

- ✓ David C. Dale, M.D., Dean  
University of Washington School of Medicine
- Richard DeVaul, M.D., Dean  
West Virginia University School of Medicine
- ✓ David B. Hinshaw, M.D., Dean  
Oral Roberts University School of Medicine
- Marten M. Kernis, Ph.D., Acting Executive Dean  
University of Illinois College of Medicine
- Donald W. King, M.D., Vice President for the Medical  
Center and Dean, The Pritzker School of Medicine
- ✓ Walter F. Leavell, M.D., Dean  
Meharry Medical College
- ✓ Leah Lowenstein, M.D., D. Phil., Vice President and Dean  
Jefferson Medical College
- ✓ Robert C. Neerhout, M.D., Acting Dean  
Oregon Health Sciences University
- Richard L. O'Brien, M.D., Dean  
Creighton University School of Medicine
- Dominick P. Purpura, M.D., Associate Vice President for  
Medical Affairs and Dean, Stanford University  
School of Medicine
- Robert H. Quinn, M.D., Acting Dean  
University of South Dakota School of Medicine
- Perry G. Rigby, M.D., Dean  
Louisiana State University School of Medicine
- Rudi Schmid, M.D., Dean  
University of California-San Francisco  
School of Medicine
- Richard H. Schwarz, M.D., Interim Dean  
State University of New York, Downstate Medical Center
- ✓ John R. Tobin, Jr., M.D., M.S., Dean  
Loyola University-Chicago, Stritch School of Medicine
- Manuel Tzagournis, M.D., Vice President for Health Affairs  
and Dean, Ohio State University College of Medicine
- ✓ Robert H. Waldman, M.D., Acting Dean  
West Virginia University School of Medicine
- ✓ Peter A. Ward, M.D., Interim  
University of Michigan Medical School

✓ Annual Mtg Breakfast

- In attendance at COD Orientation 18

## NEW DEANS' ORIENTATION

Tuesday, April 5

and

Wednesday, April 6

The Cottonwoods  
Scottsdale, Arizona

TUESDAY, APRIL 5

5:00 pm - 6:00 pm

Canyon Room A

Welcome and Overview of the AAMC

*John A. D. Cooper, M.D.*  
*President, AAMC*

*John F. Sherman, Ph.D.*  
*Vice President, AAMC*

Organization of the AAMC & Relations with Other Groups

*Steven C. Beering, M.D.*  
*Chairman, AAMC*

6:00 pm - 7:00 pm

Sonora Room &  
Courtyard

RECEPTION

*Open to new deans, participants in the orientation session, and spouses.*

WEDNESDAY, APRIL 6

9:00 am - 12 Noon

Canyon Room A

AAMC Staff Discussions of Issues and Programs

*Joseph A. Keyes, Jr.*  
*Director, Department of Institutional Development*

*August G. Swanson, M.D.*  
*Director, Department of Academic Affairs*

*Richard M. Knapp, Ph.D.*  
*Director, Department of Teaching Hospitals*

*Thomas J. Kennedy, Jr., M.D.*  
*Director, Development of Planning & Policy Development*

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NEW DEANS INVITED

- *Evangelos Angelakos, M.D., Ph.D., Interim Dean  
Hahnemann Medical College*
- *Henry Banks, M.D., Dean  
Tufts University School of Medicine*
- ✓ *William P. Bristol, M.D., Dean  
Mercer University School of Medicine*
- ✓ *Colin Campbell, M.D., Provost and Dean  
Northeastern Ohio Universities College of Medicine*
- ✓ *Arthur C. Christakos, M.D., Dean  
Duke University School of Medicine*

Saturday, April 9th

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SESSION VI

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8:30 am-12 noon, Ballroom

COD BUSINESS MEETING

12 noon

ADJOURNMENT

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PROGRAM PLANNING COMMITTEE

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Richard Janeway, M.D.  
Edward J. Stemmler, M.D.  
William H. Luginbuhl, M.D.  
Fairfield Goodale, M.D.  
Louis J. Kettel, M.D.



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ASSOCIATION OF  
AMERICAN MEDICAL  
COLLEGES

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COUNCIL OF DEANS  
SPRING MEETING

*Program*

April 6-9, 1983  
*The Cottonwoods*  
Scottsdale, Arizona

1983

SPRING MEETING  
of the  
COUNCIL OF DEANS

April 6-9, 1983

*The Cottonwoods*

PROGRAM

Wednesday, April 6th

1:00-5:00 pm, Hotel Center

ARRIVAL & REGISTRATION

SESSION I

5:30-7:00 pm, Ballroom

WELCOME & PRELUDE  
TO COD BUSINESS MEETING

PRESIDENT'S REPORT  
John A.D. Cooper, M.D.

7:00-8:30 pm, Sonora Room Court Yard

RECEPTION

Thursday, April 7th

SESSION II *Luginbuhl*

8:30-10:30 am, Ballroom

AN OMB PERSPECTIVE  
Kenneth W. Clarkson, M.D., *Associate Director*  
OMB for Human Resources, Veterans & Labor

EXTRAMURAL RESEARCH INTERESTS OF;  
THE ARMY:

Maj. Gen. Garrison Rapmund  
*Commander U.S. Army*  
Medical Research & Development Command

THE NAVY:

Robert Newburg, Ph.D.  
*Leader of Biological Sciences*  
Office of Naval Research

10:30-11:00 am, Ballroom

BREAK

SESSION III *Clawson*

11:00-1:00 pm, Ballroom

ISSUES IN MEDICARE REIMBURSEMENT  
Donald Young, M.D., *Deputy Director*  
Bureau of Program Policy,  
Health Care Financing Administration

IMPLICATIONS OF PROSPECTIVE PAYMENT  
Truman Esmond, *President*  
Health Charge, Inc.

1:00-5:00 pm

UNSCHEDULED TIME

OPTIONAL:

2:00-4:30 pm, Canyon Room A  
MICROCOMPUTER WORKSHOP  
University of Arizona, Office of Medical  
Education

5:00-6:30 pm, Ballroom

A MEDICAL CENTER UNDER SIEGE  
Raja Khuri, M.D., *Dean*  
American University of Beirut

Friday, April 8th

SESSION IV *Stemaler*

8:30-10:30 am, Ballroom

EXPERIMENTS ON THE INTEGRATION  
OF THE UNIVERSITY  
AND MEDICAL EDUCATION

Alfred E. Gellhorn, M.D., *Director Emeritus*  
Sophie Davis School of Biomedical Education

A LAYMAN'S VIEW OF THE  
MEDICAL EDUCATION EXPERIENCE

Donald Drake, *Science Writer*  
The Philadelphia Inquirer

10:30-11:00 am, Ballroom

BREAK

SESSION V *Jancusky*

11:00-1:00 pm, Ballroom

THE GENERAL PROFESSIONAL  
EDUCATION OF THE PHYSICIAN

Steven Muller, Ph.D., *President*  
The Johns Hopkins University and Hospital  
William P. Gerberding, Ph.D., *President*  
University of Washington

Members of the Panel

1:00-6:00 pm

UNSCHEDULED TIME

OPTIONAL:

2:00-4:30 pm, Canyon Room A  
MICROCOMPUTER WORKSHOP  
University of Arizona  
Office of Medical Education

3:30-4:30 pm, Ballroom

NBC NEWS SPECIAL REPORT  
"To Be A Doctor"

VA SUPERVISION; GAO

IN PREPARATION FOR THIS MEETING, JOE MAILED TO YOU A SET OF THREE DOCUMENTS INDICATING THAT I WOULD BE DISCUSSING THEM AT THIS TIME. THE DOCUMENTS ARE A MARCH 3RD LETTER FROM SENATOR ALAN CRANSTON TO THE CONTROLLER GENERAL OF THE UNITED STATES REQUESTING A STUDY OF THE ADEQUACY OF THE SUPERVISION OF SURGICAL RESIDENTS IN VA MEDICAL CENTERS; A NEWSPAPER ACCOUNT OF A PROBLEM WHICH AROSE AT THE CHARLESTON, SOUTH CAROLINA MEDICAL CENTER; AND THE VA CIRCULAR 10-81-107 WHICH PROVIDES GUIDELINES FOR THE PROPOSED SUPERVISION OF SURGICAL RESIDENTS.

YOU WILL FIND ON YOUR RETURN FROM THIS MEETING A LETTER FROM DON CUSTIS (THE CHIEF MEDICAL DIRECTOR OF THE VA), PERSONALLY ADDRESSED TO EACH OF YOU WHO CHAIRS A DEAN'S COMMITTEE. THIS LETTER WILL HAVE AS ATTACHMENTS THE SAME MATERIAL I HAVE ALREADY DISTRIBUTED TO YOU. I SCOOPED CUSTIS ON THIS IN ORDER THAT YOU WOULD HAVE THE FULL BACKGROUND ON THIS ISSUE IN TIME FOR A DISUCSSION AT THIS MEETING.

I CONSIDER IT OF THE UTMOST IMPORTANCE THAT EACH OF YOU TAKE THIS MATERIAL WITH THE GREATEST SERIOUSNESS AND PLACE A REVIEW OF YOUR PROCEDURES AT THE TOP OF YOUR PRIORITY LIST AFTER YOUR RETURN FROM THIS MEETING.

MARK NEWBERRY ABANDONED HIS PLANS TO STAY HOME FOR A BOARD MEETING SO THAT HE COULD BE PRESENT WITH US FOR THIS DISCUSSION. I THINK IT IS PROBABLY APPROPRIATE FOR ME TO STOP AT THIS POINT AND RECOGNIZE MARK FOR ANY OBSERVATIONS AND INSIGHTS HE MAY WISH TO OFFER.



**Veterans  
Administration**

In Reply Refer To: 14

As Chairman of the Deans Committee, I request your assistance. Enclosed is a copy of a letter from Senator Cranston, the Ranking Minority Member of the Veterans Affairs Committee, to the Controller General of the United States, asking that the General Accounting Office conduct a study of the adequacy of supervision of surgical residents in VA Medical Centers.

The Department of Medicine and Surgery is deeply concerned about these allegations. Although the instance may be isolated, the very fact that it could occur shows a failure of existing systems to uniformly insure adequate supervision of house staff. The Deans Committee responsibility for training includes oversight of integrated house staff programs within the VA Medical Center.

Please have your Deans Committee discuss the issue of house staff supervision at the VA Medical Center. Attached is a copy of circular 10-81-107 regarding supervision of surgical procedures performed by resident physicians. As part of your deliberation, please review this guidance provided by the Veterans Administration Central Office as well as the mechanisms for supervision which you are currently using to ensure adequate control. If additional guidance would be helpful, or, if your affiliation has developed additional unique or specific methods for assuring supervision, please share your suggestions with me. Feel free to communicate any concerns or suggestions you have regarding the generic issue of house staff supervision directly to my office.

Thank you in advance for your efforts in this area of mutual concern.

Sincerely,

DONALD L. CUSTIS, M.D.  
Chief Medical Director

Enclosures

HEW criterion is the one that is most widely applied in the community, the VA believes that it is appropriate and consistent to utilize that acceptable criterion rather than guidelines of the JCAH. Moreover, the VA must point out that it is the only one of these three organizations that delivers care nationwide, establishes guidelines, and enforces them by management decisions. (Appendix p. 244)

NAS Recommendation No. 13 - "The quality of surgical care in psychiatric hospitals is so poor that inpatient surgery in such hospitals should be eliminated." (NAS report, p. 283)

Summary of Official VA Position. The VA does not concur with this recommendation. The VA cannot accept the implication that elimination of surgery in psychiatric hospitals is the only option available. The VA agrees that quality surgical care must be provided and closing surgical services is a proper action when there is no other better alternative. The issue of the quality of surgical care in psychiatric hospitals has been of concern to the VA for the past several years and the VA has been evaluating the Surgical Services in its Psychiatric Hospitals on a regular basis. As a result, the number of surgical beds in these hospitals has been reduced and the Surgical Services in five hospitals have been closed. Throughout the VA system there are remaining only four such hospitals with a total of 97 surgical beds. One of these four hospitals uses local surgical consultants to perform the surgery.

NAS Recommendation No. 14 - "Surgery performed by residents should be supervised by a staff surgeon. A staff surgeon should be present for all regularly scheduled surgery. For emergency surgery, a staff surgeon should be in attendance in no less than 70 percent of cases. Appropriate procedures for monitoring and reporting on these requirements should be instituted." (NAS report, p. 283)

Summary of Official VA Position. The VA concurs with this recommendation. The VA acknowledges that the supervision of VA surgical residents should be improved. The VA believes, however, that it is not necessary for a senior surgeon to participate actively in all surgical procedures. What constitutes adequate supervision will vary with the skill and previous training of a particular resident physician. The VA also believes that a requirement that a senior surgeon be

present on 70 percent of all emergency cases is unrealistically high and cannot be substantiated on the basis of any data which indicates improved patient care or reduced mortality or morbidity. The VA will issue and strengthen the criteria and guidelines governing the proper supervision of surgical residents, as well as more aggressively monitor compliance.

#### Psychiatry Alternative Services

NAS Recommendation No. 15 - "Many VA psychiatric inpatients have been shown not to require hospitalization if alternative services are available. The Committee recommends that steps be taken for discharging such patients by placing special emphasis on developing and implementing alternatives to inpatient hospitalization including partial hospitalization, halfway houses, sheltered workshops, group homes, and cooperative apartments. To implement this program, the VA should conduct an early examination of its psychiatric patient services with a view to assessing patient care needs and corresponding requirements for staff. Furthermore, the relationship between VA services and community mental-health resources requires active planning for collaboration and, where appropriate, integration. In accomplishing these purposes, joint ventures should be undertaken with veterans organizations. In addition, the Committee recommends the expansion of mental-health outpatient facilities and personnel." (NAS report, p. 283)

Summary of Official VA Position. The VA concurs with this recommendation. Although the VA's efforts to reduce unduly prolonged hospitalization of psychiatric patients have met with remarkable success -- reducing the number of psychiatric beds in the VA system by nearly 50 percent in the past 10 years -- some inpatients would not require prolonged periods of hospitalization if alternative services were available. The use of extended-care facilities and outpatient activities, the characteristics of the hospitalized patients and the nature of the VA's responsibilities toward them, and the availability of appropriate resources are all important factors in this situation. The VA has plans to emphasize intensified efforts to create alternatives to hospitalization, including an assessment of current alternative programs and new forms of outpatient treatment. Most of the possible additional alternatives to hospitalization would require enabling legislation.

Excerpted from: Veterans' Administration's Response to the Study of Health Care for American Veterans: A Report to the Committee on Veterans' Affairs, U.S. Senate, September 22, 1977

SURGERY

## Recommendation No. 14

## Supervision of Surgery

NAS Recommendation: "Surgery performed by residents should be supervised by a staff surgeon. A staff surgeon should be present for all regularly scheduled surgery. For emergency surgery, a staff surgeon should be in attendance in no less than 70 percent of cases. Appropriate procedures for monitoring and reporting on these requirements should be instituted." (NAS report, p. 283)

Summary of Official VA Position. The VA concurs with this recommendation. The VA acknowledges that the supervision of VA surgical residents should be improved. The VA believes, however, that it is not necessary for a senior surgeon to participate actively in all surgical procedures. What constitutes adequate supervision will vary with the skill and previous training of a particular resident physician. The VA also believes that a requirement that a senior surgeon be present on 70 percent of all emergency cases is unrealistically high and cannot be substantiated on the basis of any data which indicates improved patient care or reduced mortality or morbidity. The VA will develop criteria and issue and strengthen the criteria and guidelines governing the supervision of surgical residents, as well as more aggressively monitor compliance.

Discussion

Although complimentary about the opportunities for training of surgical house staff in the VA system, the NAS expressed concern about the quality of supervision afforded to residents in these programs. In particular, the study was concerned that, in 69 percent of the operations performed by residents that the NAS reviewed, a senior surgeon was not actually involved in the operating room as the first assistant.

The VA agrees that the supervision of its surgical residents may be less than optimal in all instances, and has been attempting to correct these recognized difficulties. It appears that the requirement stated by the NAS that a senior surgeon scrub in as first assistant in all operations performed by residents is excessive to supervision or patient care needs. Adequate supervision does vary with the skill and previous training of a particular resident.

A meaningful approach to surgical resident supervision during performance of surgery thus consists of having the senior surgeon physically present and available in the vicinity of the operating room, and capable of taking over the surgical procedure if required. The degree of direct and supervisory involvement in the surgery will depend on the complexity of the operation and the level of training of the resident performing it. This approach to surgical resident supervision appears to be consistent with the standards used by Social Security Administration as stated in SSA Letter #372 concerning supervision of residents for Medicare reimbursement.

The VA will issue and strengthen the standards for the proper supervision of resident physician staff receiving training on all VA Surgical Services by January 1978.

Monitoring compliance with these established requirements of resident supervision will be the responsibility of the VA Central Office. These monitoring efforts will not only measure compliance with the guidelines, but also can be used to assess the adequacy of staff, equipment, and facilities on VA Surgical Services.



concentrate on improving its long term care programs in ways that will facilitate linkages with community facilities.

#### Hospital Care: General

The VA should examine the need to maintain general medical and surgical hospitals that experience a low number of applications per bed per year. The Committee recommends that, when the number of applications per bed per year falls below 20 the hospital should be closed or converted to a long-term care facility.

Rigorous procedures for admissions and utilization review should be developed and implemented within the VA system. VA hospitals should be part of the utilization-review, cost-control, and quality-assurance programs in force under PSRO and other legislation. The VA system can and should go beyond adherence to these programs and serve as a laboratory for developing, testing, and implementing more effective methods of utilization review and quality assurance. The Committee expects that this would result in substantial reduction in the numbers of acute-care beds being operated in VA hospitals (by at least 25% in 3 years).

#### Medicine

The internal-medicine services in psychiatric hospitals should be improved in quality. If this cannot be accomplished in a given institution, it is recommended that the professional services be purchased from a competent source, such as a local hospital or clinic or it should use the medical service of a nearby VA general hospital. The Chief Medical Director should report to the Congress in 2 years on the improvements made in these services.

#### Surgery

Patients considered for admission to the surgical service require more careful screening before admission. Emphasis should be on workup on an ambulatory basis with a view to reducing preoperative stay to 1 or 2 days in most cases. Dormitory, motel, or hotel accommodations paid for by the VA should be considered as a lower cost substitute for hospital admission while the patient is being studied. Facilities for outpatient surgery should be developed so as to reduce the use of inpatient care for minor procedures.

Cardiac surgery and kidney transplantation and associated diagnostic procedures should be concentrated in a smaller number of centers within the VA. Centers that do not meet JCAH standards for number of procedures and other requirements should be closed. It is expected that the number of kidney-transplant centers will not exceed 6 and that cardiac-surgery centers

will be reduced to 9. Consolidation of cardiac surgery into a few large centers is expected to bring about reduction in mortality from such surgery. When patients cannot be referred to a nearby consolidated VA center, they should be referred only to active, large centers outside the VA, with the VA paying for care exclusive of coverage by Medicare.

The quality of surgical care in psychiatric hospitals is so poor that inpatient surgery in such hospitals should be eliminated.

Surgery performed by residents should be supervised by a staff surgeon. A staff surgeon should be present for all regularly scheduled surgery. For emergency surgery, a staff surgeon should be in attendance in no less than 70% of cases. Appropriate procedures for monitoring and reporting on these requirements should be instituted.

## Psychiatry

### Alternative Services

Many VA psychiatric inpatients have been shown not to require hospitalization if alternative services are available. The Committee recommends that steps be taken for discharging such patients by placing special emphasis on developing and implementing alternatives to inpatient hospitalization including partial hospitalization, halfway houses, sheltered workshops, group homes, and cooperative apartments. To implement this program, the VA should conduct an early examination of its psychiatric patient services with a view to assessing patient care needs and corresponding requirements for staff. Furthermore, the relationship between VA services and community mental-health resources requires active planning for collaboration and, where appropriate, integration. In accomplishing these purposes, joint ventures should be undertaken with veterans organizations. In addition, the Committee recommends the expansion of mental-health outpatient facilities and personnel. In conjunction with the other facilities mentioned above, this will greatly reduce inpatient hospitalization.

The Committee recognizes that implementation of these recommendations will entail difficult and complex tasks.

Psychiatric care for significant family members, when indicated, is now authorized and should be made available by the VA. Appropriate family care will reduce inappropriate inpatient admissions and reduce the length of inpatient hospitalization.

### Psychoactive Drugs

The demonstrated practices of overprescribing and incorrect prescribing of drugs in the treatment of psychotic patients and the inappropriate

Excerpted from: Health Care for American Veterans: A Report of the Committee on Health-Care Resources in the Veterans' Administration; The National Research Council, Washington, D.C., May 1977.

### Surgery in Psychiatric Hospitals

Ten of the 24 psychiatric hospitals in the VA system have surgical bed sections. Some characteristics of surgical care in fiscal year 1975 in VA general and psychiatric hospitals are compared in Table 10-16.

TABLE 10-14

#### Selected Characteristics of Surgical Care in VA General and Psychiatric Hospitals, FY 1975

<u>Characteristic</u>	<u>General Hospitals</u>	<u>Psychiatric Hospitals</u>
No. surgical-bed sections	133	10
No. surgical beds	19,691	216
Average no. surgical beds per hospital	148	22
No. operations	249,742	2,922
Average no. operations per hospital with surgical-bed section	1,878	292
Complexity of average operation (CRV)	11.6	8.4
Crude mortality rate, %	3.3	7.1

SOURCES: VA Annual Report, 1975; VA Patient Treatment File, 1975

In fiscal year 1975, psychiatric hospitals had 1.1% of the VA surgical beds and performed 1.2% of the operations performed in VA hospitals. However, the 10 psychiatric hospitals with surgical sections had a smaller average number of beds, did fewer operations per hospital, and performed less complex operations, as measured in California Relative Value units, than the 133 general hospitals. Some psychiatric hospital patients are sent for surgery to general hospitals in the VA system, particularly for more complex procedures. However, even though the psychiatric hospitals perform less complicated procedures, the crude mortality rate for operations done in psychiatric hospitals in fiscal year 1975 was more than twice as high as the rate in general hospitals. Some of the higher surgical mortality in psychiatric hospitals may be due to patient characteristics that were not measured in this study, but the rate is so much higher than in general hospitals that it must be cause for concern. The data suggest that the volume of surgery is too low to maintain a competent standard of performance for either the surgical staff or the supporting hospital services.

### Residency Training

The VA makes a significant contribution to graduate surgical education through the residency training that it provides in affiliated

hospitals. In fiscal year 1975, the VA provided funds for the support of 1,734 residents in eight surgical specialties. Nearly all these residents were concentrated in 46 VA hospitals that performed 80% of the surgery done in VA hospitals in fiscal year 1975. A small number of residencies were scattered among 38 other VA hospitals.

The distribution of residencies in the VA is very similar to the distribution of operations, as shown in Table 10-15. The last column shows the average number of operations per resident for each specialty. The overall average of 116 compares favorably with the average of 111 for non-VA hospitals in the SOSSUS report. The numbers of operations per resident were greatest for urology and thoracic/cardiac surgery and smallest for ophthalmology.

TABLE 10-15  
Distribution of Operations and Surgical Residencies  
in VA Hospitals, FY 1975

Specialty	Fraction of Operations, % (N=201,653)	Fraction of Residencies, % (N=1,734)	No. Operations per Resident
General surgery	43	48	106
Urology	19	11	195
Orthopedic surgery	11	13	100
Otolaryngology	9	8	121
Ophthalmology	6	11	66
Thoracic/cardiac surgery	5	2	226
Plastic surgery	4	3	161
Neurosurgery	3	4	93
Total	100	100	116

SOURCE: VA: Patient Treatment File; Quarterly, Filled and Vacant Report, June 1975

Despite the availability of patients, the site visitors were concerned about the quality of the teaching. In the affiliated hospitals, the residents perform 88% of the surgery; in 69% of the operations performed by residents, the operation was not supervised by a member of the VA full-time or part-time staff service as first assistant surgeon. In the survey of VA professional staff conducted by the Committee, 15% of the full-time physicians and 12% of the part-time physicians responding thought that there was too little supervision of residents; 25% of the residents responding felt that they received inadequate supervision. Forty-one percent of the residents also

thought that the quality of education in the VA was lower than in non-VA settings.

#### Summary of Findings

Most of the patients admitted to surgery are assigned by the admission officer on the basis of inadequate information. As a consequence, 47% of the patients admitted to the surgical service are discharged without having had surgery.

Surgical services depend heavily on residents and part-time staff for surgical manpower. Residents comprise 63% of full-time equivalent surgeons and perform 79% of all operations. The full-time surgeons perform relatively few operations.

The facilities and process of medical care were evaluated in 12 general hospitals with large surgical services by means of site visits and audit of records. Operating rooms and equipment were adequate in most of the hospitals. The process of medical care, including records, was considered generally satisfactory. Utilization of operating rooms was low.

A one-day census of patients on surgical services was conducted to determine appropriate occupancy of beds. Sixty-three percent of the patients were thought to be appropriately placed on acute surgical wards. A study was also performed to determine the length of pre-operative stay in the hospital. Most of the hospitals had average preoperative stays of greater than 5 days.

The outcome of surgery was evaluated by complication rates and surgical mortality. No evidence was found of an excessive rate of complications in VA hospitals. Similarly, the mortality rate for general surgery in VA general hospitals was not excessive. However, in the 10 psychiatric hospitals with surgical-bed sections, the crude mortality rate was more than twice that in general hospitals and the number of operations performed was relatively small. Cardiac surgery was performed in 40 VA hospitals. The mortality rate for cardiac surgery was excessive in hospitals performing few such operations. It was felt that VA cardiac-surgery resources are excessive and too widely distributed.

Renal transplantation is performed in 25 VA hospitals. The majority of transplants are done in hospitals that perform fewer than 16 procedures a year. The standard set by the Joint Commission on Accreditation of Hospitals is a minimum of 24 transplants per year. Only three VA hospitals met or exceeded this standard.

The VA supports 1,734 surgical residencies. Nearly all of these are trained in 46 VA hospitals. Adequate surgical procedures are

performed to support the training of residents. There was no supervision by a full-time or part-time staff surgeon in 69% of the operations performed by residents.

TABLE 1B  
 PROJECTED INCREASES IN ENROLLMENT\*  
 1983-84 1984-85

INSTITUTION	PROJECTED ENROLLMENT 1983-84	CHANGE FROM 1983-84	PROJECTED ENROLLMENT 1984-85	CHANGE FROM 1984-85	REASON FOR CHANGE
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MIDWEST GREAT PLAINS

Northeast Ohio	105	+16	105	---	
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TOTAL		+16			
TOTAL: All Schools in Region		+17			

\*List only those institutions who reported an increase of 5 or more students

- |                                    |   |
|------------------------------------|---|
| **A. Planned expansion/contraction | C. Respond to perceived surplus of M.D.'s       |
| B. Result from financial pressure  | D. Concerns re: quality of available applicants |
| E. Other                           |   |

TABLE 1C  
PROJECTED DECREASES IN ENROLLMENT\*  
1983-84 -- 1984-85

INSTITUTION	PROJECTED ENROLLMENT 1983-84	CHANGE FROM 1983-84	PROJECTED ENROLLMENT 1984-85	CHANGE FROM 1984-85	REASON FOR CHANGE**
<u>MIDWEST-GREAT PLAINS REGION</u>					
Loyola University	130	--	120	-10	E-shift from 3 to 4 year curriculum
University of Michigan	211	-26	211	-26	A-planned contraction;B
University of Minnesota	225	-14	215	-10	A;B;C
University of Nebraska	140	-12	120	-20	C;D
Univ. of South Dakota	65	--	50	-15	A-planned contraction;C;D
Wayne State University	240	-9	224	-16	C
TOTAL		-61		-97	
TOTAL: All schools in region		-64		-97	

\*Only those institutions who reported an increase of 5 or more students



TABLE IIIB  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE\*  
 1983-84

Institution	Projected Enrollment 1983-84	Increase	Decrease
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B. Projections: Reasonably Firm but Subject to Change

MIDWEST-GREAT PLAINS REGION

University of Illinois	331		-33-50
Wayne State	240		-16

TOTAL	571		-49-67
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\*Lists only those institutions who reported changes in more than/less than 5 students

TABLE IIIC  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE\*  
 1983-84

Institution	Projected Enrollment 1983-84	Increase	Decrease
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C. Projections: Very Uncertain

MIDWEST-GREAT PLAINS REGION

University of Minnesota	225		-14
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TOTAL	225		-14
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\*Lists only those institutions who reported changes in more than/less than 5 students

TABLE IIID  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE\*  
 1983-84

Institution	Projected Enrollment 1983-84	Increase	Decrease
<u>A. Quite Firm</u>			
<u>MIDWEST-GREAT PLAINS REGION</u>			
U of Missouri-Columbia	110		-11
U of Missouri-Kansas City	90		-9
University of Nebraska	140		-13
University of Wisconsin	159		-16
<b>TOTAL</b>	<b>499</b>		<b>-49</b>

\*Lists only those institutions who reported changes in more than/less than 5 students

TABLE IIIIE  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE  
 1984-85

Institution	Projected Enrollment 1984-85	Increase	Decrease
<u>B. Projections: Reasonably Firm but Subject to Change</u>			

MIDWEST-GREAT PLAINS REGION

Loyola-Stritch	120	+10	
Rush	120		-10
Univ. of Kansas	200		-20
University of Michigan	211	+26	
Wayne State	224		-16
Missouri-Kansas City	90		-10
Nebraska	120		-20
Wright State	100		-5-15
South Dakota	50	+15	
Univ. of Wisconsin	159		-16
<b>TOTAL</b>	<b>1,394</b>	<b>+51</b>	<b>-97-107</b>

\*Only those institutions who reported increases/decreases of 5 or more students are listed.

TABLE IIIIF  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE  
 1984-85

Institution	Projected Enrollment 1984-85	Increase	Decrease
<u>C. Projections: Very Uncertain</u>			
<u>MIDWEST REGION</u>			
Univ. of Minnesota	215		-10
Missouri-Columbia	110		-11
Cincinnati	192		-19
<b>TOTAL</b>	<b>517</b>		<b>-40</b>

\*Only those institutions who reported increases/decreases of 5 or more students are listed.

## MICROCOMPUTERS IN ACADEMIC MEDICINE: A WORKSHOP ON THE ESSENTIALS

The University of Arizona College of Medicine through its Office of Medical Education is offering a special optional workshop in conjunction with the April Council of Deans Spring Meeting. The workshop will introduce microcomputing novices to microcomputer operation and to the application of some generalized information processing programs. The workshop will be in two parts on April 7th and 8th. Each part will convene between 2:00 pm - 4:30 pm.

Demands for increased research productivity, educational effectiveness, health-care efficiency and administrative accountability are becoming more frequent. Through this workshop experience, administrators of academic medical centers will clearly appreciate the range of microcomputer capabilities and techniques available to meet the demands of medical education.

Structured exercises will be used to demonstrate a variety of software programs. Experiences with these programs will provide the participant with the means to: 1) appreciate the capabilities and limitations of microcomputers, 2) anticipate administrative educational, clinical, and research applications of microcomputers in home institutions and 3) estimate the institutional cost and effect of programs which propose application of information science or microcomputer technology.

- 
- Materials for advance study will be provided prior to workshop session.
  - Equipment and facility constraints require that enrollment be limited.
  - Participants will be provided a fast paced, highly involving learning experience.
  - Participation will include hands-on computer experience, demonstrations and a limited amount of didactic material.



# association of american medical colleges

January 31, 1983

## MEMORANDUM

TO: Members of the Council of Deans  
COD Distinguished Service Members  
Canadian Deans

FR: Joseph A. Keyes, Jr.  
Director, Department of Institutional  
Development

RE: 1983 COD Spring Meeting: April 6-9, 1983  
The Cottonwoods (formerly the Alamos)  
Scottsdale, Arizona  
(602) 991-1414

## LOCATION AND SCHEDULE

This year's Spring Meeting, as we hope you have already noted on your calendar, will be held at The Cottonwoods (formerly known as the Alamos) in Scottsdale, Arizona, April 6-9, 1983. General registration will be conducted on Wednesday, April 6th from 1:00 pm until 5:00 pm. The opening session, "Welcome, Prelude to the Business Meeting, and the President's Report" will begin at 5:30 pm. It will be followed immediately by a reception. Program sessions will run from 8:30 am until 1:00 pm with a mid-morning coffee break on Thursday and Friday; the Business Meeting will be conducted on Saturday morning. The afternoons will be free in order to permit you to enjoy the facilities with your colleagues and spouses. Please note, however, that this year during the "Unscheduled Time", we have two sets of optional activities for those interested in alternatives to shopping or recreation.

## PROGRAM FOR ALL PARTICIPANTS

The 1983 Spring Meeting program is enclosed. In summary, we will begin with a series of presentations portraying some important perspectives from the Federal government that relate to our interests. The first speaker will present the view of the Office of Management and Budget, the second two will describe the extramural research interests of the Army Medical Research and Development Command and the Office of Naval Research--the two Defense Department agencies with the largest stake in supporting biomedical research--both of which anticipate expanding budgets. The second session will be devoted to an exploration of Medicare reimbursement issues. The first speaker, HCFA's chief policy formulator in the area of reimbursement, will discuss the issues arising from current policies--including those related to the implementation of the Tax Equity and Fiscal Responsibility Act. The second speaker will discuss the management implications of prospective reimbursement proposals.

The second day of the program will be devoted to an examination of undergraduate medical education. It will commence with a report on the Commonwealth Foundation supported experiments in integrating university and medical education. This will be followed by an informed layman's views of undergraduate medical education presented by an award winning science writer who followed a single class through four years and authored an insightful book on the

subject. Finally, the chairman and several members of the AAMC's panel studying the General Professional Education of the Physician will conduct a forum on that project.

#### THE COD BUSINESS MEETING

The COD Business Meeting will be conducted on Saturday morning, April 6th beginning at 8:30 am. Among the items to be discussed are planned changes in the Medical College Admission Test program and follow-up activities related to the AAMC's Regional Institute on Geriatric Medical Education.

#### INVITATION

We wish to make a special effort again this year to encourage the attendance of the deans' spouses and to facilitate their enjoyment of the meeting. In addition to their invitation to the Wednesday evening reception, we are again setting aside a Hospitality Area for the spouses each morning beginning Thursday.

The evening session on Thursday promises to be an interesting change of pace. Dr. Raja Khuri, Dean at the American University of Beirut, has a fascinating story to tell about how his institution was able to carry on providing both medical education and services during the recent turmoil in Beirut. His presentation, complete with slides, may be of interest to your spouse and he/she is invited to attend as well.

#### OPTIONAL ACTIVITIES

We have learned that not everyone is interested in availing themselves of the Arizona sun for recreational purposes. For those interested in alternatives, we are pleased to present a workshop on Microcomputers in Academic Medicine to be conducted on Thursday and Friday afternoons from 2:00 pm to 4:30 pm by the University of Arizona College of Medicine through its Office of Medical Education. Substantial hands on experience--no more than two participants/computer--intense personal instruction--as many as eight faculty "tutors"--and advanced study materials promise to make this a valuable professional experience for those interested. Pre-enrollment will be required and participation will be limited to 40 participants. Additional details are contained in the enclosed description.

To continue the theme of Friday morning--an exploration of the general professional education of the physician--there will be a showing Friday afternoon of the NBC News Special Report, "To Be A Doctor", filmed at the University of Pennsylvania School of Medicine. This film graphically portrays some of the intense personal experiences of students confronting the demands of the undergraduate medical education.

#### ACCOMMODATIONS

The Cottonwoods is a complete resort facility located two miles north of downtown Scottsdale, Arizona. All accommodations are suites. The resort is surrounded by restaurants, shops, galleries and boutiques. The majority of the COD meetings will be held at the Meeting and Banquet Center in the Ballroom.



We urge you to return the enclosed reservation card as soon as possible to be assured of receiving the accommodation you request. Rates for the suites are as follows:

Executive Suites	\$65.00/single or double
Hospitality Suites	75.00/single or double
Luxury Suites	110.00/single or double

All of the above rates are European Plan and are subject to a 4% Arizona sales tax. Accounts upon check-out may be settled by cash, check or major credit card. Personal checks up to the amount of \$50.00 can be cashed at the Front Desk when presented with proper credit information, e.g., major credit card and proper identification. Check-in time is 4:00 pm. The resort will make every effort to accommodate earlier arrivals.

Please return the room reservation card in the enclosed business reply envelope directly to me, whether or not you plan to attend, NO LATER THAN FEBRUARY 18, 1983.

#### TRANSPORTATION

The Cottonwoods is located at 6160 North Scottsdale Road, approximately 13 miles from Sky Harbor International Airport in Phoenix. Air transportation to Phoenix is provided by a number of major airlines including: American, Continental, Frontier, Pacific Southwest, Republic, Southwest, Trans World and Western.

Airport transfers will be provided by USA Holidays at a cost of \$5.75 per person, one-way. Luggage handling is included. Reservations are necessary; therefore, please indicate your flight information and time of arrival/departure on the enclosed reservation card. The USA Holidays attendants (dressed in beige and white uniforms) will be located in the baggage claim area of each terminal to assist you with your luggage and to direct you to the vans.

In addition, we have negotiated a 15% discount with Hertz for COD Spring Meeting attendees. If you are interested in renting a car through Hertz while you are in Scottsdale, simply call this toll free number, 800-654-2240 and mention the ID number, 90118 (see enclosed brochure).

#### RECREATIONAL FACILITIES

Four tennis courts, two heated pools, a jacuzzi, exercise room, parcourse (one-mile metered jogging/exercise trail) and golf privileges at nearby Orange Tree Country Club are available. In addition, a unique shopping center, the Borgata Mall, is located within 100 yards of the resort featuring galleries, boutiques and specialty stores offering Indian jewelry and unusual gifts. Free shuttle service to other major shopping areas is also available.

## DINING

The Cottonwoods Restaurant and Lounge with elegant Southwestern motif features breakfast, lunch and dinner. Five specialty restaurants are located in the Borgata Mall offering French and Italian cuisine, a deli/lounge, a gourmet shop, and a sidewalk cafe. Also within walking distance of the resort is a Black Angus Steak House and El Torito Restaurant featuring Mexican fare.

On Friday evening, April 8th, we have planned an outdoor steakfry to be held at nearby "Rawhide", a replica of an 1880's Arizona territory town. "The artifacts on display were actually in use a century or more ago and the buildings that house them are faithful reproductions or real buildings that existed in a variety of western towns." After an opportunity to browse through the shops and exhibits, we will be transported by haywagons into the desert for a cookout under the stars. The menu will include an open bar, your choice of steak or bar-b-que chicken, cole slaw, "cowboy" beans, and western garlic toast. Entertainment during the evening will be provided by a country and western trio. Transportation to Rawhide is included. The cost is \$29.00 (16 oz. T-bone steak) or \$24.75 (one-half large chicken) per person for the entire evening including tax and gratuity.

## CLIMATE

Surrounded by mountains in every direction, the area is known for its sunny desert climate which is ideal for most sports and recreational activities year-round. The temperature in early April is usually in the upper 70's to low 80's during the day with sweaters and jackets recommended for evening.

Enclosures: Hotel Reservation Card  
Alamos/Hertz brochures  
Rawhide brochure  
Recreation Information Sheet

*february 1983*

U. S. MEDICAL SCHOOLS  
PROJECTED FIRST YEAR ENROLLMENT SURVEY  
1983-84--1984-85

Department of Institutional  
Development  
April 1983

PROJECTED FIRST YEAR ENROLLMENT  
Academic Years 1983-84; 1984-85

Medical School \_\_\_\_\_

1. What do you project for your 1983-84 and 1984-85 first year class?

(The number of new entrants reported in your responses to the AAMC Fall Enrollment Survey for the academic years 1981-82 and 1982-83 is provided for comparison purposes.)

<u>Academic Year</u>	<u>First Year Enrollment</u>
1981-82	_____
1982-83	_____
1983-84	_____
1984-85	_____

2. How firm is the number for 1983-84? (check one)

\_\_\_\_\_ Quite firm.  
\_\_\_\_\_ Reasonably firm but subject to change.  
\_\_\_\_\_ Very uncertain.

3. If there is any change in 1983-84, it is likely to be an (increase \_\_\_\_, decrease \_\_\_\_) of approximately \_\_\_\_.

4. How firm is the number for 1984-85? (check one)

\_\_\_\_\_ Quite firm.  
\_\_\_\_\_ Reasonably firm but subject to change.  
\_\_\_\_\_ Very uncertain.

5. If there is any change, it is likely to be an (increase \_\_\_\_, decrease \_\_\_\_) of approximately \_\_\_\_.

6. Changes in enrollment from prior years:  
(check all that apply)

Are part of a planned (expansion/contraction) \_\_\_\_\_  
(Circle one)

Result from financial pressures on the school \_\_\_\_\_

Respond to a perceived surplus of physicians \_\_\_\_\_

Result from concerns about the quality of  
available applicants \_\_\_\_\_

Other (specify) \_\_\_\_\_

7. These changes are stimulated by the concerns of:  
(Check all that apply)

- Faculty \_\_\_\_\_
- Deans Office \_\_\_\_\_
- University Administration \_\_\_\_\_
- Board of Trustees or Regents \_\_\_\_\_
- Higher Education Coordinating Board \_\_\_\_\_
- Governor's Office \_\_\_\_\_
- Legislature \_\_\_\_\_
- Local Community \_\_\_\_\_
- Other (specify) \_\_\_\_\_

8. Remarks:

\_\_\_\_\_  
Signed - Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\* All information provided in response to this questionnaire will be classified as restricted: "Restricted Data: generally held confidential, but may be made available to qualified institutions, organizations, and individuals for bona fide purposes, at the discretion of the AAMC President."

TABLE I\*

U.S. MEDICAL SCHOOLS  
PROJECTED FIRST YEAR ENROLLMENT SURVEY

Summary Analysis  
(All Schools Reporting)

Year	Number of Schools Reporting	Number of Schools Reporting Increase	Projected INCREASE Reported	Number of Schools Reporting Decrease	Projected DECREASE Reported	Net Enrollment Change	Total Number of Students
1981-82	125						16,580
1982-83	126						16,484
1983-84	126	16	91	24	-138	-47 (.3%)	16,437
1984-85	126	5	31	9	-116	-85 (.5%)	16,352
TOTAL:		21	122	33	-254	-132	

\*For more detailed information refer to Tables I-A; I-B; I-C

TABLE II\*

U.S. MEDICAL SCHOOLS  
PROJECTED FIRST YEAR ENROLLMENT SURVEY

Summary Analysis  
By Region

Region	Number of Schools Reporting	Number of Schools Reporting an Increase	Projected INCREASE Reported	Number of Schools Reporting a Decrease	Projected DECREASE Reported	Net Enrollment Change	Total Number of Students
<u>I. Northeast</u>							
1983-84	33	5	+19	4	-25	-6	4,484
1984-85	33	-	-	2	-15	-15	4,469
<u>II. Southern</u>							
1983-84	45	8	+54	10	-34	+20	5,467
1984-85	45	4	+28	2	-30	-2	5,465
<u>III. Midwest/Great Plains</u>							
1983-84	32	2	+17	6	-64	-47	4,744
1984-85	32	-	-	5	-71	-71	4,673
<u>IV. Western</u>							
1983-84	16	1	+1	4	-15	-14	1,742
1984-85	16	1	+3	-	-	+3	1,745
<hr/>							
TOTAL (1983-84)	126	16	+91	24	-138	-47	16,437
(1984-85)	126	5	+31	9	-116	-85	16,352

For more detailed information refer to I-A; I-B; I-C

TABLE 1-A  
U.S. MEDICAL SCHOOLS FIRST YEAR ENROLLMENT PROJECTIONS

Institution	Actual		Projected	
	1981	1982	1983	1984
<u>NORTHEASTERN REGION</u>				
Connecticut	80	80	88	88
Yale	102	102	102	102
Johns Hopkins	123	120	120	120
Maryland	175	175	155	155
Uniformed Services	154	156	156	156
Boston University	135	135	135	135
Harvard	166	165	165	165
Massachusetts	102	100	100	100
Tufts	146	148	148	148
Dartmouth	85	84	84	84
UMD-New Jersey	170	170	170	170
UMD-Rutgers	130	130	130	130
Albany	129	127	128	128
Albert Einstein	178	180	179	179
Columbia	150	148	148	148
Cornell	104	101	101	101
Mt. Sinai	100	100	100	100
SUNY-Downstate	217	219	219	219
New York Med	177	177	180	180
New York University	168	170	170	170
Rochester	100	100	100	100



SUNY-Buffalo	135	135	135	135
SUNY-Stony Brook	76	100	100	100
SUNY Upstate	145	145	150	150
Hahnemann	180	180	180	180
Jefferson	223	223	223	223
Medical College of PA	100	100	100	100
Penn State	98	93	95	95
U of Pennsylvania	161	160	160	155
Pittsburgh	137	136	136	136
Temple	177	177	177	177
Brown	61	61	60	60
Vermont	<u>93</u>	<u>93</u>	<u>93</u>	<u>93</u>
	4,477	4,490	4,484	4,469

#### SOUTHERN REGION

Alabama-Birmingham	150	151	150	150
South Alabama	64	65	64	64
Arkansas	136	136	136	136
Georgetown	205	205	205	205
George Washington	150	150	150	150
Howard	129	122	122	122
Florida	113	112	115	115
Miami	135	137	138	138
South Florida	95	96	96	96
Emory	110	111	110	110
Morehouse	32	32	32	40

Medical College of GA	180	180	180	180
Mercer	-	24	36	48
Kentucky	108	96	95	90
Louisville	135	124	124	124
LSU-New Orleans	180	175	175	175
LSU-Shreveport	103	100	100	100
Tulane	147	148	148	148
Mississippi	150	150	125	100
Bowman Gray	108	109	108	108
Duke	114	114	114	114
North Carolina	160	160	160	160
East Carolina	52	64	64	66
Oklahoma	175	176	176	176
Oral Roberts	48	49	48	48
Ponce	60	40	40	40
Puerto Rico	150	141	140	140
Med U of South Carolina	165	165	165	165
Univ. of SC - Columbia	51	48	64	64
East Tennessee	49	54	54	60
Meharry	110	76	80	80
Tennessee	203	179	180	180
Vanderbilt	104	104	104	104
Baylor	168	168	168	168
Texas A&M	32	40	48	48
Texas Tech	100	100	100	100
Texas Galveston	203	203	203	203
Texas Houston	202	201	201	201

Texas San Antonio	202	203	202	202
Texas Southwestern	205	199	208	208
Eastern Virginia	96	96	96	96
Medical College of VA	169	168	168	168
University of Virginia	139	139	139	139
Marshall	36	48	48	48
West Virginia	<u>88</u>	<u>89</u>	<u>88</u>	<u>88</u>
	5,511	5,447	5,467	5,465

MIDWEST-GREAT PLAINS REGION

Chicago Medical	143	160	160	160
Loyola-Stritch	129	130	130	120
Northwestern	171	170	170	170
Southern Illinois	72	72	72	72
Rush	119	120	120	120
U of Chicago-Pritzker	104	104	104	104
University of Illinois	325	331	331	331
Indiana	305	290	290	290
Iowa	175	175	175	175
Kansas	200	200	200	200
Michigan State	104	106	106	106
Univeristy of Michigan	237	237	211	211
Wayne State	250	249	240	224
Mayo	40	40	40	40
MN-Minneapolis	239	239	225	215

MN-Duluth	48	48	48	48
Missouri - Columbia	110	110	110	110
Missouri-Kansas City	100	90	90	90
St. Louis Univ.	156	155	155	155
Washington Univ.-St. Louis	122	120	120	120
Creighton	108	112	110	110
Nebraska	153	152	140	120
North Dakota	68	55	55	55
Case Western Reserve	139	138	138	138
Cincinnati	192	192	192	192
Northeastern Ohio	92	89	105	105
Ohio at Toledo	148	150	150	150
Ohio State	233	233	233	233
Wright State	100	100	100	100
South Dakota	64	65	65	50
Medical College of WS	200	199	200	200
Univ. of Wisconsin	<u>159</u>	<u>160</u>	<u>159</u>	<u>159</u>
	4,805	4,791	4,744	4,673

-47
-71

WESTERN REGION

Arizona	88	88	88	88
California - Davis	100	93	93	93
California - Irvine	96	92	92	92
California - Los Angeles	160	168	164	164
California - San Diego	125	121	122	122
California - San Francisco	158	154	153	153

Loma Linda	142	140	140	140
Southern California	136	136	136	136
Stanford	86	86	86	86
Colorado	118	131	126	129
Hawaii	67	61	56	56
Nevada	48	48	48	48
New Mexico	73	73	73	73
Oregon	115	90	90	90
Utah	100	100	100	100
Univ. of Wash-Seattle	<u>175</u>	<u>175</u>	<u>175</u>	<u>175</u>
	1,787	1,756	1,742	1,745
		$\underbrace{\hspace{10em}}_{-14} \quad \underbrace{\hspace{10em}}_{+3}$		

	Actual	Actual	Projected	Projected
	1981--82	1982--83	1983--84	1984--85

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TOTALS	16,580	16,484	16,437	16,352
--------	--------	--------	--------	--------

Changes from 1982-83  
to 1983-84

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-47

Changes from 1983-84  
to 1984-85

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-85

Changes from 1982-83  
to 1984-85

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-132

TABLE I-B  
 PROJECTED INCREASES IN FIRST YEAR ENROLLMENT\*  
 1983-84 1984-85

INSTITUTION	PROJECTED ENROLLMENT 1983-84	CHANGE FROM 1982-83	PROJECTED ENROLLMENT 1984-85	CHANGE FROM 1983-84	REASON FOR CHANGE**
<u>NORTHEAST REGION</u>					
University of Connecticut	88	+8	88	---	
SUNY Upstate	150	+5	150	----	
<u>SOUTHERN REGION</u>					
Morehouse	32	--	40	+8	A-planned expansion
Mercer University	36	+12	48	+12	A-planned contraction
U of So. Carolina Columbia	64	+16	64	---	A-planned expansion
East Tennessee State	54	--	60	+6	A-planned expansion
Texas A&M	48	+8	48	---	
U of Texas Southwestern	208	+9	208	---	A-planned expansion
<u>MIDWEST GREAT PLAINS</u>					
Northeast Ohio	105	+16	105	---	
Total: 9 schools listed		+74		+26	
Total: All schools reporting		+91		+31	

\*Only those institutions who reported an increase of 5 or more students are listed

\*\*A. Planned expansion/contraction  
 B. Result from financial pressure

C. Respond to perceived surplus of physicians  
 D. Concerns re: quality of available applicants

E. Other

TABLE I-C  
PROJECTED DECREASES IN FIRST YEAR ENROLLMENT\*  
1983-84 - 1984-85

INSTITUTION	PROJECTED ENROLLMENT 1983-84	CHANGE FROM 1982-83	PROJECTED ENROLLMENT 1984-85	CHANGE FROM 1983-84	REASON FOR CHANGE**
<u>NORTHEAST REGION</u>					
University of Maryland	155	-20	155	----	A-planned contraction; E-did not get the anticipated budget increase.
SUNY Downstate	216	-3	206	10	A-planned contraction
Univ. of Pennsylvania	160	--	155	-5	A-planned contraction; E-relate to quality of educational offerings
<u>SOUTHERN REGION</u>					
University of Kentucky	95	-1	90	-5	A-planned contraction;B;C an attempt to equalize graduates and PGY1 positions
University of Mississippi	125	-25	100	-25	A-planned contraction;C;D
<u>MIDWEST-GREAT PLAINS REGION</u>					
Loyola University	130	--	120	-10	E-shift from 3 to 4 year curriculum
University of Michigan	211	-26	211	---	A-planned contraction;B
University of Minnesota	225	-14	215	-10	A-planned contraction;B;C
University of Nebraska	140	-12	120	-20	C;D
Univ. of South Dakota	65	--	50	-15	A-planned contraction;C;D
Wayne State University	240	-9	224	-16	C
<u>WESTERN REGION</u>					
University of Colorado	126	-5	129	+3	E-previous legislative action limited enrollment - limitation no longer exists - school is returning to original level
University of Hawaii	56	-5	56	---	A-planned contraction;B;C
Total: 13 schools listed		-120		-116	
Total: all schools reporting		-138		-116	

TABLE III  
U.S. MEDICAL SCHOOLS FIRST YEAR PROJECTED ENROLLMENT SURVEY\*

Summary Analysis of

Degree of Firmness in Projected Enrollment/  
Possible Change

PROJECTED ENROLLMENT: QUITE FIRM			PROJECTED ENROLLMENT: REASONABLY FIRM			PROJECTED ENROLLMENT: VERY UNCERTAIN			
Number of Schools Reporting	Possible Change From Projected #	Projected Enrollment Range	Number of Schools Reporting	Possible Change From Projected #	Projected Enrollment Range	Number of Schools Reporting	Possible Change From Projected #	Projected Enrollment Range	
1983	13	(+34) to (-104/105)	1,490) to (1,352-3)	12	(+39/40)to (-71/93)**	(+1,748/1,768 to ( 1,638/1616)**	3	(+10/30)to (-39)	(+440/460)to (391)
1984	3	(+14) to (-20)	(+494) to (460)	28	(+83/111)to (-220/258)	(+3,525/3,553)to (3,222/3,184)***	8	(+20/40)to (-71)	(+977/997)to (886)****

	<u>NUMBER OF SCHOOLS REPORTING</u>	<u>POSSIBLE CHANGES FROM PROJECTED NUMBERS</u>	<u>PROJECTED ENROLLMENT RANGE</u>
1983-84	28	(+83/104)to(-214/237)	(3,678/3,718)to(3,381/3,360)
1984-85	39	(+117/165)to(-311/349)	(4,996/5,044)to(4,568/4,530)

\* Only those schools who listed possible changes are included

\*\* Howard's projected enrollment calculated at 122; Ponce's projected enrollment calculated at 40

\*\*\*Ponce's projected enrollment calculated at 40 (1984-85)

\*\*\*\*Howard's projected enrollment calculated at 122 (1984-85)



TABLE III-A  
DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/POSSIBLE CHANGE\*  
1983-84

Institution	Projected Enrollment 1983-84	Possible Change From Projected No.	
		Increase	Decrease
<u>A. Quite Firm</u>			
<u>NORTHEAST REGION</u>			
Univ. of Connecticut	88	+8	
Univ. of Maryland	155		-20
<u>SOUTHERN REGION</u>			
University of Alabama	150		-10
Mercer	36		-6
U of SC Columbia	64	+16	
U of Texas-Southwestern	208	+10	-10
<u>MIDWEST-GREAT PLAINS REGION</u>			
U of Missouri-Columbia	110		-11
U of Missouri-Kansas City	90		-9
University of Nebraska	140		-13
University of Wisconsin	159		-16
<u>WESTERN REGION</u>			
University of Hawaii	56		-5
<b>TOTAL</b>	<b>1,256</b>	<b>+34</b>	<b>-100</b>

\*Only those institutions who reported increases/decreases for 5 or more students are listed.

DID/4-83

TABLE III-B  
DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/POSSIBLE CHANGE\*  
1983-84

Institution	Projected Enrollment 1983-84	Possible Change from Projected No.	
		Increase	Decrease
<u>B. Projections: Reasonably Firm but Subject to Change</u>			
<u>NORTHEAST REGION</u>			
New York University	170		-5-10
<u>SOUTHERN REGION</u>			
Howard University	122/125	+5	
Ponce	40/60	+0-20	
<u>MIDWEST-GREAT PLAINS REGION</u>			
University of Illinois	331		-33-50
Wayne State	240		-16
<u>WESTERN REGION</u>			
Univ. of Washington-Seattle	175		-10
<b>TOTAL</b>	<b>1078/1101</b>	<b>+5/+20</b>	<b>-64/86</b>

\*Only those institutions who reported an increase of 5 or more students are listed.

TABLE III-C  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/ANTICIPATED CHANGE\*  
 1983-84

Institution	Projected Enrollment 1983-84	Possible Change from Projected No.	
		Increase	Decrease
<u>C. Projections: Very Uncertain</u>			
<u>SOUTHERN REGION</u>			
Meharry	80	+10-30	
Mississippi	125		-25
<u>MIDWEST-GREAT PLAINS REGION</u>			
University of Minnesota-Minn.	225		-14
<b>TOTAL</b>	<b>430</b>	<b>+10/+30</b>	<b>-39</b>

\*Only those institutions who reported an increase of 5 or more students are listed.

DID/4-83

TABLE III-D  
 DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/POSSIBLE CHANGE\*  
 1984-85

Institution	Projected Enrollment 1984-85	Possible Change From Projected No.	
		Increase	Decrease
A. <u>Quite Firm</u>			
<u>SOUTHERN REGION</u>			
U of Texas-Southwestern	208	+10	-10
<u>WESTERN REGION</u>			
Southern California	136		-10
<b>TOTAL</b>	<b>344</b>	<b>+10</b>	<b>-20</b>

\*Only those institutions who reported increases/decreases of 5 or more students are listed.

DID/4-83

TABLE III-E  
DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/POSSIBLE CHANGE\*  
1984-85

Institution	Projected Enrollment 1984-85	Possible Change from Projected No.	
		Increase	Decrease
<u>B. Projections: Reasonably Firm but Subject to Change</u>			
<u>NORTHEAST REGION</u>			
University of Maryland	155		-3-5
Albany	128		-18
Albert Einstein	179		-10
Temple University	177		-8-17
<u>SOUTHERN REGION</u>			
University of Arkansas	136		-10
University of Florida	115		-15
Morehouse	40	+8	
Univ. of Oklahoma	176		-26
East Tennessee	60	+12	
Medical College of VA	168		-17-34
Ponce	40/60	+0-20	
<u>MIDWEST-GREAT PLAINS REGION</u>			
Loyola-Stritch	120	+10	
Rush	120		-10
Univ. of Kansas	200		-20
University of Michigan	211	+26	
Wayne State	224		-16
Missouri-Kansas City	90		-10
Nebraska	120		-20
Wright State	100		-5-15
South Dakota	50	+15	
Univ. of Wisconsin	159		-16
<u>WESTERN REGION</u>			
Utah	100	+4-8	
Washington-Seattle	175		-10

TABLE III-F  
DEGREE OF FIRMNESS IN PROJECTED ENROLLMENT/POSSIBLE CHANGE\*  
1984-85

Institution	Projected Enrollment 1984-85	Possible Change from Projected No.	
		Increase	Decrease
<u>C. Projections: Very Uncertain</u>			
<u>SOUTHERN REGION</u>			
Howard University	122/125	+5	
Mercer University	48		-6
Univ. of Kentucky	90	+5	
Mississippi	100		-25
Meharry	80	+10-30	
<u>MIDWEST REGION</u>			
Univ. of Minnesota	215		-10
Missouri-Columbia	110		-11
Cincinnati	192		-19
<b>TOTAL</b>	<b>957/960</b>	<b>+20/+40</b>	<b>-71</b>

\*Only those institutions who reported increases/decreases for 5 or more students are listed.

DID/4-83

TABLE IV

U.S. MEDICAL SCHOOLS

PROJECTED FIRST YEAR ENROLLMENT SURVEY

GROUP CONCERNS WHICH STIMULATED CHANGES IN PROJECTED ENROLLMENT

GROUP	NUMBER OF SCHOOLS
1. Faculty	38
2. Deans Office	49
3. University Administration	28
4. Board of Trustees or Regents	16
5. Higher Education Coordinating Board	10
6. Governor's Office	8
7. Legislature	17
8. Local Community	9
9. Other	3

TABLE IV-A  
U.S. MEDICAL SCHOOLS

PROJECTED FIRST YEAR ENROLLMENT SURVEY

Group Concerns Which Stimulate Changes in Projected Enrollment

<u>REGION</u>	<u>Groups</u>
<u>Northeast</u>	
Connecticut	Faculty, Deans Office
Johns Hopkins	Faculty, Deans Office
Maryland	Faculty, Deans Office, University Administration
USUHS	Board of Trustees, Other (Dept. of Defense)
Albany	Deans Office
SUNY Downstate	Faculty, Deans Office
New York University	Faculty, Deans Office
Rochester	Faculty, Deans Office
Pennsylvania	Faculty, Deans Office
Pittsburgh	Deans Office
Temple	Deans Office
<u>Southern</u>	
Alabama	Faculty, Deans Office, University Administration
South Alabama	Deans Office, Local Community
Howard	Faculty, Deans Office
Florida	Faculty, Deans Office
Mercer	Faculty, Deans Office, University Administration, Board of Trustees, Governor's Office, Legislature, Local Community
Kentucky	Faculty, Deans Office, University Administration, Higher Edu. Coord. Board, Governor's Office, Legis.
Louisville	Faculty, Deans Office, University Administration, Board of Trustees, Higher Edu. Coord. Board, Governor's Office, Legislature
LSU New Orleans	Deans Office
Mississippi	Faculty, Deans Office, University Administration, Board of Trustees
East Carolina	Faculty, Deans Office, University Administration, Legislature
Oklahoma	Faculty, Deans Office, University Administration, Board of Trustees, Higher Edu. Coord. Board
Ponce	Faculty, Deans Office, University Administration, Board of Trustees, Local Community



Puerto Rico  
South Carolina  
East Tennessee State

Faculty, Deans Office  
Other (Plan for Development)  
Deans Office, University Administration,  
Board of Trustees, Higher Edu.  
Coord. Board, Governor's Office,  
Legislature

Tennessee

Faculty, Deans Office, University  
Administration, Board of Trustees,  
Higher Edu. Coord. Board

Vanderbilt  
Virginia

Faculty, Deans Office  
Faculty, Deans Office, Higher Edu.  
Coord. Board, Governor's Office

MIDWEST/GREAT PLAINS

Chicago Medical  
Southern Illinois

Other  
Faculty, Deans Office, Higher Edu.  
Coord. Board

Rush  
Illinois

Deans Office, University Administration  
Deans Office, University Administration,  
Higher Edu. Coord. Board, Local  
Community

Indiana  
Kansas

Faculty, Deans Office  
University Administration, Board  
of Trustees, Governor's Office,  
Legislature, Local Community

Michigan State

Faculty, Deans Office, Legislature,  
Local Community

Michigan

Faculty, Deans Office, University  
Administration, Board of Trustees

Wayne State  
Minnesota-Minn.

Other (HHS, Office of the Budget)  
Faculty, Deans Office, University  
Administration, Local Community

Missouri-Columbia  
Missouri-Kansas City

Faculty, Deans Office  
Deans Office, University Administration,  
Board of Trustees, Local Community

Nebraska

Faculty, Deans Office, University  
Administration, Board of Trustees

North Dakota  
Cincinnati

Faculty, Deans Office  
Faculty, Deans Office, Board of  
Trustees, Higher Edu. Coord. Board,  
Governor's Office, Legislature

Northeastern Ohio

Faculty, Board of Trustees,  
Legislature

South Dakota  
Wisconsin

Faculty, Deans Office  
Legislature

WESTERN

UC, Davis

Deans Office, University Administration,  
Higher Edu. Coord. Board, Governor's  
Office, Legislature

UC, Irvine  
UCLA

University Administration, Legislature  
Faculty, Deans Office, University  
Administration, Board of Trustees

UC, San Diego

University Administration (System-wide),  
Legislature

UC, San Francisco  
Loma Linda  
Stanford

Colorado

Hawaii  
Oregon

Utah

Washington

University Administration, Legislature  
Faculty, Deans Office  
Faculty, Deans Office, University  
Administration  
Deans Office, University Administration,  
Board of Trustees, Legislature  
Faculty, Deans Office  
Faculty, Deans Office, University  
Administration, Legislature,  
Local Community  
Deans Office, University Administration,  
Legislature  
Faculty, Deans Office, University  
Administration

TABLE V  
REMARKS  
U.S. MEDICAL SCHOOLS FIRST YEAR PROJECTED ENROLLMENT SURVEY  
(1983-84 -- 1984-85)

NORTHEAST REGION

While we do not have a budgetary decrease for 1983-84, the increase was not what we had expected in Governor's budget (only 1.5%) so Medical School and University Administration decided to reduce class size, so financial pressures are questionable. (Maryland)

Let me stress that there are no plans at present to contract -- above comments reflect some expressed attitudes and discussions. (Johns Hopkins)

The increase in first year medical school will result in reduction of students taken with advanced standing. (Univ. of Connecticut)

Recent decision reached to continue with same number for next two years. (Hahnemann)

With transfer students, our enrollment is 200 in the third and fourth years. We do not plan any change in this number. (NY Med. Col.)

Philosophically, we would like to reduce class size--but there are legislative pressures outside the school that may prevent us from pursuing this course. (SUNY Downstate)

SOUTHERN REGION

No changes from 64 planned. (Univ. of So. AL)

As a new school, our class size is determined by the LCME to a large extent. Our desired size would be 48 per class. (Mercer)

We agreed that a modest (+ 10%) decrease in enrollment is justified desirable. However, in the face of 2 new medical schools authorized in Georgia by L.C.M.E., it is patently ridiculous for a quality school to reduce enrollment. (Emory)

As a state school, no changes are anticipated in the near future. We accept the number for which we are accredited. (LSU Shreveport)

We anticipate no changes even in the years 86-90 but who knows. (Eastern VA)

We have hopes that the LCME will grant us permission to accept 60 students which is our full projected complement. (Ponce)

State appropriated FTE's are tied to enrollment. Reductions are complicated if it entails decreased appropriations. (U of VA)

Expansion is part of plan for this new school. (Morehouse)

A contraction was planned for about 1984-85 by the Council on Higher Education but was initiated early by the University administration because of financial pressures on the school. (Louisville)

We don't anticipate a reduction in the next two years but it will come eventually because of all of the above (#7). (Texas-Houston)

#### MIDWEST-GREAT PLAINS REGION

In 1978 HEW took the position that a financial problem was being created due to an oversupply of physicians, accepting the philosophy that with each physician is associated some fixed level of health care costs. Additionally, the Graduate Medical Education National Advisory Commission recommended that medical schools reduce enrollment significantly and that efforts be made to redistribute physicians geographically and by specialty. (Wayne State)

Part of state plan to go to 96/class. As of 10/81 officially capped at 72. (Southern Illinois)

Our facilities are best suited to 120 students. (Loyola-Stritch)

The state of Wisconsin has done a physician manpower study. The staff who conducted the study raised the specter of surplus. The assumptions they used are badly flawed and the report is very vulnerable. So far, no legislator has taken up the cause, but legislative pressure to reduce class size (since we receive some state aid) is always a possibility. (Medical College of WS)

UHS/CMS has increased its class size over a period of years, to our current level of 160 incoming freshman, in concert with our planned construction of a new facility. In January 1981 we occupied our 340,000 sq. ft. teaching/research facility, and in January 1982 we expanded our class size from 145 to 160. (Chicago Medical)

Funds are tied to F.T.E. enrollment funding in State of Ohio in large. (Med. Col. OH-Toledo)

As of March 8, 1983 there is discussion about the feasibility of reducing the 1983 entering class. It is uncertain whether such will be done in 1983, 1984, or ever in the foreseeable future. (Univ. of IL)

#### WESTERN REGION

I cannot imagine a change in size of class matriculating in September 1983 and feel a change in size of class entering in September 1984 is very unlikely. (Stanford)

We had planned to start cutting back four years ago because of the chronic under-funding of clinical departments, but decided to await GMNAC uproar and pressure from Hawaii Medical Association and then do what we planned to do anyway as if in response to the frankly commercial concerns of some of the HMA membership. (Hawaii)

We will sustain a 5 to 10% decrease in budget as compared to the 1982-1983 base for FY 1983-1984. This will be without a decrease in enrollment, however. This budget will be approximately that of the 1981-1982 total budget. (Univ. of Arizona)

The future entering class size is primarily dependent upon State appropriation and future academic direction. (Colorado)