representation in official constituent bodies of the Association and urged a moratorium for such expansion for at least one year.

   The above opposition was based on both principle as well as economic factors.

3. Franz K. Bauer, Dean, USC, was elected Chairman for the following year.

MIDWEST - GREAT PLAINS - Dr. Mayer reported on the September 4 - 5, 1971 meeting of the MW-GP Region which included Plenary Sessions and meetings of their individual Councils of Deans, Faculty, Teaching Hospitals and Business Officers. A sub-committee was established to recommend an appropriate mechanism to finance the activities of the Region. Two resolutions were adopted by the Council of Faculties and reported to the Plenary Session.

1. The Council of Faculty reiterates its position urging support of institutional research support grants.

2. Since the three major constituent populations of medical schools are administration, faculty and students and since all but faculty presently have representation in the national AAMC, the Council of Faculty of the Midwest-Great Plains Region of the AAMC strongly recommends that in the coming reorganization of the national AAMC, faculty be given realistic, direct proportionate representation in the national organization.

   The second of these resolutions was passed unanimously by the entire group. Dr. Mayer did not request action of the Council because of the forthcoming retreat at which such organizational matters will be considered.

SOUTHERN - Dr. Richardson reported on the following actions taken by the Southern Deans at their meeting October 8 and 9:

1. The Deans of the Southern Region support the concept of a retreat once a year for the Council of Deans which should take the form of an institute. The first such

institute should be held this coming spring on the topic of "Governance of an Academic Medical Center."

2. The Deans of the Southern Region support the conclusion of the VA-AAMC Liaison Committee that a national meeting of administrators of VA hospitals affiliated with medical schools and the Deans of those schools would be very valuable. We note that such a meeting was considered at the VA-AAMC Liaison Committee retreat and urge that planning for such a meeting be undertaken expeditiously.

3. The Deans of the Southern Region urge that the AAMC make an official policy statement regarding the Council on Medical Education policy with respect to American students in foreign medical schools. The Association is urged to take the position that, not withstanding the implication in the AMA statement, whether or not a school undertakes to provide the year of supervised clinical experience referred to is a matter within the sole discretion of that school.

4. Ralph Cazort, M.D., Dean of the Maharry Medical College, was elected Chairman of the Southern Region for the coming year.

With respect to the third resolution, Dr. Wilson announced that a COD memo tracing the history of the AMA-FMG policy statement and stating the Association's position on the matter would be sent out shortly. Dr. Chapman indicated that if this action did not resolve the matter, further consideration would be in order at the next COD meeting.

NORTHEASTERN - No meeting was held in the Northeast Region.

VIII. New Business

A. Admissions Problems -

The exponential expansion of the number of applicants to medical school, and the pressures, stresses and strains that this was causing within the schools was discussed and the following resolution was adopted:

> That there be established an ad hoc committee, a task force or other appropriate mechanism to examine the nature and extent of admissions problems and to recommend to the COD ways to ameliorate these problems.

Additional suggestions were offered: (1) that this matter

be discussed at regional meetings, and (2) that a fact sheet on the problems be prepared by staff in advance of COD consideration of these matters.*

B. Faculty Roster Survey -

The Associated Medical Schools of Greater New York reported that:

> "There is an overwhelming resistance on the part of the faculty and many of the deans to participating in the survey."

The survey is considered to involve great expense and much effort on the part of the faculty, the Dean's Office and the business office with little tangible benefit to the school.

Mr. Murtaugh reported that the survey has been carried out since 1966 by the AAMC under contract with the NIH. It is an attempt to obtain a profile of the faculty of American medical schools their characteristics, their training background, their faculty functions and assignments. It provides basic data on the faculty structure and some insight into the dynamics of change within that structure.

Mr. Murtaugh agreed that these laudable objectives had been served more in the breach than in broadly productive results. He pointed to several enormous problems that have been encountered.

On the other hand, this data has been considerable use to the NIH and has served as one of the principle sources of information to respond to the inquiries of the Office of Management and Budget with respect to the role of NIH training grants in American medicine.

He noted that the Association is going forward with another update of the survey and that we are under considerable pressure to produce more useful information. During the course of this year we will be carrying out a very critical assessment of the forms, procedures, and methods to determine whether these objectives could be served by some simpler survey instrument.

He pointed to the continuing responsibility to provide

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* One of two substantive items to be considered at the program session at the February COD meeting will be the current situation with respect to admissions.

information to the Federal government and to be responsive to their needs.

There followed a discussion in which it was concluded that there is room to improve the efficiency and usefulness of the faculty roster survey.

Dr. Chapman called for a report at the February meeting on the status of the faculty roster.

C. National Internship and Residency Matching Program -

The proposal of the NIRMP to discontinue matching married couples was considered briefly. Apparently, the additional time and complexity involved in this procedure has become so burdensome as to lead to this proposal. Opposition to the proposal was expressed by the Deans on the grounds that it was inequitable and subverted the purpose of the program.

Dr. Cooper announced that Dr. Nunemaker, Executive Director of the Program, would be available at the Faculty Forum later in the evening to discuss the problem.

D. Statement on the Responsibility of Academic Medical Centers for Graduate Medical Education -

A motion to send the statement on graduate medical education back to committee for rewriting was defeated by a 32 to 28 vote. Before that vote, the motion had been amended to stress that the COD approved the statement in principle but desired to have the wording revised. Particular concern was expressed that the financial implications of the statement had not been "thought out" and that the statement would bring on an "overwhelming" number of requests by nonaffiliated hospitals for affiliation with academic medical centers.

In subsequent action, the Council voted to recommend to the Assembly that the word "Policy" be stricken from the title and the word "ultimately" be added to the first sentence so that it read "The Association of American Medical Colleges endorses the concept that graduate medical education ultimately should become a responsibility of academic medical centers."*

IX. Adjournment

The meeting adjourned at 5:00 pm.**

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* The statement was adopted by the Assembly and appears as an attachment to these minutes - (Appendix #II).

** The Business Session was recessed from 1:30 pm-4:30 pm during which time a program session was held. The program for this session appears as an attachment to these minutes - (Appendix #III).

APPENDIX #I

# RULES AND REGULATIONS OF THE ORGANIZATION OF STUDENT REPRESENTATIVES

## THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADOPTED BY THE ORGANIZATION OF STUDENT REPRESENTATIVES
October 28, 1971

APPROVED BY THE COUNCIL OF DEANS
October 29, 1971

The Organization of Student Representatives was established with the adoption of the Association of American Medical Colleges Bylaw Revisions of February 13, 1971.

### Section 1. Name

The name of the organization shall be the Organization of Student Representatives of the Association of American Medical Colleges.

### Section 2. Purpose

The purpose of this Organization shall be 1.) to provide a mechanism for the interchange of ideas and perceptions among medical students and between them and others concerned with medical education, 2.) to provide a means by which medical student views on matters of concern to the AAMC may find expression, 3.) to provide a mechanism for medical student participation in the governance of the affairs of the Association, 4.) to provide a vehicle for the student members' action on issues and ideas that affect the delivery of health care.

### Section 3. Membership

A. Members of the Organization of Student Representatives shall be medical students representing institutions with membership on the Council of Deans, selected by a process appropriate to the governance of the institution. The selection should facilitate representative student input. Each such member must be certified by the dean of the institution to the Chairman of the Council of Deans.

B. Each member of the Organization of Student Representatives shall be entitled to cast one vote at meetings of the Organization.

### Section 4. Officers and Administrative Board

A. The officers of the Organization of Student Representatives shall be as follows:

1. The Chairman, whose duties it shall be to (a.) preside at all meetings of the Organization, (b.) serve as ex officio member of all committees of the Organization, (c.) communicate all actions and recommendations adopted by the Organization to the Chairman of the Council of Deans, and (d.) represent the Organization on the Executive Council of the Association.

2. The Chairman-Elect, whose duties are to preside or otherwise serve in the absence of the Chairman and to succeed the Chairman in that office at the completion of his term of office. If the Chairman-Elect succeeds the Chairman before the expiration of his term of office, such service shall not disqualify the Chairman-Elect from serving a full term as Chairman, nor will his failure to be selected to represent his parent institution in the subsequent years so disqualify him.

3. The Secretary, whose duty it shall be to keep the minutes of each regular meeting and maintain an accurate record of all actions and recommendations of the Organization.

B. The term of office of all officers shall be for one year. All officers shall serve until their successors are elected.

C. Officers will be elected annually at the time of the Annual Meeting of the Association of American Medical Colleges.

D. There shall be an Administrative Board composed of the Chairman, the Chairman-Elect, the Secretary and one member chosen from each of four regions which shall be congruent with the regions of the Council of Deans. Regional members of the Administrative Board shall be elected at the Annual Meeting by regional caucus.

E. The Chairman of the Organization of Student Representatives shall annually appoint a Nominating Committee of not less than 5 voting members of the Organization who shall be chosen with due regard for regional representation.

This committee shall confer during the first two weeks in October and present at the Annual Meeting of the Organization of Student Representatives a slate of nominations from those certified as members, two names for each elective position to be filled at such meeting. Additional nominations may be made by the membership of the Organization of Student Representatives meeting.

F. The Administrative Board shall be the executive committee to manage the affairs of the Organization of Student Representatives and to take any necessary interim action on behalf of the Organization that is required. It shall also serve as the Organization of Student Representatives Committee on Committees, with the Chairman-Elect serving as the Chairman when it so functions.

Section 5. Representation on the AAMC Assembly

The Organization of Student Representatives is authorized a number of seats on the AAMC Assembly equal to 10 percent of the Organization of Student Representatives membership, the number of seats to be determined annually. Representatives of the Organization of Student Representatives to the Assembly shall be determined according to the following priority:

1.) The Chairman of the Organization of Student Representatives.

2.) The Chairman-Elect of the Organization of Student Representatives.

3.) The Secretary of the Organization of Student Representatives.

4.) Other members of the Administrative Board of the Organization of Student Representatives, in order of ranking designated by the Chairman, if necessary.

5.) Members of the Organization of Student Representatives elected by the membership in a number sufficient to fill any additional positions on the Assembly which may be vacant.

Section 6. Meetings, Quorums, and Parliamentary Procedure

A. Regular meetings of the Organization of Student Representatives shall be held in conjunction with the AAMC Annual Meeting.

B. Special meetings may be called by the Chairman upon majority vote of the Administrative Board provided there be given at least 30 days notice to each member of the Organization of Student Representatives.

C. A simple majority of the voting members shall constitute a quorum.

D. Formal actions may be taken only at meetings at which a quorum is present. At such meetings decisions will be made by a majority of those present and voting.

E. Where parliamentary procedure is at issue, Roberts Rules of Order (latest edition) shall prevail, except where in conflict with Association Bylaws.

F. All Organization of Student Representatives meetings shall be open unless an executive session is announced by the Chairman.

Section 7. Operation and Relationships

A. The Organization of Student Representatives shall report to the Council of Deans of the AAMC and shall be represented on the Executive Council of the AAMC by the Chairman of the Organization of Student Representatives.

B. Creation of standing committees and any major actions shall be subject to review and approval by the Chairman of the Council of Deans of the AAMC.

Section 8. Adoption and Amendments

These Rules and Regulations shall be adopted and may be altered, repealed, or amended, by a two-thirds vote of the voting members present and voting at any annual meeting of the membership of the Organization of Student Representatives for which 30 days prior written notice of the Rules and Regulations change has been given, provided that the total number of the votes cast for the changes constitute a majority of the Organization's membership.

## STATEMENT ON GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education ultimately should become a responsibility of academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by academic medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment; review curricula and instructional plans for each specific program; arrange for evaluating graduate student progress periodically; and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools.

The Association urges that the Liaison Committee on Medical Education, the Residency Review Committees and the Specialty Boards establish procedures which will provide for adequate accreditation of an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid super-imposing rigid program requirements on the academic medical centers.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.

# COUNCIL OF DEANS

Program Session
2:30 p. m. - 4:30 p. m.
Lincoln East
Washington Hilton Hotel
October 29, 1971

## OUTREACH ACTIVITIES OF THE MEDICAL SCHOOL -- DANGERS AND ADVANTAGES

James A. Campbell, M.D.
President
Rush-Presbyterian-St. Luke's Medical Center

David E. Rogers, M.D.
Dean and Vice President
The Johns Hopkins University School of Medicine

Sidney S. Lee, M.D.
Associate Dean - Hospital Programs
Harvard Medical School

. . . . .Break . . . . .

## PANEL AND OPEN DISCUSSION

Moderator: Carleton B. Chapman, M.D.

Panel Members:

H. Frank Newman, M.D., M.P.H.
Director
Group Health Cooperative of Puget Sound
and First Vice President
Group Health Association of America

Robert Kalinowski, M.D.
Director
Division of Health Services, AAMC

James A. Campbell, M.D.
David E. Rogers, M.D.
Sidney S. Lee, M.D.

## III. FACULTY REPRESENTATION IN THE AAMC

The attached papers on Faculty Representation in the AAMC and Guidelines for the Organization of Faculty Representatives were presented to the Executive Council on December 17. As mentioned herein, these papers emanated from the AAMC's December Retreat.

After discussing the issues raised in these papers, the Executive Council took the following action:

ACTION: On motion, seconded and carried unanimously, the Executive Council favorably recommends the proposed "Guidelines for the Organization of Faculty Representatives" to the constituent Councils for consideration.

It was agreed that this issue would be considered by the Councils, a progress report made to the Assembly in February, and the proposal returned to the Executive Council (with recommendations) in May for possible action at the Assembly meeting in November.

RECOMMENDATION: That the Council of Deans consider the matter of Faculty Representation in the AAMC and the appropriateness of the mechanism proposed in the attached documents. (Final COD action at this meeting is not essential, in that there will be another opportunity to consider this matter at the April COD meeting if necessary).

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5175

December 8, 1971

MEMORANDUM

TO: AAMC Executive Council Members

FROM: Office of the President

SUBJECT: FACULTY REPRESENTATION IN THE AAMC

The enclosed paper on faculty representation in the AAMC was prepared by AAMC staff at the direction of the participants in our December Retreat. The paper summarizes the discussion of the Retreat on this issue, and presents to the Executive Council the recommendations of the Retreat.

This subject will be open to discussion at the December 17th Executive Council meeting.

cc: Dr. Kinney, Mr. Danielson, Mr. Thomas, Dr. Wilson, Dr. Swanson, Mr. Fentress, Mr. Murtaugh

## RETREAT DISCUSSION OF FACULTY REPRESENTATION IN THE AAMC

The question of faculty representation served as the focus of discussion at the AAMC's recent Retreat (December 2-4). At issue was the basic justification for such an expansion, the mechanism by which this might best be accomplished, and all long-range implications of such an action on the Association.

Discussion of these questions stimulated a wide range of opinion. While there was general agreement on the value of involvement of the faculties, several questions were raised concerning their role in the governance of the Association. One questioned the possibility of "representation," stating that only the individual delegate would be involved and that nothing would be done to involve or truly represent the whole of the faculty. Another concern was the manageability of the Association: have we reached a critical mass beyond which point proliferation will eventually lead to paralysis.

Extensive debate on these points established a general consensus in favor of formally involving the institutional faculty in both the substance and governance of the Association. As was noted in support of this viewpoint, a primary concern of the AAMC, by definition, is medical education, and this task must eventually be accomplished by the faculty. Seven options for incorporating faculty into the governance of the Association were then solicited:

1) abolish CAS in favor of a Council of Faculties (COF), which would provide for subordinate representation of the professorial societies;

2) retain CAS and establish an Organization of Faculty Representatives (OFR) within the COD--parallel to the OSR;

3) expand CAS to incorporate junior faculty (possible rename COF);

4) establish voluntary compus chapters of the AAMC. Bring a representative of each chapter directly into either CAS or COD. When 50% of the faculties were so organized, they would form a separate council (COF);

5) reorganize regional meetings only, to include COF (Midwest example);

6) retain CAS and establish COF;

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Prepared by AAMC for discussion at December 17, 1971 Executive Council meeting.

7) replace COD with a Council of Institutional Representatives (CIR). Each school would have three delegates -- dean, faculty member, student--and one vote.

It was decided that two separate issues had to be resolved: first, how this faculty body is to fit into the AAMC governing structure, and second, how the faculties are to be organized to select a representative.

After much discussion, a consensus was reached on Option #2 above--establishing an Organization of Faculty Representatives under the Council of Deans. An integral part of this consensus was the agreement that this proposal would be presented to and discussed by each of the constituent Councils before going to the Assembly in November. It was also agreed that a moratorium be declared on future expansion of the Association until such time as all the implications of this expansion could be evaluated.

The question of organizing the faculty elicited two different proposals: (1) election of a representative by the whole of the organized faculty (Academic Senate); or (2) establishment of voluntary campus chapters, composed of those faculty members who hold AAMC individual membership and who would elect a representative from their chapter.

While the value of encouraging individual membership was recognized, consensus was reached on the first alternative. The feeling was expressed that the second option would be time-consuming, would leave some schools without faculty representation, and would tend to represent "joiners." It was also described as a "poll tax."

Thus, consensus was reached on an Organization of Faculty Representatives, structurally equivalent to the Organization of Student Representatives, both in its relationship to the governance of the AAMC and in its membership requirements. It was also agreed that AAMC staff would prepare a proposal to transmit this consensus to the December Executive Council meeting for "rigorous debate" and for referral to the February meetings of the CAS, COD, and COTH. A progress report will be presented to the February Assembly meeting, and receipt of the proposal (with amendments and recommendations) from the Councils will be expected at the May 19th meeting of the Executive Council. Final action is aimed at the November Assembly.

This paper and the attached draft Guidelines are therefore submitted to the Executive Council for the review and referral mentioned above.

# GUIDELINES FOR THE ORGANIZATION OF FACULTY REPRESENTATIVES

## ORGANIZATION

There shall be an Organization of Faculty Representatives which shall be related to the Council of Deans and which shall operate in a manner consistent with Rules and Regulations approved by the Council of Deans.

## COMPOSITION

The OFR shall be comprised of one representative form each Institutional Member and Provisional Member of the COD, chosen from the full-time faculty of each such member.

## SELECTION

A faculty representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will insure representative faculty input and be appropriate to the governance of the institution. The dean of each participating institution shall file a description of the process of selection with the Chairman of the COD and shall certify to him annually the name of the faculty member so selected.

## MEETINGS

Annual Meeting. The OFR shall meet at least once a year at the time and place of the COD Annual Meeting in conjunction with said meeting.

To facilitate the smooth working of the organizational interrelationships, the above shall be interpreted to require that the Annual Meeting of the OFR be held during the period of the Association's Annual Meeting, not simultaneously with the COD meeting. This meeting will be scheduled in advance of the COD meeting at a time which will permit the attendance of interested or designated deans.

## ACTIVITIES

The OFR will:

- Elect a Chairman and a Chairman-Elect.
- Recommend to the COD the Organization's representatives to the Assembly. (10% of OFR Membership)
- Consider other matters of particular interest to the faculty of Institutional Members.
- Report all actions taken and recommendations made to the Chairman of the COD.

RELATIONSHIP TO COD

The Chairman and Chairman-Elect of the OFR are invited to attend the COD meetings to make such reports as requested of them by the COD Chairman, to act as resource persons to express the concerns of faculty when invited, and to inform themselves of the concerns of the deans.

RELATIONSHIP TO THE EXECUTIVE COUNCIL

The Chairman of the OFR shall be an ex officio member of the Executive Council with voting rights.

RELATIONSHIP TO THE ASSEMBLY

The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the COD and a number of the OFR equivalent to 10 percent of the members of the Association having representatives in the OFR.

Each such representative (to the Assembly) shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings.

The Chairman of the Assembly may accept the written statement of the Chairman of the COD reporting the names of individuals who will vote in the Assembly as representatives chosen by the OFR.

COMMITTEES

One representative of the OFR to the Assembly shall be appointed by the Chairman of the Assembly to sit on the Resolutions Committee.

RULES AND REGULATIONS

The OFR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

FINANCES

- The Association will meet the cost of the travel required for authorized faculty participation in Association committee activities, i.e., Executive Council, Administrative Board, and designated committee meetings.

- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with faculty participation will have to be individually arranged at the institutional level.
- Association funds required to support this organization must be reallocated from currently budgeted funds reducing activities in other areas.

## IV. THE "FIFTH PATHWAY" FOR AMERICANS STUDYING MEDICINE ABROAD

### CLINICAL CLERKSHIPS FOR AMERICANS FROM FOREIGN MEDICAL SCHOOLS:

The Council on Medical Education of the American Medical Association adopted a policy statement on June 23, 1971 (Attachment I), which would permit U.S. citizens who have studied medicine abroad to enter AMA-approved residencies even though they have not fulfilled all the requirements for graduation of the institution they are attending and requirements for licensure in the country of their education (ECFMG prerequisite). As an alternative to fulfilling these requirements, the Council on Medical Education will accept a special junior clinical clerkship provided by U.S. medical schools, separate and distinct from the usual clerkships used by the school for their own students. The Council requires that these students have passed an examination such as Part I of the National Boards, the ECFMG Examination, the FLEX Examination, or a new examination to be devised for this purpose. The most recent AMA guidelines for this clinical clerkship are attached (Attachment II).

The stated purpose of this policy is to allow U.S. citizens to escape the necessity of meeting requirements for assigned social service. This is a particular requirement in Mexico. Students accepted under this policy will not be granted their degree by the foreign school. The U.S. schools accepting these students are also not expected to grant a degree.

The political pressure generated by this enlarging group of American citizens who desire ultimately to practice medicine in the U.S.A. is increasing rapidly. At present we know of three states which have made medical licensure available to American FMG's without regard to ECFMG procedures. (California, New Jersey, and Connecticut - other states are now considering the matter.)

In 1970, approximately 25,000 persons applied for 11,348 entering positions in the medical schools of the U.S.A.

Frequent review of the application-admissions process in a variety of medical schools confirms the logical observation that a large number (possibly several thousand) of adequately qualified applicants are being left over each year. Many of these persons will enroll in foreign medical schools.

The number of qualified "left-over" applicants will likely increase each year for the remainder of this decade if birth crop-applicant ratios continue.

### PRIOR ACTION BY THE EXECUTIVE COUNCIL:

On December 16, 1970, the AAMC Executive Council considered

this matter and felt that provision of clinical clerkships for foreign medical graduates was a matter for individual consideration by the individual schools and that no additional Association policy was necessary.

On December 17, 1971, this matter was reconsidered by the Executive Council and was referred to the Council of Deans for its consideration.

EXISTING AAMC PROGRAMS FOR FOREIGN STUDENT TRANSFER:

COTRANS (Coordinated Transfer Application System, beginning 1970) in 1970 matched 82 American FM students with U.S.A. medical schools 39 additional American FM students were transferred on advanced standing outside COTRANS, making a total of 121 transfers.

Data for 1971 is not yet available but applications for COTRANS have increased substantially.

Less than half of the schools of medicine have agreed thus far to participate in COTRANS.

How many spaces are available for transfer on advanced standing in the medical schools of the U.S.A.?

No solid data seems to be available. However, it is estimated that if an aggressive effort were exerted by the schools, a number of these students could be accommodated.

RECOMMENDATION: That the Council of Deans adopt the following policy statement:

All U.S. medical schools are urged to pay increased attention to American students in foreign medical schools by being receptive to applications to transfer on advanced standing via COTRANS, which uses Part I, National Board of Medical Examiners, as a qualifying screen.

Attachment III is a resolution passed by the Midwest-Great Plains Region on this subject on January 11, 1972.

## American Students in Foreign Medical Schools *

The established policy of the American Medical Association with reference to the eligibility of foreign medical graduates for appointment to approved internships or residencies is modified as follows:

1. A new pathway for entrance to AMA approved internship and residency programs, other than those existing under previous AMA policies, is available as of July 1, 1971, for students who have fulfilled the following conditions:

   (a) have completed, in an accredited American College or university, undergraduate premedical work of the quality acceptable for matriculation in an accredited U. S. medical school,

   (b) have studied medicine at a medical school located outside the United States, Puerto Rico, and Canada, but which is recognized by the World Health Organization,

   (c) have completed all of the formal requirements of the foreign medical school except internship and/or social service.

2. Students who have completed the academic curriculum in residence in a foreign medical school and who have fulfilled the above conditions may be offered the opportunity to substitute for an internship required by a foreign medical school, an academic year of supervised clinical training (such as a clinical clerkship or junior internship) prior to entrance into the first year of AMA approved graduate medical education. The supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education.

3. Before beginning the supervised clinical training, said students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must pass a screening examination acceptable to the Council on Medical Education, such as Part I of the National Board examinations, or the ECFMG examination, or the FLEX examination.

4. Said students who are judged by the sponsoring medical schools to have completed successfully the supervised clincial training are eligible to enter the first year of AMA approved graduate training programs without completing social service obligations required by the foreign country or obtaining ECFMG certification.

5. The Council on Medical Education will recommend to all state boards of medical examiners that they consider for licensure all candidates who have completed successfully the supervised clinical training on the same basis as they now consider foreign medical candidates who have received ECFMG certification.

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*Policy Statement of the Council on Medical Education
Adopted June 23, 1971

## U.S. CLERKSHIPS FOR U.S. CITIZENS STUDYING MEDICINE ABROAD

### TENTATIVE GUIDELINES

The following guidelines are intended to relate specifically to the needs of American students who have completed four years of study at the Universidad Autonoma de Guadalajara, for remedical clerkships in accordance with the recommendations of the Commission on Foreign Medical Graduates and the Council on Medical Education. In addition, these guidelines are developed with the possibility that they will be of more general usefulness if similarly oriented clerkships are found to be necessary for individuals who have attended other foreign medical schools.

The following comments are intended to be suggestions, with final decision in all important areas to be made by the sponsoring U.S. medical school.

It should be recognized that the students who have been granted a Carta Pasante from the Universidad Autonoma are a heterogeneous group. The group contains a number of individuals who in less competitive times would have been able to gain admission to a United States medical school as well as students who should not be, under any circumstances, expected to pursue successfully a medical school career in the United States. These guidelines are intended to encourage clerkship training for the first group. Specifically, reasonable efforts should be made to direct the remedial education and training to those students who are of approximately the same order of competence as students admitted to U.S. schools. Alternate lists kept by some medical schools might be useful in this matter. Each U.S. school will need to develop its own means of assuring competence. The schools are not being urged to provide remedial training for students who are far below their minimal standards.

Those American educators who have had experience with Guadalajara students and those individuals who have studied the Guadalajara school are agreed that at the end of four years of training, the students, i.e. the holders of the Carta Pasante or Diploma, usually will have had little clinical experience. Many, in fact, have had no formal introductory courses in history taking and physical examination, and none has had clinical experience comparable to that in the typical American clerkship.

The following are suggested as guidelines for the clerkship:

(1) The feasibility of providing the students with individualized instruction in history taking and physical examination at the onset of the clerkship should be considered.

(2) In keeping with the recommendation of the Commission on Foreign Medical Graduates, the clerkship should be one full academic year in duration.

(3) In view of the need for general experience, it is suggested that the clerkship cover several of the more general disciplines. The Mexican "internship" for which this clerkship is intended to be a substitute is comprised of three months each of medicine, surgery, pediatrics, and obstetrics-gynecology.

(4) The clerkship should be under the sponsorship of a U.S. medical school which should have responsibility for the program. It is suggested that these students should not be trained side by side with American medical students since their background is quite different. It is suggested, however, that the training be in a hospital affiliated with the medical school and under the supervision of physicians who hold medical school appointments.

(5) The medical school should have final responsibility for determining the criteria for admission to the program, the characteristics of the program itself, and the evaluation (if any) at the end. The minimum requirement would be for the medical school to certify to the Universidad Autonoma that the student had been in attendance for the full duration of the clerkship.

(6) There must be a screening examination which, combined with evaluation of other credentials, would provide assurance of competence to undertake the clerkship. It is suggested that Part I of the National Board Examination or the first part of Flex might be suitable for this purpose.

(7) It is suggested that it would be highly desirable for the medical school, in addition to providing whatever evaluation it deemed desirable to the Universidad Autonoma and the student, to use an American institution as the central repository for such an evaluation in the event it might prove to be necessary in subsequent years. It was felt that the interest of the United States public might not be fully protected if the student and the Universidad Autonoma were the only custodians of the evaluation.

(8) Recognizing that such a program would require some expenditure of effort or money, or both, by the medical school, it is suggested that the medical school might charge the student an appropriate fee. It is generally agreed, in view of the informal nature of the arrangement between the student and the medical school and the uncertainty regarding legal relationships, that tuition should not be charged without careful consideration of the legal implications.

(9) In order to emphasize the educational nature of the experience for the student and to clearly differentiate the experience from an externship, it is recommended that the hospital not be permitted to remunerate the student and that the student not be permitted to accept any remuneration for his services either from the hospital or from staff physicians.

GRL:kc
4/8/71

Revised
5/26/71
HCN:lwt

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GLEN R. LEYMASTER, M.D.
DIRECTOR
DEPARTMENT OF
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The Midwest-Great Plains Region of the AAMC has reviewed the June 23, 1971 statement of the Council on Medical Education of the AMA which proposed to establish a pathway by which American citizens who are students attending medical colleges outside the U.S. and Canada may enter U.S. programs of graduate education in medicine. ( The "Fifth Pathway" ).

The proposal would establish special clerkships approved by American medical colleges to substitute for required foreign internships. It is noted that such students may enter the special clerkships for the subsequent graduate program without completing the requirements for either the degree or licensure in the nation of their schooling. Therefore, be it moved that this plenary session on the MW-GP Region recommend the following statements in response to the CME proposals:

1. Each member college should develop admissions and evaluation mechanisms which would allow matriculation of the students concerned at undergraduate levels appropriate to their measured knowlege and skills, and leading to the granting of the M.D. degree. Mechanisms could include but not be limited to COTRANS, and would be determined by the member institution. Such programs would supply a graduated, educational response to the measured student capabilities, rather than a rigid, time limited experience that is oriented to a group rather than an individual student.

2. Since the proposed "clerkship" relates principally to matriculants of one foreign medical school who have

not completed the degree requirements of the nation in which that school is located; and since the recommendation above would provide adequate opportunity for those and other students to earn an uncompromised degree: member institutions should look with disfavor on involvement in a program where their responsibility for quality education is diluted. Such dilution and compromise occurs in the proposed "Fifth Pathway" clerkship.

Resolution adopted by the Midwest-Great Plains Region on January 11, 1972.

The Deans of the Southern Region urge that the AAMC make an official policy statement regarding the Council on Medical Education policy with respect to American students in foreign medical schools. The Association is urged to take the position that, not withstanding the implication in the AMA statement, whether or not a school undertakes to provide the year of supervised clinical experience referred to is a matter within the sole discretion of that school.

Resolution adopted by the Southern Region on October 10, 1971

## V. POLICY STATEMENT ON THE FREESTANDING INTERNSHIP

At the September 17th Executive Council meeting, the attached material recommending the elimination of the freestanding internship was passed out. At that time, Council members did not have an adequate chance to review the statement and the recommendation of the Ad Hoc committee was subsequently tabled.

One of the major questions raised in discussion was the need for a clearer definition of a "freestanding" internship. A definition of the meaning of the term may be found in the attached memcranda from the AMA.

The matter was again raised at the December 17, 1971 meeting of the Executive Council as an appropriate compliment to the "Statement on the Responsibility of Academic Medical Centers for Graduate Education." The Executive Council removed the matter from the table and referred it to the Council of Deans and the other Councils for their consideration.

RECOMMENDATION: That the Council of Deans consider the Policy Statement on Eliminating the Freestanding Internship and recommend its adoption to the Executive Council.

POLICY STATEMENT ON ELIMINATING THE FREESTANDING INTERNSHIP

At its December meeting, the House of Delegates of the AMA approved the concept that the freestanding internship should be eliminated. Subsequently, memoranda from the AMA's Council on Medical Education were circularized on December 28, 1970 and March 18, 1971, explaining the implications of this policy (copies of memoranda attached).

The AAMC has made no public statements regarding this development. It is clear that eliminating the freestanding internship is consistent with the development of a more logical continuum of medical education and with the policy statement which will be presented to the Assembly in October regarding the responsibility of academic medical centers for graduate medical education.

A committee consisting of Dr. John Parks (COD), Dr. Tom Kinney (CAS) and Mr. Irvin Wilmot (COTH), Dr. August Swanson (Staff) met on September 3rd and approved the following statement.

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

Recommendation:

The committee recommends that the Executive Council approve this statement and forward it to the Assembly for consideration along with the policy statement on the responsibility of academic medical centers for graduate medical education.

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COUNCIL ON
MEDICAL EDUCATION

# MEMORANDUM

TO: All Hospitals with Approved Graduate Programs
All Deans of Medical Schools
All State Boards of Medical Examiners
All Medical Specialty Boards
All Residency Review Committees
All Medical Specialty Societies Represented on Residency Review Committees

FROM: C. H. William Ruhe, M.D.,
Secretary, AMA Council on Medical Education

SUBJECT: Integration of Internship and Residency Training

DATE: December 28, 1970

At the AMA Clinical Session in Boston on December 2, 1970, the AMA House of Delegates approved the third of a series of three actions aimed at integration of the internship and residency years, and emphasizing the continuum of undergraduate and graduate medical education. The first action was taken in December, 1968 with adoption of the statement that "an ultimate goal is unification of the internship and residency years into a coordinated whole."

The second action was in June, 1970, with approval of two statements establishing dates by which integration of internships with residency programs must be completed.

At the December, 1970 meeting, the third action was the adoption of a report entitled "Continuum of Medical Education," which contained ten specific statements recognizing the relation of the previous actions to the requirements of state licensing bodies, the requirements for certification by medical specialty boards, the operation of intern and resident matching programs, the interdependence of undergraduate and graduate programs, and other matters. The complete report is attached.

The actions taken represent further efforts toward implementation of the recommendations of the Citizens Commission on Graduate Medical Education (Millis Commission). They emphasize the necessity for increasing assumption, by the teaching faculty or professional staff of a teaching institution, of corporate responsibility for all of the educational programs offered by that institution.

Full effectiveness in implementation of these actions will depend upon cooperative efforts and complementary actions by teaching institutions, state licensing bodies

and medical specialty boards. The AMA Council on Medical Education hopes that such cooperation and complementary action will lead to shortening of the total time required for medical education and greater emphasis upon the unity and the continuum of medical education.

The Annual Congress on Medical Education, to be held at the Palmer House, Chicago, February 14-15, 1971, will include as a part of its program a discussion of these matters and will provide a forum for the exchange of ideas and opinions, and for explanation of the goals of the unification of the internship and residency years into a coordinated whole.

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COUNCIL ON
MEDICAL EDUCATION

Report of the Council of Medical Education
Approved by the A.M.A. House of Delegates, December 1970

## CONTINUUM OF MEDICAL EDUCATION

Report L of the Board of Trustees, presented at the AMA Annual Meeting in June, 1970, stated the results of continuing studies by the Board of Trustees and the Council on Medical Education of the various provisions of the Report of the Citizens Commission on Graduate Medical Education. Two specific recommendations in the Report, aimed at the unification of the internship and residency years into a "coordinated whole," were adopted by the House of Delegates. These were as follows:

1. After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole;

2. After July 1, 1975, no internship program shall be approved which is not integrated with residency training to form a unified program of graduate medical education.

The action of the House of Delegates in adopting these recommendations did not abolish the internship program, but did require that it be made an integral part of a total program of graduate medical education. The advanced deadlines were set to permit institutions to reorganize their programs of graduate medical education to conform to these requirements.

The effective implementation of these recommendations requires that related organizations and agencies, such as the state licensing boards, the examining boards in medical specialties, and the faculties of medical schools, reevaluate the requirements stated in their current policies.

To insure that the desired transition from the undergraduate curriculum to a unified program of graduate medical education can be effected, it is recommended that the following statement on the Continuum of Medical Education be adopted:

1. That the first year of medical education following receipt of the M.D. degree be accredited by an appropriate residency review committee;

2. That all state licensing boards be notified that, effective July 1, 1970, the first year of an approved residency program, including family practice, is acceptable to the Council on Medical Education as an internship approved by the American Medical Association;

3. That it be recommended to the specialty boards that they consider giving credit toward certification for appropriate clinical experience afforded prior to the granting of the M.D. degree;

4. That medical schools be asked to examine the need for four calendar years of undergraduate medical education and to consider the possibility of beginning graduate medical education in the fourth year;

5. That within the area of graduate medical education joint cooperative efforts be encouraged between university faculties and community hospitals in order to produce a larger number of physicians to provide for the delivery of health care;

6. That within university medical centers and their affiliated hospitals university faculties jointly with the faculties of their affiliated hospitals assume greater corporate responsibility for the conduct of graduate education;

7. That the principle of a voluntary matching program be preserved, and that the only point at which this can be preserved is at the time of obtaining the M.D. degree;

8. That the director of a unified program of graduate medical education be responsible to insure that trainees in the program are adequately grounded in such of the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology as are appropriate to the program and to individual career goals;

9. That all specialty boards requiring three or more years of graduate experience permit the substitution of at least one year of graduate education in medicine, surgery, pediatrics, or family practice for their own stated requirements;

10. That the future design and development of post-M.D. education programs, and curricula leading to qualification for examination by a specialty board, should emphasize:

    a. The educational goal,
    b. The personal motivation,
    c. The learning capabilities,
    d. The individual evaluation,

of each post-M.D. candidate, without reference to calendar perimeters of a fixed or limiting character.

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COUNCIL ON
MEDICAL EDUCATION

# MEMORANDUM

TO: All Directors of Approved Graduate Training Programs
All Deans of Medical Schools
All Medical Specialty Boards
All Residency Review Committees
All Medical Specialty Societies Represented on Residency Review Committees

FROM: C. H. William Ruhe, M.D.,
Secretary, AMA Council on Medical Education

SUBJECT: Implications of Recent Actions to Integrate Internship and Residency Programs

DATE: March 18, 1971

On December 28, 1970, a memorandum was sent to all hospitals with approved graduate programs reporting recent actions by the American Medical Association aimed at integration of internship and residency education and emphasizing the continuum of undergraduate and graduate medical education. The present memorandum is intended to amplify and explain that report, and to consider the implications of the unification of graduate training programs.

The Council on Medical Education has approved the following statements for the guidance of program directors:

1. Unification of internship and residency years into a coordinated whole implies that the total program must be directed by one individual. This person must necessarily, therefore, have the responsibility and authority for direction of the residency program in that specialty, and he must be responsible for preparation of the entire application, describing all years and the relationship of each year to the others.

2. The program director should have the option of either requiring or recommending a specific type of "internship year" acceptable as a part of his residency program, depending upon the resources of the institution and the undergraduate experience and career objectives of the candidate.

3. The program director should have the option of designing the internship year as a traditional rotating experience, a rotating experience with a specified

major, or a straight experience limited largely to the specialty field concerned. He should have complete freedom in the design of this internship year and would not need to designate it by any of the above three standard terms. The program director should have the option of including within the internship year specific experiences of particular value to the trainee in his future career, even though the specialty board concerned may have stated that it would not give credit for certain of these experiences toward eligibility for certification.

The institution has the ultimate, corporate responsibility; the program director has the administrative responsibility, but, in order to exercise this responsibility, he should have available the collective judgment of his counterparts in the related specialties.

4. The program director might elect to assign the trainee to an outside hospital for his internship year, would assume responsibility for his educational program for that period of time, and would have to describe in a convincing way those elements of the outside program that assure coordination with the program in the parent hospital. He might also accept trainees who have had experience in other institutions approved for such training.

5. The program director would have to specify the conditions under which a candidate appointed to the first, or internship, year would be eligible for appointment to the subsequent years of the program.

## The Future Status of the Internship

When the House of Delegates adopted the statement in Report L of the Board of Trustees, in June, 1970, some program directors interpreted the action on the "free-standing internship" to mean that the rotating internship was being abolished; others interpreted it to mean that any internship in a hospital without a medical school affiliation was being abolished; some simply assumed that all internships were being abolished.

The action of the House of Delegates did not abolish internships, but did require that they be made an integral part of a total program of graduate medical education. Deadlines have been set far enough in advance to permit institutions to reorganize their programs of graduate medical education in order to be able to conform to these requirements if they wish to continue to offer such education.

The term "free-standing internship" has been misinterpreted by a number of program directors. It was intended to indicate those internships not related

to residencies, whether the residencies are in the same hospital as the internship or in other hospitals.

1. Examples of free-standing internships would include:

   (a) an internship offered in a hospital that has no residency programs and that has no relationship to other hospitals for graduate training;

   (b) an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere.

2. Examples of an internship, or first year of graduate education, integrated with residencies, would include:

   (a) a rotating internship in one hospital integrated with one or more residencies within that hospital;

   (b) a rotating internship in one hospital integrated with one or more residencies in another hospital;

   (c) a straight internship within one hospital integrated with a residency in that specialty, either solely in that hospital or in a group of hospitals;

   (d) a straight internship structured on the same lines as the residency and integrated in two or more hospitals for the entire training period;

   (e) a straight internship in two or more hospitals integrated with a residency offered in only one of the hospitals.

## Critical Mass

In the report adopted at the December, 1970 meeting of the House of Delegates, entitled "Continuum of Medical Education," Item 8 expresses the need for a "critical mass" within any hospital approved for graduate medical education. A successful graduate training program cannot be carried out in a vacuum. However, because the minimum requirements differ from specialty to specialty, the minimum critical mass for good training must be determined for each specialty. In internal medicine, for example, there must be a residency in general surgery. For a residency in family practice, there must be creditable departments of radiology and pathology. The general requirements stated in the "Essentials of Approved Residencies" are applicable to all programs, and provide minimal safeguards.

Memorandum-Implications of Recent Actions to Integrate Internship and Residency Programs

March 18, 1971

The director of a unified program of graduate medical education must be responsible to insure that the trainees in his program are adequately grounded in such of the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology as are appropriate to the program and to individual career goals. The Council on Medical Education and its Advisory Committee on Graduate Medical Education recognize the value of the concept of a basic two years of graduate education, from the standpoint of facilitating lateral mobility and allowing the candidate to delay committing himself to a premature choice of a specialty. Nevertheless, the Council also recognizes the fact that there is currently a strong trend in students toward early branching within the undergraduate program. Thus there could be a conflict between the desire to shorten the total span of specialty education and the desire to provide breadth of training before the candidate concentrates on narrower specialty training.

Program directors should structure graduate training programs so that they provide not only the requisites acceptable to the specialty boards but also insure that adequate breadth of training is provided without significantly prolonging the total span of training. One step in this direction is the acceptance by most of the examining boards in the surgical specialties of the principle of an examination after a basic two years of surgical training.

## Cooperation of Other Organizations and Agencies

Coordination and integration of internships and residencies can be carried out only with the effective cooperation of medical schools, state licensing boards, and the examining boards in the medical specialties. The medical schools in many instances are studying their curricula, and are considering the possibility of concentrating undergraduate medical education in such a manner that at least a portion of the final year can be used to provide graduate education. University faculties, jointly with the faculties of their affiliated hospitals, should assume greater corporate responsibility for the conduct of graduate education, to insure that a meaningful experience is afforded each graduate. In order to produce a greater number of physicians to provide for the delivery of health care, cooperative efforts should be developed and encouraged between university faculties and community hospitals.

Both the December 28, 1970 Memorandum and the present Memorandum have been sent to all state licensing boards so that each of these agencies will be aware of the fact that, as of July 1, 1970, the Council on Medical Education considers the first year of any approved residency program, including that of family practice, as the equivalent of an internship approved by the American Medical Association. This policy should make it possible for trainees to obtain some of the experience normally available in an internship during their fourth year

of medical school, so that, upon graduation, they could be accepted into the first year of a residency program, provided the specialty board in that field does not require an internship, or will give credit for clinical experiences obtained in the final year of medical school.

The American Board of Medical Specialties, which now acts as the coordinating body for the approved examining boards, has also been notified of the adoption of these policies. It is hoped that the specialty boards will give consideration to the possibility of providing credit toward certification for appropriate clinical experience obtained prior to the granting of the M.D. degree, and consider also the possibility, in those specialties requiring three or more years of graduate experience, of permitting substitution of at least one year of graduate education in medicine, surgery, pediatrics, or family practice, for stated requirements of the individual boards.

If the specialty boards find it possible to reorient their requirements for certification so that less emphasis is placed on calendar perimeters, future graduate programs could be designed in such a way that the house officer would be able to achieve his educational goal in as short a time span as possible, based on the program director's individual evaluation of the trainee, which would take into consideration the latter's personal motivation and learning capabilities.

## Future Procedures and Evaluations

The effective date of July 1, 1975, was chosen to provide for the orderly implementation of these policies, and to give program directors, medical schools, specialty boards, and licensing boards an opportunity to develop effective implementation of the recommendations.

It seems desirable that, for the present at least, the principle of a voluntary matching program for graduate medical education be preserved. The only point at which this can be preserved is at the time of obtaining the M.D. degree. In the case of a specialty for which the board does not require an internship, there may be developed a matching of the first year of the residency. This is being done on a limited basis in the March, 1971 Matching Program, and a separate matching program has been carried on during the past year for residencies in radiology and in orthopedic surgery, both of which specialties do require an internship.

It has been the policy of the Department of Graduate Medical Education to survey approved programs at intervals of about thirty to thirty-six months. This schedule of surveys will be maintained during the years intervening prior to July 1, 1975, and programs will be evaluated during that time on the basis of previous "Essentials of an Approved Internship" and "Essentials of Approved Residencies."

Memorandum-Implications of Recent Actions to Integrate Internship and Residency Programs

March 18, 1971.

During the past year, as many program directors are aware, straight internships in internal medicine, surgery, obstetrics-gynecology, and pediatrics have been evaluated by the residency review committees in such specialties, and the straight internships in pathology have been evaluated by the American Board of Pathology along with residencies in that specialty. The rotating internships are currently evaluated by the Internship Review Committee, which will continue to carry on this responsibility at least until 1975.

Applications for new, free-standing internships in general will not be accepted for survey unless it can be shown that the program would be implemented as of July 1, 1971. Program directors considering the establishment of a rotating internship at this time should plan an intramural program of internship and residency training or should develop affiliations with other hospitals so that such a coordinated program could be offered. Many hospitals might also be eligible to consider the possibility of offering a three-year family practice program, the first year of which can be credited as an internship.

# VII. THE FACULTY ROSTER STUDY

Faculty Roster Project - Status and Plans

At the October meeting there was an expression of concern over the time and effort required to provide the data input to the faculty roster file. Questions were raised about the advisability of continuing the project since to date there has been so little in the way of "tangible benefits to the school". The following is presented in response to the Chairman's request for a report on this project.

History of the Project:

The annual survey has been carried out since 1966 under contract with NIH; NIH has requested an up-dating of the file and this will be in the hands of the schools this month. This request will again be in the form of computer print-outs, requiring a minimum of effort on the part of faculty and school administration to incorporate changes since the last up-date.

Objectives of the Project:

The data represent the only comprehensive body of information on the persons holding faculty appointments in medical schools; this data base is the sole source of intelligence on the educational and professional backgrounds, current academic and department assignments and duties, and participation in Federal training and research programs.

Use of the Data:

The data have been of considerable use to NIH in responding to inquiries from the Federal Office of Management and Budget; the file has been a source of information on the effectiveness of the graduate training programs of the Institutes.

AAMC staff have also been able to provide data relating to the faculty at a particular school, on request from the school.

Plans for the Project:

Admittedly, the potential use of the file has not yet been realized. In agreement with NIH, however, AAMC staff will develop within the next several months plans for analysis of the data around such salient points as the factors surrounding the sources and origins of medical school faculty; the major reasons for faculty losses; length of faculty appointment; faculty participation in research,health care, and administration, in addition to instructional duties; the extent of participation by voluntary faculty in the educational process. These analytical reports will focus on the aggregates for all medical schools, but there will be the capability for providing faculty profiles for each school, for self-study and analysis if desired.

In addition, over the next several months, NIH and AAMC will review the entire project with an advisory committee. This group will consider the feasibility of alternative ways to collect the desired information, with the view of reducing the burden on the schools and the cost of the project, and yet maintain this sole source of information on faculty. Medical school representatives will be asked to serve on this advisory group.

In summary, AAMC staff are moving to a more effective participation in the planning and control of the project; and will be responsible for assuring that the data become available in the form that assures their most effective use.

JR:rk
1/13/72

VIII.

ELECTION OF PROVISIONAL INSTITUTIONAL MEMBERS

Following the "Prerequisites and Election Procedures for AAMC Institutional Membership," the following developing medical schools are eligible for election to Provisional Institutional Membership:

Southern Illinois University School of Medicine

Mayo Medical School

Texas Tech University School of Medicine

Eastern Virginia Medical School

RECOMMENDATION: The Council of Deans recommends to the Executive Council the election of the above schools to Provisional Institutional Membership in the Association of American Medical Colleges.

## INFORMATION ITEM

### Relationship of the BOS to the Council of Deans

The Administrative Board of the Council of Deans met with leadership of the Business Officers Section on October 29, 1971. The meeting resulted in a request by the Board for a report from the BOS regarding their projected program for the coming year. The report was submitted by the BOS and reviewed by the Administrative Board on December 16, 1971. The response of the Board to the BOS proposal was communicated by letter from Marjorie P. Wilson, M.D. to Thomas A. Fitzgerald (copy attached). Mr. Fitzgerald will meet again with the COD Administrative Board to respond to the requests contained in the letter on February 3, 1972.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

December 22, 1971

Thomas A. Fitzgerald
Assistant Controller
New York University Medical Center
New York, New York 10016

Dear ~~Mr. Fitzgerald~~ Tom:

The Administrative Board of the Council of Deans reviewed the proposed Business Officers Section Program for 1972, which you submitted for their consideration. The Board has asked that I convey to you the substance of their deliberations and the actions resulting therefrom.

I was specifically instructed to convey to you the Board's recognition of the substantial contribution of the Business Officers Section to the Association and its member schools. In particular, the Board noted the important role that the Section has played and proposes to continue with respect to the professional development of its membership. It is this function which the Board considers the Section uniquely well-suited to perform.

The Board considered itself at something of a disadvantage in their endeavor to review your proposal, not in any case because of the nature of your submission, but rather because it had been informed that as a result of the Airlie House Retreat, a formal statement was being drafted for the approval of the Executive Council defining the nature and function of organizations of the Association not presently provided for in the Association Bylaws. Such an action by the Executive Council, anticipated for their meeting of February 5, 1972, will obviously require that existing sections and groups bring themselves in to conformance with such guidelines as are adopted. Thus the dilemma, and the potential for any action taken at this time to be considered inappropriate. Nonetheless, because of the commitment of the Board to review the proposal of the BOS, the Board determined not to delay such interim action as it considered feasible. In any event, the actions of the Board will undoubtedly be considered by the Executive Council in its deliberations on this topic.

Initially, the Board specified its understanding of the purposes of the sections related to the Council of Deans as follows:

1. The professional development of the membership;

2. The provision of expert advice and consultation to the Association on matters within the functional areas under the purview of the membership;

3. The identification of problems or potential problem areas within the functional areas under the purview of the membership, and participation in the design and implementation of programs directed toward their solution.

The Board then proceeded to review the program proposal in light of these purposes, and determined it appropriate to endorse the program to the extent that it conforms to the following guidelines:

1. The financial and statistical standards activities should be concentrated on supporting the efforts of the AAMC staff and appropriate Association-wide committee to make appropriate revisions in the LCME Annual Medical School Questionnaire, Part I - Financing.

2. Recognizing that the professional development activities are a uniquely appropriate endeavor for the Section, the Board counsels a modest start for the programs to be conducted in conjunction with the Annual Meeting. It therefore recommends that these be sharply focused on the functional areas directly within the cognizance of the business officers, and be limited to several areas of primary concern to the BOS. The Board further requests the opportunity to review at its February 4 meeting, more specific plans for the programs to be conducted at the Annual Meeting.

3. External relations activities of the BOS should be conducted only with respect to those activities formally communicated to and planned in conjunction with the President of the Association.

4. Information resources activities are related to and result from further AAMC decisions concerning the further development of medical center information systems.

5. Internal governance committee activities such as those relating to bylaws and nominations should be deferred pending the approval of the Executive Council of the statement specifying the nature and function of organizations of the Association other than those provided for in the current Association Bylaws.

Finally the Board agreed to recommend to the Executive Council that the Association reimburse the expenses incurred in conducting one meeting annually of the BOS Executive Committee held in Washington, D.C. at the Association headquarters, providing such expenses do not exceed the sum of $3000. The limitation with respect to the location of the meeting was designed to facilitate the attendance of appropriate staff at minimal additional expense. The Board agreed to waive this limitation with respect to this year's meeting in recognition of the imminence of these meetings and the advance planning which has already been undertaken.

I hope that the Board's perspective is adequately communicated by the above paragraphs. I think that it is quite evident that the Deans are supportive of the BOS activities, and are highly desirous of integrating them more closely with the other organs of the Association. It is because of this view that the Board acted in a manner which may seem to impinge on the autonomy of the BOS. Their primary concern is that the Association speak with one voice in its dealings with outside agencies and that all relevant inputs are made prior to such contacts. With respect to internal policy matters, they have indicated a similar concern: that there be an orderly and rational process by which all relevant expertise and perspectives are considered prior to the determination of an appropriate course of action.

Tom, I regret that I will be unable to be present for your January 28th meeting. I have asked my Deputy, Dr. James Schofield, to attend in my stead and I am certain that you will find that I am well represented.

I hope your meeting proves as productive as its promise. In the meantime, Happy Holidays.

Best regards,

Marjorie P. Wilson, M.D.
Director
Institutional Development

cc: Carleton Chapman, M.D.
Thomas Campbell
Joseph S. Murtaugh
James R. Schofield, M.D.