Association of American
Medical Colleges

COUNCIL OF DEANS
SPRING MEETING

PROGRAM

ACADEMIC MEDICINE—
CROSSCURRENTS
OF THE EIGHTIES

March 29–April 1, 1981
The Broadmoor
Colorado Springs, Colorado

1981 SPRING MEETING OF THE COUNCIL OF DEANS

March 29–April 1, 1981
Colorado Springs, Colorado

ACADEMIC MEDICINE— CROSSCURRENTS OF THE EIGHTIES

PROGRAM

Sunday, March 29

1:00 p.m.- 5:00 p.m. ARRIVAL & REGISTRATION — *Mezzanine Main*

SESSION I

5:30 p.m.- 7:00 p.m. WELCOME & PRELUDE TO COD BUSINESS MEETING — *Main Ballroom*

7:00 p.m.- 8:30 p.m. RECEPTION TO WELCOME NEW DEANS AND THEIR SPOUSES — *Pompeiian Room*

Monday, March 30

SESSION II

8:30 a.m.- 10:30 a.m. — *Main Ballroom*

THE ACADEMIC MEDICAL CENTER AND THE COMPETITIVE ENVIRONMENT
—Robert M. Heyssel, M.D.
Executive Vice-President & Director
The Johns Hopkins Hospital
—Emmett H. Heitler
Former Chairman of the Board
Samsonite Corporation
Member AAMC National Citizens Advisory Committee

10:30 a.m.- 11:00 a.m. BREAK — *Mezzanine Main*

SESSION III

11:00 a.m.- 1:00 p.m. — *Main Ballroom*

COMMERCIALISM AND MEDICINE
—Arnold S. Relman, M.D.
Editor
The New England Journal of Medicine

U.S. FOREIGN MEDICAL STUDENTS: A PERSPECTIVE ON THE GAO REPORT
—William B. Deal, M.D.
Dean
University of Florida College of Medicine

1:00 p.m.- UNSCHEDULED TIME

Tuesday, March 31

SESSION IV

8:30 a.m.- 10:30 a.m. — *Main Ballroom*

MEDICINE AND THE UNIVERSITY
—William H. Danforth, M.D.
Chancellor
Washington University
—Donald Kennedy, Ph.D.
President
Stanford University

10:30 a.m.- 11:00 a.m. BREAK — *Mezzanine Main*

SESSION V

11:00 a.m.- 1:00 p.m. — *Main Ballroom*

MEDICINE IN THE EIGHTIES: A WASHINGTON PERSPECTIVE
—Edward N. Brandt, Jr., M.D.
Assistant Secretary for Health
Department of Health and Human Services

1:00 p.m.- UNSCHEDULED TIME

Wednesday, April 1

SESSION VI

8:30 a.m.- 12 Noon COD BUSINESS MEETING — *Main Ballroom*

12 Noon ADJOURNMENT

aamc association of american medical colleges

AGENDA

FOR

COUNCIL OF DEANS

SPRING BUSINESS MEETING

SESSION I
SUNDAY, MARCH 29, 1981
5:30 P.M.–7:00 P.M.

SESSION II
WEDNESDAY, APRIL 1, 1981
8:30 A.M.–12 NOON

MAIN BALLROOM
THE BROADMOOR
COLORADO SPRINGS, COLORADO

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

FUTURE MEETING DATES

AAMC ANNUAL MEETING----------October 31-November 5, 1981
Washington Hilton Hotel
Washington, D.C.

1982 COD SPRING MEETING----------March 28-31, 1982
Kiawah Island
Charleston, South Carolina

COUNCIL OF DEANS
SPRING BUSINESS MEETING
Main Ballroom
The Broadmoor Hotel
Colorado Springs, Colorado

AGENDA

Session I
5:30 pm - 7:00 pm
Sunday, March 29, 1981

Page

I. Welcome and Overview of the Meeting
   Steven C. Beering, M.D.

II. Briefing on President Reagan's Budget Proposals
   --Handout materials

III. The Legislative Agenda
   --Handout materials

RECESS

Session II
8:30 am - 12:00 Noon
Wednesday, April 1, 1981

IV. Report of the Chairman
   Steven C. Beering, M.D.

V. Report of the President
   John A. D. Cooper, M.D.

VI. Approval of Minutes---------- 1

VII. Consideration of the President's Budget

VIII. Consideration of the 1981 Legislative Agenda

IX. A Single Route to Licensure---------- 12

X. United States Foreign Medical Students Committee--Status Report
   --Handout materials

XI. Report of the Ad Hoc Committee on Competition
   --Handout materials

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS
ANNUAL BUSINESS MEETING
Monday, October 27, 1980
2:00 pm - 5:00 pm
Georgetown East & West
Washington Hilton Hotel
Washington, D.C.

MINUTES

I. Call to Order

The meeting was called to order at 2:00 pm by Stuart Bondurant, M.D. Dr. Bondurant introduced and welcomed a special guest, Dr. Lammers, Chairman of the Association of Medical Deans in Europe. Dr. Lammers expressed his pleasure at being in attendance.

II. President's Report

Dr. Cooper began his report by commenting on the new spirit of cooperation between the five major organizations (AMA, AHA, AMS, CMSS, AAMC) in the private sector relating to medical education and medicine. He further explained that Mr. Womer would later describe in more detail the changes which have occurred in those groups.

Dr. Cooper then reminded the Council that Dr. Murray Grant would be at Tuesday's Assembly meeting talking about the GAO report on the study of the foreign medical schools that are catering to the U.S. students. Since that report had not yet been formally accepted by the House, however, he would be unable to discuss the final findings and recommendations.

Dr. Cooper also reported on a new project undertaken by the Association: a cooperative agreement with the Administration on Aging. During the two-year project, the staff will be working with the various aging centers that have been funded as well as those in the planning stages. The project will not evaluate the programs, but will assist in improving communication among the programs, arranging consultants where requested, and scheduling workshops to promote the interchange of information among the various centers. Dr. Thompson Bowles, George Washington University, will be working with us as our principal consultant.

Another resident's conference is scheduled for January. This will be devoted to a three-part discussion of evaluation: 1. Evaluation of residents as students; 2. Program evaluation (accreditation, etc.); and 3. The role of residents in evaluating others. The thirty six residents from the major medical specialties will be attending.

Finally, Dr. Cooper reported on the Association's planning for a task force to study the professional education of the physician. This would follow the completed task force studies on continuing medical education and graduate medical education. We are hopeful that necessary funding for that project will be acquired from a foundation.

At the conclusion of his report, Dr. Cooper recognized Marjorie Wilson and Joe Keyes on the occasion of their ten year anniversary on the AAMC staff and thanked them for their contributions.

III. Program Session

Dr. Cornelius Pings, Director of the National Commission on Research and Vice Provost and Dean of Graduate Studies at the California Institute of Technology spoke on the relationship between academic research and the Federal government. He highlighted a number of the key recommendations appearing in the Commission's five subject reports. His primary theme was that there is no single overriding threat to the productive partnership between government and academia in the pursuit of science. Rather, the effort threatens to suffocate from the continuing accretion of conditions and requirements associated with government support.

IV. Quorum Call

Dr. Bondurant announced the presence of a quorum.

V. Chairman's Report

Dr. Bondurant began by mentioning the A-21 regulations and noting the involvement of the AAMC and the COD in efforts to improve them. He explained that efforts to seek further modification will be started in the near future. He urged the deans to accumulate experience as they attempt to comply with the regulations and to make any problems known to the AAMC.

Dr. Bondurant then discussed the report of the Association of Academic Health Centers entitled, "The Governance of Academic Health Centers." He characterized the recommendations in that report as being "global imperatives." Because of a concern among many deans and others, the Administrative Boards and Executive Council asked the leadership of the AAHC to meet with them. John Hogness, AAHC President, acted as spokesman and advised that the report had never been adopted by the Board of the AAHC. Dr. Hogness explained that it had been received as an information item, that there was no intent to act on it. He assured the Administrative Boards there was no intent that the recommendations be perceived as either global or imperative. In fact, Dr. Hogness pointed out that on the inside cover of the document itself was the statement that the report did not represent the position of the AAHC nor had it been acted on or endorsed by the governing body of the AAHC.

The next item Dr. Bondurant brought up was a description of the follow-up of the 1980 COD Spring Meeting. There were a number of issues concerning the interface between undergraduate and graduate medical education that were left unaddressed. These issues were referred by the COD Board to the task force on the general professional education of the physician. The Administrative Board had decided that this represented the most desirable approach for managing the issues in context and comprehensively.

Dr. Bondurant reported that it was the current thinking of the AAMC not to generate a global, comprehensive, point-by-point response to the GMENAC Report. Rather an agenda item at the Officers' Retreat scheduled for December would be to discuss an outline of a brief AAMC response to the GMENAC Report.

Dr. Bondurant concluded by reporting on his meeting the previous evening with the OSR officers. He described the OSR officers as vibrant, strong and interested students. Issues which they choose to address during the coming year include possible additions to the curriculum in medical schools, modifications of the educational process, questions concerning the role of national boards, GMENAC, and student financial aid.

VI. Consideration of Minutes

The minutes of the April 9 and April 12, 1980, Spring Business Meetings held at the Hilton Inn & Conference Center at Inverrary in Ft. Lauderdale, Florida, were approved as submitted.

VII. Consideration of Assembly Action Items

A. Election of Institutional Members

The Council of Deans on motion, seconded and carried, recommended the election of the Uniformed Services University of the Health Sciences School of Medicine, the University of Nevada School of Medical Sciences, and Wright State University School of Medicine to Full Institutional Membership by the AAMC Assembly.

B. Election of Distinguished Service Members

Dr. William Deal, who was among the candidates for election to Distinguished Service Membership, removed his name from the list because he had recently reassumed his position as Dean at the University of Florida College of Medicine.

The Council of Deans on motion, seconded and carried, recommended that the AAMC Assembly elect the following persons to Distinguished Service Membership:

Theodore Cooper
Frederick C. Robbins

C. Report of the Nominating Committee and Election of Officers

On recommendation of its nominating committee and on motion, seconded and carried, the Council of Deans elected William H. Luginbuhl, M.D., University of Vermont College of Medicine, as its Chairman-Elect, and David R. Challoner, M.D., Dean, St. Louis University School of Medicine, as Member-at-Large of the Council of Deans Administrative Board.

In a subsequent action, the Council endorsed the recommendation of its nominating committee that the Assembly elect:

Chairman-Elect of the Assembly--Thomas K. Oliver, Jr., M.D.
Chairman, Department of Pediatrics,
Children's Hospital of Pittsburgh

Council of Deans Representatives to the Executive Council--
Edward J. Stemmler, M.D., Dean, University of Pennsylvania School of Medicine
Richard H. Moy, M.D., Dean & Provost, Southern Illinois University School of Medicine
Richard Janeway, M.D., Dean, Bowman Gray School of Medicine of Wake Forest University
John W. Eckstein, M.D., Dean, University of Iowa College of Medicine

VIII. Discussion Items

A. A Comparative Analysis of Selected Health Manpower Proposals

Dr. Edward Stemmler presented a brief description of the current health manpower scene. A comprehensive chart outlining the comparisons and contrasts between the Current Law, the Kennedy/Schweiker Bill, and the Waxman Bill was contained in the agenda.

Dr. Stemmler recalled that the work of the Task Force in Support of Medical Education had begun three years ago. The approach selected was to develop a draft document which received preliminary endorsement of the AAMC. This document guided our discussion and testimony on the legislation that had been drafted for consideration. Both the House and Senate had passed bills which would come up for conference in mid-November. A letter had been sent to the conferees. It acknowledged the reaffirmation of the Federal government's role in the support of medical education; proposed a compromise on the two differing positions of the House and Senate; and urged that capitation be continued through fiscal '81 as a means of phasing in the new National Incentive Priority Grant Program, the Senate enacted replacement of the capitation grants.

The Association supported the continuation of the exceptional financial need student assistance program and the modifications of the HEAL program, which is contained in both bills. Since the sole lender for HEAL, the Chase Manhattan Bank, has decided not to lend additional funds under the current interest limitations, the AAMC supported raising the interest ceiling to make those funds available. The Association also supported the service contingent loan program.

In the Senate bill, there is proposed a reduction in the authorized funding for the National Health Service Corps scholarships and the creation of a state service scholarship program as well as some modification in the repayment of loans provided to the students. The Association supports all these elements.

The Association had taken a strong position against the extension of the period during which the VQE requirement would be waived; however, we also took the position that it is proper for alien physicians in this country to remain here until they can complete their specialty training. The AAMC also supported the concept that National Health Service Corps personnel may be assigned to certain hospitals in urban areas that are badly in need of personnel, but not for training purposes.

In addition, the Association opposed the introducion of federal support for chiropractic programs and recommended against the continuation of the GMENAC as a statutory body.

Dr. Bondurant thanked AAMC staff members Dr. Tom Kennedy and Mary McGrane and Task Force Chairman, Dr. Ed Stemmler, for their work on this legislation.

B. Health Research Legislation

Dr. Robert Berliner spoke on this item before the Council of Deans. Both Houses of Congress had passed health legislation bills which differ in their provisions, but the major item of conern related to the proposal in the House bill to require authorizations in time and amount for each of the Institutes on a three year cycle (with a provision to extend to a fourth year in case the reauthorization should not occur in time at the end of the third year). The House bill would eliminate the authority of the Congress to appropriate funds under the authority of Section 301 of the Public Health Act, which has been the only thing that saved the appropriations in the Heart & Cancer Institute on several occasions.

A major concern about the House bill is that it acts as an invitation to the Congress to hang various pet projects on the legislation each time it comes up. For example, since 1969 more than 200 earmarks had been put on the funds for the National Science Foundation during the reauthorization process. Most of these were pet projects of single representatives.

Prior to the recent adjournment of Congress when there was a possibility that a conference might be held between the House and Senate conferees, a meeting was arranged by Senator Kennedy with representatives from the Association of American Universities and others. The group was unanimous in urging that Senator Kennedy stand fast for the Senate version of the legislation. The only preferred alternative to that, the group suggested, was that there be no bill at all. A third possibility was also considered: a single authorization for the NIH, renewable on a seven year cycle, with retention of the 301 authority as a back-up.

Finally, Dr. Berliner encouraged the Council members to communicate with their Congressional representatives, particularly those who are on the Conference Committee, strongly urging the position that the periodic reauthorization in time and amount for the Institutes would be a very serious mistake.

Discussion centered on what would happen if the two bills came to an impasse. It was the opinion of Dr. Kennedy that if the manpower bill came to an impasse, support could continue under a continuing resolution. If there were an impasse on the research bills, nothing detrimental would happen to the Institutes because Section 301 authorities give them operating authority under which funds could continue to be appropriated.

C. Committee on the Identification of the Unique Characteristics of the Teaching Hospital

Mark Levitan, Director of the University of Pennsylvania Hospital, chairman of this committee, presented a report to the Council. As background, he explained that the committee grew out of a 1979 COTH meeting in which several discussion workshops concluded that the term teaching hospital encompasses institutions with very significant differences in patient service and in educational roles. These differences resulted in wide variation in costs across teaching hospitals. The committee's task was to study the characteristics of the teaching hospitals in qualitative and quantitative terms attempting to construct either homogeneous groupings of hospitals or some kind of continuous distribution which would measure the intensity and complexity as well as other characteristics.

The committee met to provide direction to the AAMC staff who had prepared a paper on patient case mix which dealt with the question of output measures within hospitals. At the first meeting, the committee made four recommendations: (1) that the AAMC staff continue to monitor case mix researchers and reimbursement experiments focusing on patient diagnosis; (2) that the AAMC sponsor a workshop to explore the major issues in case mix measurement and reimbursement; (3) that the AAMC obtain appropriate data to evaluate the health care financing administration assumptions for constructing a case mix index describing hospital intensity; and (4) that the AAMC staff develop a comprehensive work plan for studying the characteristics and costs of teaching hospitals.

At its second meeting, the committee approved the study of the characteristics and costs of teaching hospitals with five objectives: (1) to describe teaching hospitals in terms of the types of patients treated, the patient education and research services provided, and the financial resources required for their operation; (2) to examine the DRGs developed at Yale as a means of describing patient case mix; (3) to build a data base permitting an assessment of third-party efforts to quantify the intensity of patient case mix; (4) to identify significant differences between teaching hospitals which may be used to separate them into relatively homogeneous groups, and (5) to describe the extent to which differences in types of patients treated and the kinds of programs and services provided.

The study was structured so as to select a sample of thirty teaching hospitals. That study is underway with some preliminary reports expected in late May. Mr. Levitan concluded by acknowledging the excellent efforts of Dr. Jim Bentley and Mr. Peter Butler of the AAMC staff.

D. Committee on Competition

Dr. Robert Tranquada, chairman of the Ad Hoc Committee on Competition, presented a preliminary progress report to the Council. The role of the committee is to assess the potential impact of competition on teaching hospitals, to develop and recommend AAMC policy on competition, to identify alternative initiatives that individual institutions might undertake in a price competitive market and to consider legislative initiatives for the AAMC.

While the committee has only met once, the AAMC staff has produced a factual initial draft document outlining a number of the considerations involved. The committee now has to begin to consider some quantitative notions.

E. Accreditation Committees Reorganized

Mr. Charles Womer, AAMC Chairman, highlighted a couple of points not contained in the description in the agenda book. First, the implementation date proposed for the new ACGME and ACCME is January 1, 1981. The ABMS, although it doesn't have a meeting scheduled until February or March, is going to proceed on the basis that all of the sponsoring organizations agree with the reorganization.

A second point was the staffing of the ACGME. It was agreed that AMA would staff that agency under a written agreement for 18 months. Following this period, the quality of the staffing would be evaluated and if inadequate, ACGME would be free to enter into an agreement with another sponsoring organization to staff it.

Mr. Womer reported that during the meetings that were held there seemed to be a sincere effort among the representatives to make the accreditation process work. Although a number of compromises had to be made, all groups were willing to make them.

IX. Information Items

Several information items were contained in the agenda. These included: Medical Sciences Knowledge Profile Program, Universal Application Form for Graduate Medical Education, External Examination Review Committee, General Accounting Office Study of U.S. Citizens in Foreign Medical Schools, Clinical Laboratory Regulation, Disposal of Hazardous Wastes, Graduate Medical Education National Advisory Committee's Report, and Medicare's Altered Policy on Reimbursement of "Moonlighting" Residents. Dr. Bondurant asked for comments from the floor on any of the items and hearing none he proceeded to old and new business.

X. New Business

A. Adoption of Statement Regarding Action of Board of Regents of the University of the State of New York

Dr. Bondurant directed the members' attention to the resolution which had been handed out. This statement opposed the recent policy adopted by the Board of Regents of the University of the State of New York to accredit certain foreign medical schools. The New York deans had proposed a couple of modifications in the statement so Dr. Bondurant read those to the Council. After some discussion, the deans offered a few minor suggestions altering the language.

One concern expressed was the possible implication in the statement that the present accrediting system could not only accredit national schools in the United States but other schools as well. Dr. Bondurant responded that the language was deliberately chosen to avoid the assertion that there was no possible way a foreign school could be accredited.

In regard to the legal aspect of New York State accrediting certain foreign medical schools, Dr. Bondurant explained that the states have the legal authority and responsibility to charter institutions. Some states are silent with respect to accreditation. Other states may have language with respect to accreditation, but the states have opted, so far, to place primary reliance on the professional and regional accrediting agencies. Thus throughout higher education, the weight of practice is very heavily on the side of the accreditation process being a private sector activity.

Because this statement had to be formulated so quickly, it was suggested that considerable authority be given to the Council of Deans Administrative Board or Executive Council to develop the final language which supported a well-reasoned argument, based upon, but not necessarily limited to, the wording in this specific statement. On motion, seconded and carried, this was passed by the Council.

The statement of the AAMC Assembly regarding the policy of the Board of Regents of the University of the State of New York to accredit certain foreign medical schools as it was passed at its Annual Meeting on Tuesday, October 28, 1980, is appended to these minutes.

B. Proposed Regulations of National Association of Independent Colleges and Universities

Dr. Alvin Sutnick brought this item to the Council's attention. He had recently received some information from the National Association of Independent Colleges and Universities that regulations were under development which relate the selection of candidates for the National Health Service Corps to the level of tuition of the medical schools they attend. This favors students who attend schools with lower tuitions and works to the detriment of those students who attend schools with higher tuitions. This is especially a serious threat to the students in the private medical schools, particularly those schools in states that do not generously support medical education.

Since the AAMC had recently been informed of this and was in the process of tracking it, it was decided that the staff would make a determination as to the implications of this and thus design a plan of action on this matter.

C. Appreciation

Dr. Bondurant thanked Dr. Neal Gault, whose term on the Board was expiring, for his six years of devoted and significant service to the COD Administrative Board and presented him with a gift as a token of appreciation. Dr. Bondurant also recognized Dr. Ted Cooper's membership on the Administrative Board for the past year.

Before relinquishing the gavel as chairman of the Council of Deans, Dr. Bondurant reiterated that during his tenure of the past fifteen months, he realized that the need and potential of the COD is greater than ever; clearly the task of coordinating the efforts of medical schools is becoming even more complex, but he pledged the continued support of the members of the COD to Dr. Steven Beering, who at that time rose to assume the chair.

Dr. Beering, as his first order of business, recognized the tireless efforts and devoted leadership which Dr. Bondurant exercised during his tenure as chairman. Dr. Beering then presented him with an engraved gavel as a token of appreciation for his many contributions.

Dr. Beering then spoke to the Council regarding the 1981 COD Spring Meeting, explaining that the planning committee was constructing the agenda of issues for discussion at that meeting. The program was tentatively titled, "Crosscurrents of the Eighties," and in addition to the formal presentation, several items would be discussed at the business meeting.

He then recognized Dr. Lammers, Dean of the Medical School at Froningen, Netherlands, and also Chairman of the two year old organization, the Association of Medical Deans in Europe. Dr. Lammers expressed his appreciation for the opportunity to observe the Council's meeting and consequently invited Dr. Beering, as a representative of the AAMC's Council of Deans, to attend their next meeting in Madrid, Spain, in September 1981.

XI. Adjournment

The meeting was adjourned at 5:15 pm.

STATEMENT OF THE ASSEMBLY OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ADOPTED AT ITS ANNUAL MEETING, TUESDAY, OCTOBER 28, 1980

The Assembly believes that the policy adopted by the Board of Regents of the University of the State of New York to accredit certain foreign medical schools will be an inducement to many students to seek a less than adequate professional educational experience. The policy will inevitably degrade the quality of care available to the people of New York and potentially the nation.

The new accreditation policy will grant privileges in New York to students from foreign medical schools equivalent to those afforded medical students in the United States medical schools. The Assembly does not believe that the evaluation of foreign medical schools, proposed by the Board of Regents of the State of New York, could possibly be as effective as the national accreditation process. The Assembly supports the maintenance of a single national standard and system for evaluating and accrediting medical schools.

The process contemplated by the Board of Regents of the State of New York would be based on an evaluation of responses to a questionnaire and in some cases a site visit paid for by the institution being accredited. National accreditation decisions are based on a time-tested process involving an extensive review of observations and evaluations by a panel of experts.

All medical schools in the United States are organized as, or part of, non-profit institutions. The Assembly believes that accreditation by the Board of Regents of the State of New York will be sought primarily by foreign for-profit schools dedicated to recruiting U.S. citizens as students, and that those granted accreditation will use the imprimatur of the Board of Regents of the State of New York to enhance their recruiting efforts.

The Assembly believes that the policy is not in the public interest and that it ought to be reconsidered.

A SINGLE ROUTE TO LICENSURE

(Status Summary)

Based upon the National Board of Medical Examiners' 1973 decision to implement its Goals and Priorities Committee's recommendation that there should be a qualifying exam at the interface between undergraduate and graduate medical education, the Federation of State Medical Boards is proposing to have its constituent medical licensing boards adopt a "single route to licensure." To be precise, the proposal should be termed a single examination route to licensure because the basic principal is that all physicians to be licensed to practice will have to pass the same sequence of examinations. The characteristics and qualifications of the faculty granting the degree will not be considered.

The first examination in the sequence (FLEX I) will be at the interface between undergraduate and graduate medical education. Its purpose is to ensure that graduates have the clinical competencies needed to assume limited responsibility for patient care in a supervised graduate medical education program. FLEX I will be given between February and April of the senior year. The second examination (FLEX II) will be required to obtain an unrestricted license to practice. It will be available to candidates after the completion of one or two years of graduate medical education.

A corollary of the Federation's proposal is that the National Board's diploma, awarded on the basis of having passed Parts I, II and III of the Board's certification sequence and having graduated from an LCME accredited medical school, will no longer be accepted by the Federation's constituent boards as an alternative licensing credential.

The NBME and the Federation have been working closely together. The Board's Comprehensive Qualifying Examination (CQE) is planned to be FLEX I. To date, both organizations have adopted the posture that policies for medical licensure are totally the responsibility of the several licensing boards and the Federation is proceeding on their behalf. NBME officials express the position that the Board concurs with the need for the FLEX I-II sequence and is willing to provide the CQE examination to the Federation. Surprisingly, the Board's officials have not been concerned about the eventual loss of recognition of their diploma by licensing boards. Recently the Board did announce its intention to continue to grant a diploma to graduates of LCME accredited schools who have passed Part I and FLEX I-II. However, the value of the diploma as a licensure credential is unclear. The Board's announced intention appears to be to mollify those who are concerned about the loss of the Part I examination.

The Association's 1975 response to the GAP Committee Report (attached) has been viewed as AAMC support for a single route to licensure. However, a review of that response shows that the Association wanted the passage of Parts I and II of the National Board sequence to be considered equivalent to the passing of a qualifying exam. The Association also recommended that

the LCGME, and not the state boards, be the agency requiring the examination. The concept of a "single route to licensure" was not debated during the preparation of the Association's response to the Goals and Priorities Committee report.

At the 1981 Council of Academic Societies Interim Meeting, the National Board and the Federation presented their proposal. Nearly a day-and-a-half was devoted to a discussion of the proposal by 62 CAS representatives from 51 societies. Representatives were provided an opportunity to examine a sample of 330 representative questions that have been selected for the FLEX I examination.

In developing the specifications for the FLEX I examination, the NBME identified five abilities and selected ten tasks. These were formed into a 50 cell grid (attached). Inspection of this grid reveals that only 12 cells are amenable to evaluation by written examination. The remaining 38 require evaluation by competent faculties through repeated direct observations of students in a variety of educational settings. This finding is a major cause for concern for U.S. medical schools. It means that the proposed single route to licensure will neglect the role faculties play in determining who will be granted a medical degree. Passing the FLEX I-II examination sequence will provide the same licensure to practice medicine to graduates of the burgeoning foreign-chartered schools and graduates of accredited U.S. schools, but the U.S. graduates will have met a different standard.

The specifications and content of FLEX II have not been developed or determined. The CAS representatives attending the meeting expressed the view that the FLEX I sample of questions lacked a rigorous emphasis on the basic sciences. It is quite possible that FLEX I will be significantly less rigorous than Parts I and II of the present National Board certification sequence.

The goal of the CAS Interim Meeting was to open a discussion between medical school faculties, the Federation and the Board. In their rush toward a "single route to licensure," both of these organizations appear to have forgotten the historical relationship between them, the medical schools and their faculties. The faculties share their interest in ensuring that the privilege to be a physician and practice medicine is granted only to those who are fully qualified. The findings of the meeting reinforced the essential role that faculties play in evaluating the achievement of medical students as they progress through their curricula.

A major factor impelling the Federation toward the single route proposal is the explosive growth in the number of U.S. citizen graduates of foreign-chartered schools. Many in this group are aggressively litigious. The Federation believes that the single route to licensure will protect their member boards from legal challenge because all physicians will have to pass the same examination to be licensed. Presently, 75-85% of U.S. graduates become licensed by endorsement of their NBME diploma. Foreign graduates must pass the Federation Licensing Examination.

The Association's Ad Hoc External Examinations Review Committee, chaired by Carmine Clemente, Ph.D., Director of the Brain Research Institute at UCLA, has endorsed the proposition that all physicians should meet the same standard for licensure. However, the committee is moving toward the concept that different methods of evaluation are needed to determine if the standard is met. The methods must be varied depending upon the characteristics of the institutions and the educational programs which lead to the awarding of the degree. For graduates of schools not accredited by the LCME a method must be used to evaluate whether the skills, attitudes, and behaviors contained within the 38 cells of the 50 cell grid have been attained.

The schedule for the implementation of FLEX I-II is not firm. The NBME began the development of a new collaborative approach to test question development in 1980. This approach, which provides for collaboration between clinicians and basic scientists, is supposed to provide test items in the basic sciences with clinical relevance. Two or more years may be needed to complete this effort. Meanwhile, it is hoped that the discussion begun at the CAS Interim Meeting will be enlarged and that all of the ramifications of the proposed "single route to licensure" will be fully explored.

Attachments

Installation of the Chairman

Dr. Mellinkoff presented the gavel to Dr. Leonard W. Cronkhite, Jr., the new AAMC chairman. In accepting, Dr. Cronkhite expressed the Association's appreciation and thanks for Dr. Mellinkoff's dedicated leadership and sense of humor during his year as chairman.

Adjournment

The Assembly was adjourned at 4:05 p.m.

Addendum

Response of the AAMC to the Principal Recommendations of the Goals and Priorities Committee Report to the National Board of Medical Examiners

The Association of American Medical Colleges has long been engaged in furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals, and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This is a response to the National Board of Medical Examiners' Goals and Priorities (GAP) Committee report entitled, "Evaluation in the Continuum of Medical Education."

The responses recommended in this document are a consensus derived from a task force report which provided the basis for extensive discussion and debate by the Councils, the Organization of Student Representatives, and the Group on Medical Education. The consensus was achieved through deliberation by the Executive Council and is now presented to the Assembly for ratification.

On the assumption that the report of the Goals and Priorities Committee, "Evaluation in the Continuum of Medical Education," has been widely read, an extensive review and analysis is not provided here. The report recommends that the NBME reorder its examination system. It advises that the board should abandon its traditional three-part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam "Qualifying A," and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as "Qualifying B." This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: (*a*) assist individual medical schools in improving their capabilities for intramural assessment of their students; (*b*) develop methods for evaluating continuing competence of practicing physicians; and, (*c*) develop evaluation procedures to assess the competence of "new health practitioners."

Responses

1. The AAMC believes that the three-part examination system of the National Board of Medical Examiners should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education.

2. The AAMC recommends that the National Board of Medical Examiners should continue to make available examination materials in the disciplines of medicine now covered in Parts I and II of the National Board exams, and further recommends that faculties be encouraged to use these materials as aids in the evaluation of curricula and instructional programs as well as in the evaluation of student achievement.

3. The AAMC favors the formation of a qualifying exam, the passing of which will be a necessary, but not necessarily sufficient, qualification for entrance into graduate medical education programs.

Passage of Parts I and II of the National Board examination should be accepted as an equivalent qualification.

The following recommendations pertain to the characteristics and the utilization of the proposed qualifying exam: (*a*) The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed. (*b*) The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas. (*c*) The exam should be criterion-referenced rather than norm-referenced. (*d*) Test results should be reported to the students taking the exam, to the graduate programs designated by such students, and to the schools providing undergraduate medical education for such students. Item analyses and other aggregate data should be made available to institutions desiring to assess their curricula and educational programs. (*e*) The exam should be administered early enough in the students' final year that the results can be transmitted to the program directors without interference with the National Intern and Resident Matching Program. (*f*) Students failing the exam should be responsible for seeking additional education and study, and medical schools should be encouraged to provide the additional academic assistance if students so request. (*g*) Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the United States.

4. The AAMC doubts that medical licensure bodies in all jurisdictions will establish a category of licensure limited to practice in a supervised education setting. Therefore, the AAMC recommends that the Liaison Committee on Graduate Medical Education should require that all students entering accredited graduate medical education programs pass the qualifying exam. The LCGME is viewed as the appropriate agency to implement the requirement for such an exam.

5. The AAMC should assume leadership in assisting schools to develop more effective student evaluation methodologies and recommends that the Liaison Committee on Medical Education place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

6. The AAMC recommends that the LCGME and its parent bodies take leadership in assisting graduate faculties to develop sound methods for evaluating their residents, that each such faculty assume responsibility for periodic evaluation of its residents, and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are ready to be candidates for board exams.

7. The AAMC recommends that physicians should be eligible for full licensure only after the satisfactory completion of the core portion of a graduate medical educational program.

Proposed Comprehensive Qualifying Evaluation Program

ABILITIES / TASKS	A Knowledge & Understanding	B Problem Solving & Judgment	C Technical Skills	D Interpersonal Skills	E Work Habits & Attitudes
1. Taking a History	1-A EXAM	1-B EXAM	1-C	1-D RATINGS INTERACT. ASSESS.	1-E RATINGS
2. Performing a Physical Examination	2-A EXAM R	2-B EXAM R	2-C SIM. LAB. RATINGS CHECK LISTS	2-D RATINGS INTERACT. ASSESS.	2-E RATINGS
3. Using Diagnostic Aids	3-A EXAM ATI	3-B EXAM ATI	3-C SIM. LAB. RATINGS CHECK LISTS	3-D RATINGS	3-E RATINGS
4. Defining Problems	4-A EXAM NG	4-B EXAM NG	4-C (NYI)	4-D (NYI)	4-E RATINGS
5. Managing Therapy	5-A EXAM S	5-B EXAM S	5-C SIM. LAB. RATE CHECK LISTS	5-D RATINGS INTERACT. ASSESS.	5-E RATINGS
6. Keeping Records	6-A RATINGS R	6-B (NYI) R	6-C	6-D	6-E RATINGS
7. Employing Special Sources of Information	7-A RATINGS ATI	7-B RATINGS ATI	7-C (NYI)	7-D RATINGS	7-E RATINGS
8. Monitoring & Maintaining Health	8-A EXAM NG	8-B EXAM NG	8-C	8-D RATINGS	8-E RATINGS
9. Assuming Community & Professional Responsibilities	9-A RATINGS S	9-B RATINGS S	9-C (NYI)	9-D RATINGS	9-E RATINGS
10. Maintaining Professional Competence	10-A RATINGS	10-B RATINGS	10-C RATINGS	10-D RATINGS	10-E RATINGS

Abbreviation	Proposed Type of Evaluation
EXAM	= Comprehensive Qualifying Examination
CHECKLISTS	= Ratings made by faculty or other trained observers while observing a specific event such as a physical examination of an adult patient
RATINGS	= Ratings over time by faculty, nurses, or other health personnel, and/or patients and patients' families of performance

Abbreviation	Approaches to Evaluation
INTERACT ASSESS	= Direct observation of verbal interaction of student/patient or student/simulator pairs
SIM LAB	= Observation of specific types of performance in a simulation laboratory using various mechanical devices

(NYI) = None identified yet; i.e., no competencies have been identified yet for this cell of the matrix

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