



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**SPRING BUSINESS MEETING**

**SESSION I  
WEDNESDAY, MARCH 20, 1985  
5:30 P.M.-7:00 P.M.**

**SESSION II  
SATURDAY, MARCH 23, 1985  
8:30 A.M.-12 NOON**

**THE BALLROOM  
COTTONWOODS RESORT  
SCOTTSDALE, ARIZONA**

FUTURE MEETING DATES

1985 AAMC Annual Meeting

October 26-31  
Washington, DC

1986 COD Spring Meeting

April 2-5  
Key Largo, Florida

COUNCIL OF DEANS  
SPRING BUSINESS MEETING  
The Ballroom  
The Cottonwoods Resort  
Scottsdale, Arizona

AGENDA

	<u>Page</u>
I. Call to Order	
II. Report of the Chairman	
III. Approval of Minutes	1
IV. Discussion Items	
A. General Professional Education of the Physician .....	9
1. COD "Readers" Commentary .....	10
2. COD "Readers" Identification of Potential AAMC Initiatives .....	33
3. Draft Minutes of 1/14/85 Board Meeting Regarding GPEP Follow-up Activities .....	37
4. GPEP Follow-up Activities--Executive Council Agenda Excerpt .....	43
B. Graduate Medical Education .....	51
1. "Statement of Issues - AAMC Committee on Financing Graduate Medical Education" .....	52
2. Action of the ACGME on Clinical Skills Evaluation ....	68
3. Graduate Medical Education in Academic Medical Centers	70
4. Matching Medical Students for Advanced Residency Positions .....	71
5. National Medical Researcher Matching Program .....	74
C. Activities of the Federation of the State Board of Medical Examiners --Edward Wolfson, M.D. Chairman of the FSMB	

Agenda continued:

	<u>Page</u>
D. Use of Animals in Research: Planned Activities of National Association for Biomedical Research --Frances Trull Executive Director Foundation for Biomedical Research National Association for Biomedical Research	
E. Membership of Investor-owned Hospitals in the COTH .....	98
F. Proposal of <u>ad hoc</u> Group on Medical Residency Funding for the Fiscal Year 1986/NIH/ADAMHA .....	110
V. Information Item	
A. AAMC Clinical Evaluation Program .....	131
B. Clinical Research and Prospective Payment .....	133
C. The LCME's Use of NBME Examination Results .....	136
VI. Old Business	
VII. New Business	
VIII. Adjournment	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS  
ANNUAL BUSINESS MEETING

Monday, October 29, 1984

2:00 - 5:00 p.m.

Williford A & B

Conrad Hilton Hotel

Chicago, Illinois

Minutes

I. Call to Order

Edward J. Stemmler, M.D., Chairman, called the meeting to order at 2:04 p.m. He declared the presence of a quorum.

II. Chairman's Report

In brief remarks, Dr. Stemmler reflected on the discussions which have taken place in the past year on the role of the deans and their position within the Association. With Dr. Cooper's announcement of his intention to retire, these discussions have assumed a new level of significance. The Chairman exhorted the deans to participate vigorously in the coming months, in deliberations about Dr. Cooper's successor and future directions for the AAMC. He urged that they channel their views through the Administrative Board so as to enhance its role in the governance structure. He also expressed the hope that his "Dear Colleague" letters during the previous year have conveyed a sense of the issues faced and dealt with by the Administrative Board and the Executive Council.

III. President's Report

John A.D. Cooper, M.D., Ph.D., reviewed the Association's 13 year history in examining the impact and influence of new computer and communication technologies on medical education, biomedical research, and medical practice. Continued interest in this area is reflected in a seminar scheduled in January sponsored by the AAMC's Management Education Programs: "Information Management in the Academic Medical Center: Problems and Opportunities". Another initiative, planned in collaboration with the National Library of Medicine, is a conference in March 1985 entitled "Medical Education in the Information Age". Dr. Cooper encouraged the deans to give serious attention to their invitations to this conference. The resources available will allow approximately 45 schools to participate. Key policy makers from the executive and legislative branches of the government and representatives from the computer industry will be invited to attend. The conference will include discussion on the role of the library and bibliographic systems and other data bases in support of clinical decision-making, the development of expert systems such as INTERNIST, and the educational use of computers. The conference will also consider the education

and training of physicians needed to provide future leadership in these areas.

IV. Consideration of the Minutes

The minutes of the Spring Business Meeting were revised to correct the spelling of "New Madrick Fault" appearing on page 8 of the agenda book to "New Madrid Fault". The minutes were approved as amended.

V. Report of the Nominating Committee and Election of Officers

Richard Reynolds, M.D., presented the report of the Nominating Committee. For the deans' information, he announced that William T. Butler, President, Baylor College of Medicine, and Robert S. Daniels, M.D., Dean, University of Cincinnati College of Medicine, will be nominated to the Assembly the next day to fill two three-year terms on the Executive Council, and L. Thompson Bowles, M.D., Ph.D., will be nominated to fill a Council vacancy for a one-year term. Virginia Weldon, M.D., will be recommended for nomination as Chairman-Elect of the Assembly. Dr. Reynolds then moved the nominations of D. Kay Clawson, M.D. for Chairman-Elect of the Council of Deans, and of Walter F. Leavell, M.D., Thomas H. Meikle, M.D., and Henry P. Russe, M.D. for members-at-large Administrative Board. The motion was seconded and approved.

VI. Election of Institutional Members

It was moved that the Universidad Central del Caribe, having received full accreditation, be elected to institutional membership in the Association. The motion was seconded and approved.

VII. Discussion Items

A. Report of the Panel on the General Professional Education of the Physician

The Southern deans conducted small group discussions on each of the major conclusions of the GPEP report, at their fall meeting in Houston. Dr. Stemmler asked the group leaders to give brief reports to initiate the COD discussions of that report. Dr. Thomas Bruce, spoke first on the purposes of a general professional education. Dr. Bruce reflected the deans' thinking that, despite limitations on the deans' power within their institutions, it is possible to influence constructive curricular change. To do so does not require a different medical school organizational structure. Basic scientists were identified as important as role models for critical thinking and problem solving. Clinical faculty were especially important as positive role models in forming appropriate attitudes and teaching interpersonal skills. Faculty need to see each student as a whole person, with family, feelings, aspirations; they need to reflect a sensitivity to these dimensions in their interactions with students.

One school's tradition of a freshman retreat for students and faculty was an example of how this might be fostered. The deans were pleased with the health promotion/disease prevention recommendation. They believed that the philosophic differences between public health with its emphasis on group benefits and traditional medicine with its focus on the care of individuals need to be explored further, as these relate to how students are taught.

Dr. Arthur Christakos reported on the second GPEP conclusion: baccalaureate education. He noted that, while the deans felt this area deserved attention, they resisted the implication that there is something currently very wrong with medical school graduates. He stated various conclusions that were reached. A "balanced" rather than a "broad" baccalaureate course of study was what was sought. This demands both some required science coursework and freedom of choice in other areas. No specific requirements beyond the basic ones should be specified by the medical schools. Many of the desired skills of entering students depended upon the quality of education at the elementary, secondary, and college level, particularly expository writing skills. Medical school is not the appropriate place for remedial work in this area. MCAT scores indicate something about the academic potential of students, and if medical schools emphasize the science portions of this test, they should at least admit it. The addition of an essay section to the MCAT has value in emphasizing academic achievement beyond the required science courses. Finally, direct communication with premedical advisors and with regional or national premedical advisory organizations is invaluable to dispelling misconceptions by the advisors and by applicants concerning admissions policies. A brief discussion of several of these points followed.

Dr. Fairfield Goodale reported on the third GPEP conclusion: acquiring learning skills. The deans in his group recognized that students span a continuum ranging from independent to passive learners. While agreeing that it would be helpful to identify students at various positions on this continuum, the deans were not generally aware of reliable and valid methods for doing so. They supported the use of evaluation methods to assess analytical skills and opined that at least 25 percent of a student's grade should be derived from methods such as essays, research papers, oral exams, computer simulations, and taped patient interviews. They also objected to the use of the word "subjective" to describe evaluation methods other than multiple choice examinations. The deans generally agreed with comments regarding the NBME exams and felt that a useful change would be to report the scores only as pass or fail.

Dr. Goodale indicated the importance with which the deans viewed implementation of the recommendations regarding the reduction of scheduled time and lecture hours, and the promotion of independent learning and problem solving. All

deans in the group, however, reported unsatisfactory experiences in trying to reduce the curriculum load, primarily because problem-solving methods of teaching require both increased faculty time and faculty learning. Finally, the deans strongly endorsed the need for faculty to become familiar with computer technology and its application to medical education.

Dr. William Deal reported on the GPEP conclusion regarding clinical education. In general, the group endorsed each of the six recommendations made in this area. They emphasized the importance of faculty acquiring skills to evaluate and provide feedback on students' performance as they progress through their clerkships. Faculty tend to reinforce excellent performance more easily than to identify student deficiencies and plan strategies for improvement. The distortion of elective programs caused by students' pursuit of a residency program was seen as a serious issue which requires the cooperation of program directors for its resolution. Better integration of basic science and clinical education was clearly desired. A strategy for achieving this goal was the example of one school which places a three-month required basic science block of time subsequent to the core clerkships and preceding the elective period. The perceived relevance of the material at that point appears to be much greater and motivates the students to master it.

In speaking to the conclusion regarding enhancing faculty involvement, Dr. Paul Larson reported the deans' very negative reaction to the recommendation for a distinct organizational unit with academic responsibility and budgetary accountability for the educational program. The deans did admit that there is sometimes a disconnection between the developmental work of the curriculum committee and the implementation of the plan by faculty. Nevertheless, for changes to occur, the need must be seen by the dean, department chairman, and faculty. Initiatives to institute change can come from students, legislators, faculty, and university administration. The deans supported the recommendation for establishing a mentor system, but noted that large class sizes have diminished the capacity of many schools to mount effective programs. The University of Maryland program, which includes a faculty-first year student retreat, was highlighted as an effective effort in this area.

#### B. Financing Graduate Medical Education

Richard Knapp, Ph.D., Director of the Department of Teaching Hospitals, reviewed the Association's current activities in dealing with various legislative initiatives affecting the financing of graduate medical education. He reported that a committee has been formed to address this matter. Deans are represented on the committee by Drs. Weston, Kettel, Stoneman, and Petersdorf. Dr. Charles Sprague, the Executive Council Distinguished Service Member, is also on the committee. An

organizational meeting was held on September 12, together with educational sessions for each of the four Administrative Boards. Dr. Knapp promised that a workbook prepared for that committee meeting, consisting of appropriate background material including data presentations and important articles, would be sent in the next two weeks to each dean as well as to members of the other Councils. A copy of the testimony presented to Senator Durenberger's Committee by Dr. Stemmler and Thomas Smith, President of Yale-New Haven Hospital, had already been distributed. Dr. Knapp reported that the next committee meeting is scheduled for November 27th and he asked the deans for their help and support as the committee undertakes this difficult and important task.

C. Challenges Facing the Council of Deans and the AAMC: A Discussion of Issues and Priorities

Dr. Stemmler introduced Charles Sprague, M.D., to address the group on his thoughts concerning future directions for the AAMC. Dr. Sprague began his presentation by tracing the evolution of the AAMC from the "Deans Club" to a broad-based, highly sophisticated organization addressing an ever-widening range of health issues. This paralleled the evolution of the medical school, from an umbrella institution directed by the dean to a component, albeit a critical one, of a different umbrella organization, the academic health center. The changes in the role of the deans within their institutions has been followed by changes in the role of the Council of Deans within the AAMC. While the broadening of the AAMC recommended by the Coggeshall Report and accomplished under Dr. Cooper's leadership was timely and appropriate, Dr. Sprague suggested that the AAMC should now consider reversing directions and look to narrowing the scope and sharpening the focus of Association activities. He rejected ideas for creating an organization to speak for all health professions. What was needed in his view was greater collaboration and coordination among various organizations in areas of common interest. In this regard, Dr. Sprague noted with pleasure the recent meetings between the Executive Committees of the AAMC and the AAHC.

Dr. Sprague commented on the deans' felt lack of involvement in the many activities of the Association. He recalled that regional meetings among deans in the past had been very productive and were often the origin of issues later addressed at the national level. He suggested that the deans consider grouping themselves on other bases than just simply geography, for example, similarity of mission and objectives.

Dr. Sprague noted the problems of full involvement of the CAS in the affairs of the Association caused by the asynchronous timing of their member societies' meetings and those of the AAMC. Similarly, he indicated that questions have been raised about membership in COTH of those hospitals which have only peripheral relationships to medical schools. In his view, the

gap between teaching hospitals with primary and secondary affiliations is certain to widen with the inevitable change in patient care reimbursement policies.

Dr. Sprague mentioned but did not discuss two other areas which he felt deserved priority attention by the AAMC in the future: the financing of medical education and technology transfer. He concluded his presentation by suggesting that a task force be appointed to analyze carefully and deliberately the future course of the Association and that perhaps consideration be given to a second Coggeshall Report.

A limited discussion which followed Dr. Sprague's presentation was opened by Dr. Daniel Tosteson, who suggested that a change in the name of the organization to "The Association of American Medical Centers" might better reflect the institutions in which deans work. Dr. Richard Janeway endorsed this idea as better reflecting the cooperative relationships between medical schools and teaching hospitals that the AAMC actually represents. After some further discussion, both clarified that they were not implying by this idea a broadening of representation from other health professions schools in the Association. The comment was made that any change in the name of the Association should proceed slowly.

Dr. Janeway also indicated that a search committee for Dr. Cooper's successor has been formed and would be announced to the Assembly the next day. He described the broad charge given to the committee as generally consonant with Dr. Sprague's ideas and could perform the functions of his suggested task force. This appeared to be accepted by the deans and the idea of a separate task force was not discussed further.

#### VIII. OSR Report

Dr. Pamelyn Close reported that 105 schools were represented in the OSR meetings this year and thanked the deans for their support of student attendance. The OSR meeting focused on the GPEP report. Small group discussions were held on: 1) baccalaureate education and acquiring learning skills; 2) clinical education; and 3) faculty involvement. The discussions produced a number of very specific recommendations for implementing changes called for by GPEP. Dr. Close encouraged the deans to consider the recommendations which will be listed in the OSR minutes. Other highlights of the meeting were presentations by Dr. Quentin Young and Dr. Robert Petersdorf on the changing circumstances of medical practice in the coming years.

An OSR Report completed in the past year also focused on economic changes affecting medical practice, and another which dealt with ethical dilemmas encountered by third and fourth year students. The latter has been followed-up by collaboration with the Society of Health and Human Values aimed at producing case studies for use in the medical school curriculum.

Dr. Close expressed the students' concerns shared by deans about maintaining the academic integrity of the fourth year and not losing it to the residency hunt. She announced OSR plans to produce a compendium on computers in medicine and reported that the students again recommended that NBME exam results be reported only in terms of pass/fail.

In conclusion, Dr. Close asked the deans to consider increased representation and involvement of house staff in the AAMC affairs. This has been a topic of continuing interest by the OSR. Dr. Stemmler responded to this point by stating that this issue would be put before the COD Administrative Board and channeled into deliberations about the Association's future directions.

#### IX. New Business

One item of new business was introduced by Dr. William Stoneman, St. Louis University College of Medicine. He expressed his concern about the number of students seeking transfer for a portion of their junior year to enroll in clerkships at other institutions for the purpose of enhancing their chances for obtaining residency positions at those institutions. This practice has been encouraged by residency program directors. Dr. Stoneman noted that language in the LCME draft Standards, requiring supervision of required clerkships by members of the school's faculty, is intended to take care of this problem. However, he felt that the problem is a smouldering one which is bound to get worse with increased competition for residency positions. The problem holds dire consequences for the junior year curriculum, and requires a concerted and strong stand by schools of medicine.

A show of hands confirmed impressions that many other deans were beginning to experience this problem. With Dr. Stoneman's permission, Dr. Stemmler accepted the statement as an item of business to be referred to the COD Administrative Board.

Dr. Stemmler announced that the first set of responses to a request for biographical information from deans has been compiled in a COD Roster. The booklets were available for distribution at that time. A second request for information from deans not yet included will be forthcoming.

Dr. Stemmler presented a certificate and gift to two deans who have retired from the Administrative Board: John Chapman, M.D., Dean, Vanderbilt University School of Medicine, and Fairfield Goodale, M.D., Associate Vice President for Health Affairs and Executive Dean, Bowman Gray School of Medicine of Wake Forest University. A certificate and gift will also be sent to M. Roy Schwarz, M.D., Vice President for Medical Education and Science Policy, American Medical Association, who was not present.

X. Installation of New Chairman

With the major business completed, Dr. Stemmler presented Arnold Brown, M.D., Dean, University of Wisconsin College of Medicine, as the new Chairman of the Council of Deans. Dr. Brown, in his first action, read the following motion:

"The Council of Deans of the Association of American Medical Colleges expresses its appreciation to Edward Stemmler for his outstanding tenure as Chairman of the Council. His emphasis on bringing us closer together by enlarging the participation of all the deans in the affairs of the Council and the Association, and by improving the communications between us has significantly improved our organization. His receptivity to new ideas, his close attention to our concerns in the affairs of the Council, his evenhanded conduct of administrative matters, his reasoned and effective advocacy of our views before a variety of forums, and his persistent good humor, place him among our most respected and admired chairmen"

The motion was seconded and approved unanimously. Dr. Brown then presented Dr. Stemmler with a token of appreciation for his year of service.

XI. Adjournment

The meeting was adjourned at 4:42 p.m.

## GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN (GPEP)

When the Executive Council received the report of the Panel on the General Professional Education of the Physician (GPEP), they announced that it would develop a "mechanism to review the report and to advise on its use in the development of Association policies and the design of Association programs." Dr. Stemmler, then chairman of the Council of Deans, appointed a small group to engage in a close reading of the GPEP Report for the purpose of identifying those recommendations which were: a) purely within the confines of local consideration and action, b) those that might suggest some form of inter-institutional cooperation, and c) those that required deliberation and activity at the national level through the AAMC. The four readers convened through conference call and produced a list of topic areas that suggested a role for the AAMC.

Each of the readers commented on each recommendation of the GPEP Report. Their commentary, collated by recommendation, appears on pgs. 10-32. The group then met by telephone conference call and produced a list of topic areas that suggest a role for the AAMC (see pgs. 33-36). The COD Administrative Board discussed this matter on January 24, 1985. An excerpt of the draft COD Administrative Board minutes appears on page 37 .

The AAMC Executive Council January agenda contained a series of proposed follow-up activities for consideration (see pgs. 43-50). The Council deferred action in order that it have the benefit of a joint discussion involving the COD and the CAS Administrative Boards. That meeting will take place on April 3, 1985. Meanwhile, the CAS has established a working group on the GPEP Report which will meet on Wednesday, March 13, 1985.

## CONCLUSION 1

### Recommendation 1

In the general professional education of the physician, medical faculties should emphasize the acquisition and development of skills, values, and attitude by students at least to the same extent that they do their acquisition of knowledge. To do this, medical faculties must limit the amount of factual information that students are expected to memorize.

#### Stemmler:

The balance between acquisition and development of skills, values, and attitudes by students and the need for students to acquire this knowledge must be left up to the faculty of the individual school. Clearly the need to acquire knowledge and the culture into which that knowledge is placed has always been a dilemma in education and will continue to be. The interpretation of this problem and the plans towards its resolution constitute the fundamental style of any individual school.

#### Brown:

primarily the responsibility of the medical schools and their faculties; help could be provided by the AAMC to schools and faculties by developing and giving seminars, courses, and texts relating to the acquisition of the necessary skills and concepts to effect this recommendation

#### Moy:

AAMC should advocate this to the individual institutions as well as to the LCME. Specifically, I think that each institution should be expected to state publicly the general objectives that they wish to achieve in their graduates by the time they have finished the curriculum and also to have in place sufficient mechanisms of evaluation that they can be sure that they have reasonably achieved these objectives. Except for this general expectation, however, I would expect that the institutions would be given broad degrees of freedom to define their goals and evaluation mechanisms.

#### Chapman:

There must be a balance between the development of skills, values and attitudes and the acquisition of knowledge such that the combination provides a useful outcome. Knowledge without access to the target of that knowledge is not useful and access to the target is not useful without the background of information and skill.

The institutional profile is an institutional strategic policy plan of the school.

The Association might play an important role in the identification of schools by profile in a manner such that schools may identify the profile

and, accordingly, either emphasize or modify that profile in accord with institutional strategic design.

### Recommendation 2

The level of knowledge and skills that students must attain to enter graduate medical education should be described more clearly. This will require closer liaison between those responsible for general professional education and those responsible for graduate medical education.

#### Stemmler:

Our Association may play a leadership role in exploring, along with the community of medical schools, the possibility of defining the level of knowledge and skills that students should attain as a requirement for receipt of the M.D. degree. This requires a broad examination of the total acquisition of knowledge and skills acquired by an individual studying medicine up to the time of board certification. Although this would be a formidable undertaking it is one worth considering if the recommendation made in number 2 is serious.

#### Brown:

This will require a national effort that should be led by the AAMC.

#### Moy:

AAMC general advocacy of this recommendation is entirely appropriate. Here again, I think that a more specific insistence that institutions clearly write out their commencement objectives as mentioned in Recommendation 1 is appropriate and that this should be advocated through the LCME. I think AAMC should also continue to point out the inappropriate use of National Boards as currently constructed for the selection of residents, particularly when only Part I is available.

#### Chapman:

Institutions need to identify the relationship between requirements to enter and the efforts required once entered. Further, the relationship between what is understood and practiced as students in requirements for the M.D. degree must be viewed as approaches to further education and training. The Association might play a useful role by profiling students in relationship to the points of emphasis identified by school emphasis.

### Recommendation 3

Medical faculties should adapt the general professional education of students to changing demographics and the modifications occurring in the health care system. Future practice will be shaped more by these changes and modifications than by the traditional medical care system of the past three decades.

#### Stemmler:

Individual schools, public or private, assume different responsibilities in order to fulfill their missions. How a school adapts to its external environment depends upon its interpretation of what constitutes its mission. This recommendation should be left up to individual school's discretion.

#### Brown:

primarily the responsibility of the medical schools and their faculties

#### Moy:

AAMC is very effective in identifying such issues and making debate upon them and recommendations concerning them available to its major constituencies; such as the Council of Deans, Council of Teaching Hospitals, and Council of Academic Societies. It could well be appropriate for AAMC staff to identify ways to more directly include students in the debates or make available to faculties resources and programs that would more directly involve students in these ambient affairs.

#### Chapman:

The general professional education of students must include the ecology of medical care as well as the substance of the care of patients and must be incorporated into the institutional strategic plan as implemented by departments and faculty.

Recommendation 4

Medical students' general professional education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease.

Stemmler:

Whether a school chooses to include the broad concerns of communities and the promotion of health and prevention of disease is a choice that should be left up to the individual faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC should provide general advocacy for this goal, but I do not think it should be more prescriptive than that.

Chapman:

Medical students must engage the excitement of health promotion and disease prevention in the same way that most now engage treatment and remedy. The Association can serve as a clearing house for circumstances which encourage these efforts.

CONCLUSION 2

Recommendation 1

College and university faculties should require every student, regardless of major subject or career objective, to achieve a baccalaureate education that encompasses broad study in the natural and social sciences and in the humanities.

Stemmler:

Our Association ought to initiate a collaborative effort shared by the major associations of higher education, to achieve the purposes of this recommendation. We are here speaking about the kind of education that should be possessed by an educated public. Included herein would be a broad study not only of the natural, social sciences, and humanities, but, also, a fundamental understanding of human biology. The baccalaureate

degree has not been compromised just for preparation for medicine. Rather, the entire cultural shift toward preparation for future employment has permeated undergraduate education. We can certainly associate ourselves with a movement of renewal initiated by higher education itself, a movement that is so necessary for the future of our society.

Brown:

this will require the development of a broad concensus that can only be obtained by the joint efforts of the medical schools and baccalaureate level colleges. This can be best catalyzed by the AAMC

Moy:

AAMC should provide general advocacy for the achievement of a baccalaureate degree before entering medical school. There is no longer any cogent need to take students after three years of college. My own experience suggests AAMC advocacy for broader educational experience would be best directed at college presidents and university vice presidents of academic affairs rather than premed advisors.

Chapman:

Preparation for a position in society is the principal effort reflected in a collegiate education. The "topping" upon this substance should orient toward medicine though it should not divert one from the substance of this purpose. The institution determines this goal; the faculty implements it. A statement of this objective and its expected outcomes could be an effective means whereby evaluation of this recommendation is achieved. m  
319/

#### Recommendation 2

In framing criteria for admission to medical school, faculties should require only essential courses. Whenever possible, these should be part of the core courses that all college students must take. Medical school admissions committees' practice of recommending additional courses beyond those required for admission should cease. Some institutions may wish to experiment by not recommending any specific course requirements.

Stemmler:

Our Association could lead a discussion of admissions requirements. Here I would strongly recommend that the discussion focus itself, not on course requirements, but rather on the knowledge content required by individuals who are to enter medicine. By approaching the question in this way, we leave open the possibility that the colleges themselves may reorganize their course content toward the streamlining of education in science. Another approach to this question would be to stimulate a broad national study of biological science education in America. The purpose of such a

study would be to address the need for simplicity and integration in the study of modern biology.

Brown:

primarily the responsibility of the medical schools and their faculties with strong support of the deans.

Moy:

AAMC should provide general advocacy for the concept, but not be directly prescriptive, to medical schools. One role for the AAMC might be to study the admissions results of classes of medical schools that have different policies in regard to required and recommended courses to see if there are any measurable differences.

Chapman:

Admission requirements could be based in a context related to an understanding or skill or approach which has a reasonable expected outcome in adult life as related to the requirements of the profession. The statement of a requirement should reflect a needed outcome upon which wise judgements, effective actions and constructive approaches can be mounted as adult citizens of a community with special emphasis in medicine. Scholarship and scholarly endeavor should be defined by precept at all levels of the educational experience and interaction with those of scholarly approach must be the experience at all levels. It is the individual interaction between teacher and learner which defines the attitude and approach which leads to scholarly endeavor as a way of life. Medical students are admitted to study with the faculty. Decisions regarding admission to this status are properly a faculty matter within the broad institutional policy. Faculty members who make such decisions must be encouraged to evaluate the decision-making process in relationship to the basis for that decision made in a retrospective look as well as a prospective plan for the future. The Association may be helpful in identifying relationships between criteria used, observations made and outcomes experienced.

### Recommendation 3

College faculties should make the pursuit of scholarly endeavor and the development of effective writing skills integral features of baccalaureate education.

Stemmler:

Our Association should prod our colleague associations in higher education to address this fundamental requirement of scholarship. To be candid, the colleges themselves should be pressing for better preparation of students by the elementary and secondary schools.

Brown:

this must be worked out at the local level between the medical schools and the colleges from which their students come

Moy:

AAMC should provide general advocacy, but with the specific continued exploration, of a composition section of the MCAT.

Chapman:

Scholarship and the ability and facility to communicate the basis and outcome of scholarship is essential to the substance and progress of the profession. The accreditation and certification process of medical education must require these qualities in the educational program. The Association, as a party interested in medical education, can have an important effect in this regard.

#### Recommendation 4

Medical school admissions committees should make final selection decisions using criteria that appraise students' abilities to learn independently, to acquire critical analytical skills, to develop the values and attitudes essential for members of a caring profession, and to contribute to the society of which they are a part.

They should use the Medical College Admission Test only to identify students who qualify for consideration for admission. Medical faculties should determine whether the relative weights accorded by their admissions committees to the scores in the six sections of the Medical College Admission Test are consistent with the best use of the examination as a predictive instrument.

The Association of American Medical Colleges is encouraged to continue its efforts to add an essay section to the Medical College Admission Test.

Stemmler:

Recommendations of this sort directed at admissions decisions have always suffered because of the lack of discernable criteria needed to predict success. To the extent possible, our Association might promote efforts to identify such discriminators.

The role and function of the MCAT are clearly under our purview. I do believe that we should take the time to examine the positive and negative outcomes of the current form of MCAT and to determine whether adjustments ought to be made. This would require an active undertaking by our Association.

Brown:

both the schools and the AAMC will have to address this recommendation; the schools by the criteria they use in their admission process and the AAMC in any modification of the MCAT

Moy:

I agree that the AAMC should continue to explore the use of the essay. It would be very difficult to demand, let alone enforce, the use of the MCAT's as recommended by GPEP. AAMC might challenge the institutions to study the results of their use of the MCAT to see if high scores, particularly at the expense of other attributes, result in the quality product they apparently expect.

Chapman:

The judgment regarding the balance among objective measures of performance and ability as modified by judgment based on subjective criteria should be a policy decision of faculty represented by properly constituted committees. Preparation, ability and motivation are all essential to a successful program of learning. The Association may be helpful in helping schools to identify the balance in the process which now exists and accordingly help schools to modify this process where it is felt desirable.

#### Recommendation 5

Communication between medical school and college faculties about the criteria medical faculties use to select students for admissions should be improved.

Stemmler:

The communication between the medical school and college faculties is, in general, the business of individual schools. Nonetheless, the AAMC may wish to consider programs which facilitate such communication.

Brown:

primarily the responsibility of the medical schools

Moy:

AAMC should give general advocacy.

Chapman:

The communication needs to be improved in ways which inform through understanding. The Association may be very helpful through interaction with the organization of Health Professions advisors and other related groups. Individual schools can also be important in this regard at their own initiative.

### CONCLUSION 3

#### Recommendation 1

Medical faculties should adopt evaluation methods to identify: (a) those students who have the ability to learn independently and provide opportunities for their further development of this skill; and (b) those students who lack the intrinsic drive and self-confidence to thrive in an environment that emphasizes learning independently and challenge them to develop this ability.

#### Stemmler:

The evaluation of students is the responsibility of individual faculties. Techniques to evaluate students who have the ability to learn independently by some explicit standard may require the development of those standards. The Association may or may not wish to be involved in such an undertaking.

#### Brown:

primarily the responsibility of the medical schools and their faculties; the role of the AAMC should be to collect and circulate the appropriate literature on such evaluation methods.

#### Moy:

AAMC should provide general advocacy for this recommendation. More specific advocacy should come from the LCME; however, it does anticipate the availability of potentially complex and sophisticated evaluation mechanisms that the schools perhaps should have, but I suspect that many of them don't. The area of problem-solving skills and the capacity for independent learning might be something AAMC should study at the level of the MCAT examination or undergraduate content.

#### Chapman:

Students who have a zest for learning differ significantly from those students who do not. Evaluation and the results of evaluation are the common currency for the identification of success or the lack of it. It is essential that medical faculties adopt methods to evaluate those who do and those who do not express this zest for learning on a continuing basis. Medical faculties should arrange the curriculum to have sufficient structure to afford guidance and sufficient flexibility to encourage initiative. Information transfer is not necessarily teaching nor is it necessarily learning. The institution should adapt the mode of teaching and the expectation of learning to the anticipated optimal outcome as to behavioral development in the learner. The Association may be helpful in identifying the spread and variation of approaches in this regard and share these with institutional membership.

### Recommendation 2

Medical faculties should encourage students to learn independently by setting attainable educational objectives and by providing students with sufficient unscheduled time for the pursuit of those objectives.

#### Stemmler:

The management of time is the responsibility of school faculties.

#### Brown:

primarily the responsibility of the medical schools and their faculties

#### Moy:

All are necessary corollaries of Recommendation 1.

#### Chapman:

Time management in relation to educational objectives should be an interaction between students and faculty. The Association could be very helpful in identifying schools by unscheduled time in relationship to student attitudes, student performance and student outcomes as measured by some independent effort. This observer is not entirely consonant with meeting obtainable educational objectives through unscheduled time coefficients. I am, however, willing to be taught that there is an important relationship between the two. There may be--there may not be. Perhaps the Association can be helpful identifying the relationship, if any.

### Recommendation 3

Medical faculties should examine critically the number of lecture hours they now schedule and consider major reductions in this passive form of learning. In many schools, lectures could be reduced by one third to one half. The time that is made available by reducing lectures should not necessarily be replaced by other scheduled activities.

#### Stemmler:

The reduction of lecture hours is the responsibility of school faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

All are necessary corollaries of Recommendation 1.

Chapman:

There is a potential premise expressed in the recommendation that lecture hours equal a passive form of learning. Perhaps the Association can be helpful in identifying means whereby lecture hours can be guidance efforts toward a more active form of learning.

Recommendation 4

Medical faculties should offer educational experiences that require students to be active, independent learners and problem solvers, rather than passive recipients of information.

Stemmler:

The nature of the educational program within an individual school is the responsibility of the school faculty.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

All are necessary corollaries of Recommendation 1.

Chapman:

The style and emphasis of the educational program as to active/passive or positive/negative in the independent learning and problem-solving sphere is a matter of school profile. The Association could be helpful in assisting each school to identify that profile in a meaningful way which can be measured and, accordingly, altered if thought feasible by the faculty.

### Recommendation 5

In medical schools whose programs emphasize the development of independent learning and problem-solving skills, the evaluation of students' academic performance should be based in large measure on faculty members' subjective judgments of students' analytical skills rather than their ability to recall memorized information. The Association of American Medical Colleges should institute a program to assist faculties in adopting and using evaluation methods to judge medical students' abilities and to analyze and solve problems.

#### Stemmler:

Again evaluation methodology belongs to the school faculties. The emphasis in the utilization of faculty member's subjective judgments offers some risk that must be balanced by the utilization of more objective measurements. This has been a problem in education since the beginning of education and will continue to be so.

Our Association might well attempt to institute programs aimed at assisting faculties in using methods which can judge the ability of medical students to analyze and solve problems.

#### Brown:

primarily the responsibility of the medical schools and their faculties; the AAMC should develop courses, seminars, and workshops for faculty on the use of such evaluation methods.

#### Moy:

I strongly disagree with the word "subjective" since several institutions have come up with reasonable objectives, reproducible mechanisms for evaluating clinical competence, skills, and behavior. However, I do agree that the AAMC can assist institutions by continued identification and testing of these sophisticated mechanisms and making them more broadly available to other institutions. As stated previously, I feel strongly that institutions should be called upon to clearly state their overall objectives and the demonstrate that they have the internal evaluation mechanisms to determine that they have achieved these objectives. Step 1 is simply the application of the same scholarship and discipline to education that institutions expect from their laboratory researchers and clinicians. Step 2, however, does require the establishment of new, sophisticated evaluation mechanisms and I think most institutions will require considerable assistance over the next several years to achieve that. I think this is a clear and important role for the AAMC.

Chapman:

Evaluation is the common currency of how people understand and place a priority value on achievement. A profile is more desirable than a grade. The attached profile used by this observer has been found to be satisfactory if endorsed and used fully and vigorously by the faculty. The latter is an important issue and occasionally an important problem. The Association might well help in assisting faculties to develop methods which are both valid and reliable in this regard.

#### Recommendation 6

Medical schools should designate an academic unit for institutional leadership in the application of information sciences and computer technology to the general professional education of physicians and promote their effective use.

Stemmler:

It is the business of the school to determine whether or not it should designate an academic unit for the application of information sciences and computer technology.

Brown:

the responsibility of the medical schools

Moy:

I think this recommendation is too directive. I think AAMC can identify that there are institutional needs to be met, but that institutions should be allowed to meet this need within their own structures and traditions.

Chapman:

The use of mechanical representation of information, its storage and application is a means by which human factors of management and analysis may be enhanced. These powerful tools need to be a part of the program of study and achievement in all schools. Many schools are seeking to move in this direction by adopting a methodology without clear indication of where that methodology leads nor what its outcome will be. The Association may be helpful in identifying those institutions with clear vision of outcome and relating it to methodology whereby that outcome is approached.

## CONCLUSION 4

### Recommendation 1

Medical faculties should specify the clinical knowledge, skills, values, and attitudes that students should develop and acquire during their general professional education.

#### Stemmler:

The explicit designation of the clinical knowledge, skills, values, and attitudes that students should develop and acquire is the fundamental responsibility of a school of medicine. Our Association might well take an active role in providing a forum by which the schools can share their efforts toward this end.

#### Brown:

primarily the responsibility of the medical schools and their faculties; the role of the AAMC would be to develop general criteria that individual schools could consider

#### Moy:

Quite obviously I very strongly agree with this and feel it should not be only a clear expectation by the AAMC, but should be a requirement of the LCME for accreditation. If an institution submitted a program project research grant involving many departments and had no clearly defined objectives as to what it was they were trying to achieve, it not only would fail to be funded, but would reflect very badly on the sophistication of the institution.

#### Chapman:

Clinical knowledge, clinical skills, clinical values and those attitudes addressing the clinical situation should be identified in ways which can be addressed in descriptive terms relating that description to the performance of each student in the clinical context. The approach used at this institution is reflected on the attached evaluation program.

### Recommendation 2

Medical faculties should describe the clinical settings appropriate for required clinical clerkships and, in conjunction with deans, department chairmen, and teaching hospital executives, plan organizational strategies and resource allocations to provide them.

Stemmler:

The description of the appropriate clinical setting for clinical clerkships is the business of the school's faculty. Our Association might well provide a forum through which the schools share information toward that end.

Brown:

primarily the responsibility of the medical schools, teaching hospitals and faculties

Moy:

AAMC should give general advocacy to this concept, but the specific identification and judgment of clinical settings is more properly the responsibility of the LCME.

The setting in which clinical care is provided, taught, and received must be a joint endeavor among those who have the responsibility for clinical care of the patient, responsibility for the setting in which that care is given and responsibility for the teaching and learning exercised in that care. In the ordinary circumstance, the department is the initiating point in charge of that setting as it relates to patient care. Where the department is also the clinical service, the chief or chairman of that department or service is integral to the proper functioning of both service and academic department. The Association may be helpful in identifying agreements and arrangements consonant with effective teaching and learning, effective care and agreeable circumstances.

Chapman:

The setting in which clinical care is provided, taught and received must be a joint endeavor among those who have the responsibility for the clinical care of the patient, responsibility for the setting in which that care is given and responsibility for the teaching and learning exercised in that care. In the ordinary circumstance, the department is the initiating point in charge of that setting as it relates to patient care. Where the department is also the clinical service, the chief or chairman of that department or service is integral to the proper functioning of both service and academic department. The Association may be helpful in identifying agreements and arrangements consonant with effective teaching and learning, effective care and agreeable circumstances.

### Recommendation 3

Those responsible for the clinical education of medical students should have adequate preparation and the necessary time to guide and supervise medical students during their clinical clerkships.

Stemmler:

The nature and qualifications of the faculty utilized to educate medical students is the business of the schools.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC's role here should be strong general advocacy aimed primarily at the expectation that medical schools will hold a very high priority for the commitment to the faculty to undergraduate medical education. They are being paid to do it, they have the faculty title that expects that they do it, and they should bring to it the same scholarly discipline that they bring to their other professional activities.

Clinical education of medical students requires more than appropriate care of patients and must be provided in a timeframe and with a support system consonant with those responsibilities. The point that the experience should be sufficiently flexible to provide for a controlled initiative is important here. The functioning of the student as part of the group effort toward the welfare of the patient is also an important goal in this regard. Faculty members who practice the art of care, the science of medicine and the effort of teaching should be so rewarded in status or otherwise.

Chapman:

Clinical education of medical students requires more than appropriate care of patients and must be provided in a timeframe and with a support system consonant with those responsibilities. The point that the experience should be sufficiently structured to afford guidance and safety and sufficiently flexible to provide for a controlled initiative is important here. The functioning of the student as a part of the group effort toward the welfare of the patient is also an important goal in this regard. Faculty members who practice the art of care, the science of medicine and the effort of teaching should be so rewarded in status and otherwise.

Recommendation 4

Medical faculties should develop procedures and adopt explicit criteria for the systematic evaluation of students' clinical performance. These evaluations will provide a cumulative record of students' achievements as they progress through their clerkships. Faculty members should share timely evaluations with students: they should reinforce the strengths of their performance, identify any deficiencies, and plan strategies with them for needed improvement. These procedures should facilitate the

recording of faculty members' impressions of the students' personal characteristics and attitudes.

Stemmler:

The procedures used to evaluate clinical clerks or clinical performance of medical students is the business of the schools. Our Association should continue its effort to provide assistance to the schools as they further refine the fulfillment of these responsibilities.

Brown:

primarily the responsibility of the medical school and their faculties

Moy:

Obviously I strongly agree with this recommendation except for the now implied assumption of subjective faculty evaluation. Evaluation of skills, judgment, behavior and problem solving is extremely important and I think it is most timely to solve this whole problem since obviously it is now possible. I would recommend strong AAMC advocacy and strong LCME expectation.

Chapman:

Evaluation and how an organization evaluates and reports performance is one of the hallmarks of an organization which has a defined program of quality which can be modified in ways which support the enhancement of that quality. Evaluating clinical performance carries with it a different type of responsibility. The means whereby this institution evaluates our clinical performance is provided in the attachment.

Recommendation 5

Medical faculties should encourage their students to concentrate their elective programs on the advancement of their general professional education rather than on the pursuit of a residency program.

Stemmler:

Our Association should do more than to make such a recommendation but, rather, provide some leadership to minimize the adverse effects of current competition for residency positions upon the undergraduate medical curriculum.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC should provide general advocacy not only to institutions but also to LCME and ACGME, but should not be further prescriptive.

Chapman:

Electives have become a prominent part of American medical education. Selectives have developed as intermediates between required and fully elective pursuits. Pursuit of a residency position has become an emotional imperative for many students. Departmental specialty groups are perpetuating a circumstance which, at times, promotes this anxiety and diminishes what could be a better spent elective program. The Association may be helpful in identifying these circumstances where they appear to exist and counsel with those specialties and organizations which appear to be encouraging a less than wholesome opportunity in the elective experience.

#### Recommendation 6

Where appropriate throughout the general professional education of physicians, basic science and clinical education should be integrated to enhance the learning of key scientific principles and concepts and to promote their application to clinical problem solving.

Stemmler:

The nature of a school's curriculum is clearly the business of the individual faculties.

Brown:

the responsibility of the medical schools

Moy:

Here also AAMC should give general advocacy to institution but not be prescriptive.

Chapman:

Circumstances wherein understanding is enhanced through multi-disciplinary participation could be highlighted in ways which provide institutions the opportunity of focusing upon the problem and its solution rather than upon the discipline and its content. The "territoriality" of the curriculum needs to be modified in such a way that the focus is not possession of territory in the curriculum but responsibility for teaching an approach toward the solution of a problem or problems. Perhaps a problem-oriented curriculum could be designed in a way that individual schools and, within schools, departments could select from the approach; that approach which seems best in the context of the individual school. Financial support for

the educational program must necessarily be multi-variant and will be distinctly school related with the integrity of the school relying heavily upon the integrity of departments. The Association can provide leadership through seminars and other information generating efforts that address economic matters for deans, departmental chairmen and others having similar responsibilities.

## CONCLUSION 5

### Recommendation 1

Medical school deans should identify and designate an interdisciplinary and interdepartmental organization of faculty members to formulate a coherent and comprehensive educational program for medical students and to select the instructional and evaluation methods to be used. Drawing on the faculty resources of all departments, this group should have the responsibility and the authority to plan, implement, and supervise an integrated program of general professional education. The educational plan should be subject to oversight and approval by the general faculty.

#### Stemmler:

The organization and supervision of a school's curriculum is the business of the individual schools.

Brown: primarily the responsibility of the medical schools and their faculties

#### Moy:

AAMC should give general advocacy for this need, acknowledging the more direct oversight of the LCME. Here again, there is a need to be met, but I think that the specific structures should be left to the individual institutions.

#### Chapman:

The organization to which the school turns for coordination and development is ordinarily the department. Rarely does an institution-wide committee have sufficient "muscle" that circumstances can be modified significantly. The department chairs are integral in this regard as are the departments. A person within the dean's office who has principal responsibility of overseeing, coordinating and developing the curriculum through tactical expertise is essential for a developing educational program. In the final analysis, it will be a departmental decision implemented by departmental members.

## Recommendation 2

The educational program for medical students should have a defined budget that provides the resources needed for its conduct. Expenditures from this budget should be as distinctly related to the educational program as are other funds restricted to specific purposes, such as research or research training.

### Stemmler:

How a school organizes its finances toward the implementation of its educational program is clearly the business of the schools.

### Brown:

responsibility of the deans of the medical schools

### Moy:

I find this a very troublesome recommendation. While I can see the potential power of it in clearly identifying to faculty that they are being significantly paid to perform quality undergraduate medical education and may provide some further leverage to the administrative structure; on the flip side, however, are all the perils of coming up with readily available, but probably not sophisticated estimates of the costs to educate medical students which can be compared and contrasted across institutions. We may come to this as a result of the insistence of state legislatures and the "unbundling" of teaching hospitals, but I am concerned about being able to get this genie back in the bottle.

### Chapman:

The identification of budget in relationship to educational program is properly the responsibility of individual schools. It is doubtful to this observer that a direct relationship between income for education and expenditure for education will be possible or, perhaps, even desirable. With current realities, Recommendation 2 does not appear to this observer to be amenable to precise interpretation in implementation. However, a budgetary allocation for education can be implemented and should be. That it be the entire support for education, I think, overstates the response.

## Recommendation 3

Faculty members should have the time and opportunity to establish a mentor relationship with individual students. The practice of having a large number of faculty members, each of whom spends a relatively short period of time with medical students should be examined critically and probably abandoned.

Stemmler:

This recommendation is aimed at the nature of the internal culture of a school. It belongs under the responsibility of the schools.

Brown:

responsibility of the medical schools and their faculties

Moy:

Here again, I would advise general advocacy realizing the LCME also has oversight here, but avoid being too prescriptive.

Chapman:

The interaction of a student and a faculty member is fundamental to the learning process and, for most faculty, fundamental to faculty satisfaction. Departments should support it, faculties should practice it, and schools should endorse it as a working principle or a rule. Faculty members must proficiently practice their professional role while, at the same time, broaden the base of their activities such that students view them both as professionals in a discipline specific to their interests and training as well as physicians and scientists of a more generic form. Faculty status and faculty promotion should be accorded with these points in mind. While individual faculty members should be directly related to individual medical students, a general program of student affairs and counseling students in the context of their career could be a prominent part of the organizational framework of the school of medicine. The priority of education and the development of both faculty and students as an integral part of the responsibility of the dean and the chairmen is a hallmark by which a school should be known as well as that hallmark related to research and service.

Recommendation 4

Medical schools should establish programs to assist members of the faculty to expand their teaching capabilities beyond their specialized fields to encompass as much of the full range of the general professional education of students as is possible. The Association of American Medical Colleges should facilitate the development of these programs.

Stemmler:

The responsibilities to be assumed by faculty members in the undergraduate medical education come under the auspice of the schools. Here our Association might well consider initiating a program of grants to selected faculty for the development of competence in the field of general professional medical education.

Brown:

primarily the responsibility of the medical schools and their faculties; the AAMC must provide courses, seminars, workshops, and gather the appropriate literature

Moy:

I agree that the AAMC could provide very important leadership here. The general assumption is that a mentor would have to be a highly sophisticated generalist. While this is desirable, it is not necessarily true. The important factor is that in self-directed learning you are assisting the student in learning for themselves, not giving them the answers, and in fact, the mentor as well as the other members of the small group can learn a great deal from the student who has effectively solved his own assigned learning needs. This is, however, very much a skill and can be acquired. I think this could be a very important role for the AAMC.

Chapman:

Teaching teachers how to teach is, in this observer's view, not a highly productive program of effort. Channeling energies and providing opportunities for understanding as well as providing prototypes for consideration can be important contributions on the part of the Association. Recognition awards for teaching, both locally and nationally, can also be helpful either by the Association or otherwise at the local level. Special grants such as those from the national funds for medical education can also be helpful.

#### Recommendation 5

Medical faculties should provide support and guidance to enhance the personal development of each medical student.

Stemmler:

This is clearly the responsibility of school faculties.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC can advocate and raise the level of concern. Here again, LCME provides specific oversight to see that these support mechanisms are in place.

Chapman:

Personal development of the medical student is a very personal matter to the student which can, through guidance from faculty and offices of student affairs and others, be facilitated though it is a highly personal thing. Experience on a national level to how students interact with their schools through student affairs and faculty advisory systems might be helpful. In general, the faculty advisory system beyond the mechanical process of enrollment and registration has been disappointing. Areas in which greater success have been achieved would be of interest to schools generally and might be an effort on behalf of schools by the Association.

Recommendation 6

Experience indicates that the commitment to education of deans and departmental chairmen greatly influences the behavior of faculty members in their institutions and their departments. By their own attitudes and actions, deans and departmental chairmen should elevate the status of the general professional education of medical students to assure faculty members that their contributions to this endeavor will receive appropriate recognition.

Stemmler:

This belongs to the individual schools.

Brown:

primarily the responsibility of the medical schools and their faculties

Moy:

AAMC can provide considerable assistance here by keeping the agenda of quality general professional education of the physician actively before the Council of Deans and the Council of Academic Societies.

Chapman:

Certainly the commitment to education of deans and departmental chairmen is integral to the behavior of faculty members. Deans can interact with the process through their recruitment efforts of chairmen and chairmen through their recruitment efforts of faculty and for deans, the selection of the deanship as academic leader of the faculty and students should be a prominent part of the consideration of any selection. Medical education as an ancillary effort is an unacceptable set of circumstances. One important Association contribution is the annual questionnaire to graduating seniors who are asked to reflect upon the most positive and most negative aspects of their educational experience. In my view, this is an important activity which should be continued and even enhanced based upon input from the several deans and from faculty.

COD "READERS" IDENTIFICATION OF POTENTIAL GPEP FOLLOW-UP ACTIVITIES

A telephone conference call on January 17th, which included Drs. Brown, Chapman, Moy and Stemmler, resulted in the identification of the following items for COD Board consideration. Relevant references from the GPEP Report to be found in the Agenda Book, are shown in parentheses.

- o LCME -- the fact that the LCME is nearing the conclusion of its process of revising the standards of accreditation presents a window of opportunity for the Board to send a message to the LCME regarding ways in which the LCME can be instrumental in effectuating the GPEP recommendations. Dr. Moy strongly suggested that the LCME be encouraged to request that each school establish commencement objectives, i.e., knowledge, skills, attitudes, and behavior which the student would be required to master as a prerequisite for the award of the MD degree. Concomitantly, each school should be required to demonstrate that it both had in place and utilized evaluation instruments that could assess the level of achievement of the commencement objectives.

(See Conclusions 1-1 [p.8], 1-2 [p.9], 3-1 [p.15], 3-2 [p.16], 3-3 [p.17], 3-4 [p.17], 3-5 [p.18]. 4-1 [p.20], 4-4 [p.22], 4-5 [p.23] and attached GPEP Report excerpt.)

- o NBME -- recognizing the significance of the evaluation instruments in establishing the motivational sets of students and faculty, the Board should consider strategies by which the NBME could be made a less negative influence on medical education. An AAMC task force might explore ways in which the NBME could reduce the inappropriate use of their scores in such matters as progress evaluations and resident selections; for example, by moving to a pass/fail representation of examination results.

(See Conclusion 3-5 [p.18] and attached GPEP Report excerpt.)

- o Graduate Medical Education -- the Board should explore ways to provide additional impetus to efforts to persuade specialty groups to avoid using techniques for selecting residents which are disruptive of the academic process; i.e., premature selection of medical students into the second post-graduate year or beyond and the practice of requiring students to participate in on-site electives as a condition of eligibility for selection to the residency program. (The phenomenon to which Dr. Stoneman refers to on page 56 of the agenda book.)

(See Conclusion 4-5 [p.23] and attached GPEP Report excerpt.)

- o Admission to medical school -- the Board should give thought to ways in which the number of required courses prerequisite to

admission to medical school could be reduced to the absolute minimum. In addition, mechanisms by which the Association might facilitate fruitful communication between medical school officials responsible for medical school admissions and undergraduate health profession advisors should be explored.

(See Conclusions 2-2 [p.12] and 2-5 [p.25].)

- o Faculty education -- the Board should consider ways in which the Association could play an active role in the development of programs for faculty to introduce them to and develop skills in teaching methods most conducive to the development of independent learning and problem-solving skills.

(See Conclusion 5-4 [p.27])

- o Student evaluation -- the AAMC was thought to be particularly well suited to the task of assisting faculty in developing appropriate methods for assessing, advising, promoting, and certifying students. The Clinical Evaluation Project was cited as an impressive example of how this could be productively undertaken.

(See Conclusions 3-1 [p.15], 3-5 [p.18], and 4-4 [p.23].)

- o Clinical clerkships -- the recent changes in the teaching hospital environment, brought about in part by changes in the

methods of reimbursement, create problems in the conduct of the traditional clinical clerkships. The exploration of the dimensions of these problems and the search for alternatives are appropriate endeavors for the AAMC.

(See Conclusion 4-2 [p.20].)

DRAFT MINUTES COD ADMINISTRATIVE BOARD DISCUSSION OF

JANUARY 24, 1985

A. GPEP Follow-up Activities

Dr. Brown reminded the Board that four members, Drs. Brown, Chapman, Moy, and Stemmler, had agreed to engage in a close reading of the GPEP report with the purpose of identifying those recommendations which were: a) purely within the confines of local consideration and action, b) those that might suggest some form of inter-institutional cooperation, and c) those that required deliberation and activity at the national level through the AAMC. The four readers convened through conference call and produced a list of topic areas that suggested a role for the AAMC. see attachments I & II).

LCME

In relation to several of the GPEP recommendations, Dr. Moy had suggested that the LCME require that each school describe its commencement objectives, (i.e., the knowledge, skills, attitudes, and professional behavior the school required to be demonstrated as a condition for the award of the M.D. degree) and demonstrate that it had in place mechanisms to evaluate students against those objectives. Several Board members noted the magnitude of this recommendation, suggested that few schools could now meet such a standard and expressed concern that it contained a potential homogenizing effect. Nevertheless, there was substantial support for the proposition that passing a series of courses should not, in itself, be regarded as adequate assurance that

a student is prepared to enter graduate medical education. Dr. Schofield, Secretary to the LCME, noted that since 1975 the LCME committee has asked schools to list its objectives for the educational program. He was particularly concerned about the feasibility of the LCME requiring each school to have in place formal evaluation mechanisms to assess students against its objectives. Dr. Schofield also noted the large degree of correspondence between the GPEP report and Draft #12 of the new LCME standards. He also described the review and approval process. The board concluded that it would review the new LCME standards in the context of their final ratification, expected at the April Executive Council meeting, with an eye toward this issue.

#### NBME

Discussion of this issue centered on the influence of the NBME examinations on medical school instruction, how movement toward a pass/fail score reporting system might diminish this influence, and the way in which the AAMC might have a positive impact in this area. Dr. Swanson stated at the outset that it was the sense of the GPEP panel that the NBME examinations have a negative influence on teaching and instruction in medical schools. It was his view that the AAMC ought to enter into discussions with the NBME if invited, or to approach them, if not. He noted that the AAMC has not had significant interaction with the Executive Board of that organization in recent years. In discussing specific issues related to the examination, for example, advocacy of pass/fail score reporting, there was a sense that it would be difficult to achieve consensus among faculties and the schools. Schools tend to use the examination in different ways and differing views of the value of

and importance of the score information abound. Drs. Butler and Stemmler saw the NBME issue as one needing to be viewed within the general context of evaluation in medical schools. Dr. Stemmler felt that the AAMC's role should be in increasing the awareness of faculties as to the nature and limitations of the NBME assessment in order to assist them in their determination of its appropriate place in their evaluation system. A consensus did emerge that the deans should continue to look at evaluation in the broader sense and the role of the NBME in that process, that they work with the NBME in exploring areas of commonality and in avoiding current pitfalls in the use of the examination, and that they invite one of their members, Dr. Tom Bowles, who also sits on the NBME's Executive Committee, to report at the next meeting current activities of the NBME at the next Administrative Board meeting.

#### Graduate Medical Education

The four GPEP readers felt that the Board should explore ways to persuade specialty groups to avoid using procedures for selecting residents that are becoming increasingly disruptive to the academic process. Of particular concern was the premature selection of medical students into the second post-graduate year or beyond and the requirement that students participate in on-site electives as a condition of eligibility for selection into the residency program. Dr. William Stoneman, Dean at St. Louis University School of Medicine, had, in a letter to the Board, noted that this latter practice was beginning to intrude on the third year program as well as the fourth year. Dr. Schofield opened the discussion by reading language from draft #12 of the LCME standards that encourages schools to withhold letters of

recommendation and other credentials for their students seeking residency positions until the fall of their senior year. Dr. Kettel noted that the effectiveness of this recommendation depends upon the importance attached to dean's letters in the selection process. Dr. Swanson highlighted the need for more and better documentation of these problems and suggested that the AAMC graduation questionnaire could be used to survey students' experience with the residency application process.

#### Admission to Medical School

The specific issue addressed was whether and how the AAMC might take a role in effecting a reduction in the number of courses required by medical schools for admission, policies which are seen as interfering with the attainment of a broad undergraduate education. The likelihood that any AAMC initiative in this area would be effective was regarded as small. It was the widely held view that the standard for premedical students is set by the school with the longest list of requirements. Consequently, impact could only be achieved by uniform constraint among all 127 schools. However, the deans did endorse increased efforts at the local level to improve communications between the medical school and premedical advisors. The extent to which misinformation on admissions policies continues was noted. This communication was also seen as vital in the face of the projected declining applicant pool.

Dr. Stemmler suggested a broader initiative for the AAMC to undertake, perhaps with the support and cooperation of other organizations: an examination of biological science education at the secondary and post-secondary levels from the perspective of the knowledge expected of entering medical students. Such a study might lead to ways

of re-packaging science education to effect improved articulation of educational objectives at the college and medical school interface.

The role of the MCAT in this area emerged in the discussion. Board members observed that the MCAT is the one factor in all these deliberations about GPEP directly under the AAMC's control. The test has a direct impact on both the content of undergraduate courses and students' course selection. Some limited review of the MCAT program was called for by several deans to seek ways to ameliorate the negative effects the test has on undergraduate education. As one example, Dr. Meikle suggested the possibility of not reporting MCAT scores above a certain point.

In further consideration of GPEP follow-up activities, the Board then reviewed the questions for discussion posed in the Executive Council agenda in Dr. Swanson's memorandum outlining possible AAMC post-GPEP activities. First considered was the area of faculty development. The Board generally supported the concept that AAMC sponsor seminar-workshops for deans and department chairmen aimed at developing more effective approaches to teaching and learning. It suggested that if effective consultants could be identified, schools might benefit from bringing in teams that would demonstrate techniques such as socratic dialogue, which place greater demands on the learner than the lecture system.

The proposal to develop annual seminars for admissions deans regarding the appropriate uses of the MCAT received a somewhat limited endorsement from the Board. Several members observed that this would probably not be effective unless admissions committee members are involved. It was suggested that the seminar, perhaps modeled on the

Simulated Minority Admissions Exercise (SMAE), should focus on the MCAT in the context of the broader issue of student selection. Board members opined that there were other activities that the AAMC should undertake to improve the use of the examination, but except for a look at score reporting schemes that eliminate distinguishing among students at the high end of the score range, none were suggested. Returning to the domain of student evaluation, the Board reiterated its support for the proposal for the AAMC to enter into discussions with the NBME on score reporting policies and the use of the examination.

Suggesting that, as written, it lacked sufficient specificity, the Board refrained from endorsing the proposal for an AAMC task force on the clinical education of medical students. There was general concurrence with the view that changes in the teaching hospital environment are causing problems for clinical education. These observations were seen as a valid and demanding high priority attention from the AAMC. However, it was not clear to the deans that a task force was the appropriate mechanism to deal with this issue. One alternative mentioned was to support a scholarly study by individuals with experience and expertise.

Finally, the Board strongly endorsed the notion that the problem of the resident selection process is as increasingly intruding into the undergraduate medical education program, an area of high priority for AAMC action. They agreed that the trend toward requiring that a student take a particular clerkship at an institution in order to be considered for residency training in that specialty has resulted in premature specialization and a consequent distortion of the student's general professional education. The Board was not clear on the best strategy for

### GPEP FOLLOW-UP ACTIVITIES

The final report of the Association's project on the General Professional Education of the Physician and College Preparation for Medicine has received wide attention. Over 50,000 copies have been distributed. More than half of these were requested by medical school deans, faculty members, and students. However, attention and action are not necessarily sequential. It has been observed that most of the conclusions and recommendations of the GPEP Panel are not new. The Afterword by John Cooper points out that the Association's Commission on Medical Education arrived at very similar conclusions and recommendations in 1932.

During the project, 83 medical schools organized discussions within their institutions about the general professional education of medical students. Many of these, and others who were not involved in the project, are now examining the Panel's conclusions and exploring how its recommendations can be implemented. At the Annual Meeting, the Council of Deans discussed the five conclusions of the report. The Council of Academic Societies devoted an afternoon to its consideration. The Group on Medical Education held a plenary session entitled, "Practical Responses to the GPEP Recommendations," and the Organization of Student Representatives held small group discussions on implementation strategies for GPEP.

Now, as never before, the Association is expected to develop strategies to assist its constituents to improve medical student education. Although many activities might be undertaken, the following are considered both feasible and likely to be effective.

#### Introducing Alternative Approaches to Teaching and Learning

A major challenge is contained in the first recommendation of Conclusion One.

"In the general professional education of the physician, medical faculties should emphasize the acquisition and development of skills, values, and attitudes by students at least to the same extent that they do their acquisition of knowledge. To do this, medical faculties must limit the amount of factual information that students are expected to memorize."

To change the emphasis of medical student education toward the development of the skills, values, and attitudes they will need for a lifelong career in medicine and away from an information intensive inundation will require a

basic philosophical change in faculty perceptions of their educational responsibility and a concomitant modification of their commitment to medical students. Presently, most faculty members consider that their educational commitment has been fulfilled when they have told a medical school class what they know about their area of expertise. Engaging students in Socratic dialogue or assisting students to analyze problems and seek out needed information themselves is beyond most faculty members' personal experience. Talent for this approach to teaching and learning are not likely to develop de novo in most of our institutions.

The Association could develop and sponsor a program that offered deans and departmental chairmen a four- or five-day workshop to introduce them to alternatives in teaching and learning using the strategies that were employed in the development of the AAMC's Management Advancement Program. In that case, a prestigious institution (The Sloan School of MIT) agreed to work with an Association committee to develop a management program tailored to the needs of deans and departmental chairmen. The program was introduced with considerable fanfare, carefully monitored, and modified as experience directed. Similarly, a nationally recognized group of educators (from one or more institutions) could be recruited to plan a program tailored to accomplishing the recommendations set forth in GPEP. The target audience would initially be deans and chairmen, and the purpose would be to expand their knowledge about how teaching and learning might be changed at their institutions. A second phase could provide opportunities for teams of faculty members from several institutions to work through their plans with an expert faculty of educators. Experience gained in the course of such a program should provide ideas for strategies to disseminate alternative approaches more widely and involve individual faculty members. Subsidization of the program would initially be required, but eventually it would be supported by tuition.

#### Questions for Discussion:

1. Should the AAMC develop and sponsor a program of seminar-workshops on alternative approaches to teaching and learning for deans and departmental chairmen?
2. Are there different strategies to introduce key medical school faculty members to alternative approaches to teaching and learning that should be tried?

#### Evaluation of Academic Achievement

Throughout the course of the GPEP project, the methods of evaluation of academic achievement were faulted as forces that perpetuate current approaches to teaching and learning. Both the Medical College Admission Test and the National Board of Medical Examiners' examinations were criticized.

#### The MCAT

The GPEP Panel recommended that medical faculties should use the MCAT examination only to identify students who qualify for consideration for admission and

should avoid using small differences in MCAT scores to differentiate among candidates with comparable academic qualifications in making selection decisions. The Panel also encouraged the Association to continue its effort to add an essay section to the Medical College Admission Test.

The Division of Educational Measurement and Research has an ongoing program to educate admissions deans and committees about the appropriate and inappropriate use of the MCAT and 26 medical schools are participating in a long range project to assess the predictive validity of the examination. A pilot program to determine the feasibility of adding an essay section is underway.

Experience demonstrates that despite efforts to ensure that the MCAT is used appropriately, inappropriate use persists. For example, admissions deans are urged to use the six subtest scores as an indication of an applicant's strengths and weaknesses, but all too frequently it is found that the six scores are totalled or averaged to provide a single number that is used to rank applicants.

A major difficulty in establishing and maintaining policies for the appropriate use of the MCAT at the institutional level is the rate of turnover of those responsible for the admission process. It is estimated that 25 to 30 percent of deans for admission are replaced annually and members of admissions committees turn over at an even higher rate. Programs on the appropriate use of the MCAT are presented regularly at regional meetings of the Group on Student Affairs and at the annual meeting. However, participation is voluntary and the time available is limited.

An alternative to the present program could be to have an annual seminar of two days' duration for admissions deans and their principal administrative assistant. Medical schools that require students to submit MCAT scores would have newly appointed deans for admission and their administrative assistants attend the seminar at least once for the school to remain eligible to receive MCAT scores.

#### Questions for Discussion:

1. Should the Association develop an annual seminar to instruct deans for admissions and their administrative assistants in the appropriate use of the MCAT?
2. Are there other activities that the AAMC should undertake to improve the use of the MCAT examination?

#### NBME Examinations

The GPEP Panel urged the AAMC and the National Board of Medical Examiners to undertake discussions toward diminishing the influence of licensing examinations on programs of medical student education. The policies on the use of NBME examinations by the medical schools are shown below.

Use of the NBME exam, Part I	<u>No.</u>	<u>%</u>
Exam optional	29	22.8
Student must record score	35	27.6
Student must record passing total score	59	46.5
Student must record passing score in each section	3	2.4
Scores used to determine final course grades	14	11.0

Use of selected sections of NBME exam, Part I,  
by departments to evaluate students

Anatomy	4	3.2
Behavioral sciences	2	1.6
Biochemistry	9	7.1
Microbiology	9	7.1
Pathology	10	7.9
Pharmacology	6	4.7
Physiology	4	3.2

Use of NBME exam, Part II

Exam optional	35	27.6
Student must record score	41	32.3
Student must record passing score to graduate	48	37.8
Scores used to determine final course grades	15	11.8

In about 75 percent of the schools, the Part I and Part II examinations are used for evaluating student achievement, departmental programs, or both. This dependence of our institutions on the results of the National Board's licensing examinations tends to perpetuate the concentration of both faculty and students on teaching and learning facts.

The Panel suggested that separate scores in each discipline not be reported by the National Board, and only a total score provided. Many constituents have suggested that only passing or failing should be reported.

Accomplishing changes in NBME score reporting policies will require delicate negotiations with the National Board and among our constituent institutions. The Association could establish a task force to plan and conduct such negotiations.

Questions for Discussion:

1. Should the AAMC enter into negotiations with the NBME to change their score reporting policies?
2. Are there other approaches to reducing the effect of NBME's licensing examinations on medical students' education?

## The Clinical Clerkship

The GPEP Panel recommended that:

"Medical faculties should describe the clinical settings appropriate for required clinical clerkships and, in conjunction with deans, departmental chairmen, and teaching hospital executives, plan organizational strategies and resource allocations to provide them."

This recommendation stemmed from the often made observation that the clinical settings for clerkships are considerably different now than 20 years ago. The complexity of services provided by tertiary teaching hospitals and the growing emphasis on maximum utilization of diagnostic and therapeutic facilities in the shortest possible time often deny junior medical students the opportunity to learn and develop fundamental clinical knowledge and skills. In a questionnaire promulgated in 1982 at the beginning of the GPEP project, the following question was asked:

"Because teaching hospitals' fiscal viability requires that they continue to provide complex medical services, must special pedagogical approaches be developed to make them satisfactory settings for junior clerkships?"

The response was as follows:

<u>Position</u>		<u>Yes</u>	<u>No</u>	<u>No</u> <u>Opinion</u>	<u>No</u> <u>Response</u>	<u>Total</u>
Clinical Faculty	n	260	122	21	0	403
	%	64.5	30.3	5.2	0	40.7
Basic Science Faculty	n	144	30	53	17	244
	%	59.0	12.3	21.7	7.0	24.6
Deans and Associate Deans	n	181	44	5	2	232
	%	78.0	19.0	2.2	.9	23.4
Teaching Hospital Directors	n	76	31	5	0	112
	%	<u>67.9</u>	<u>27.7</u>	<u>4.5</u>	<u>0</u>	<u>11.3</u>
Total	n	661	227	84	19	991
	%	66.7	22.9	8.5	1.9	100.0

Mitch Rabkin, in his 1984 plenary session address, reported observations that confirm the need to examine the clinical education of medical students. Rabkin stated:

"Over recent decades, for many reasons, the clinical needs of hospitalized patients have grown, differentiated, and evolved. Concomitantly, the teaching and learning needs of students have developed with comparable vigor. But, if the clinical needs of hospital patients and the teaching and learning needs of students ever were fully congruent, it was probably in the days when training was tantamount to apprenticeship and medicine was more observation and comfort than intervention. These two

sets of needs--those of hospital patients and those of students--have not only grown but diverged over the past half century; they still overlap to some extent, but surely are not congruent. As we move into the twenty-first century we need a clear-eyed examination of each set of needs and how best to meet them. Defining approaches to each--to patient care and to teaching--will make for better awareness of the areas of overlap and greater appreciation of the unmatched areas where singular opportunities for innovation exist."

Adapting the clinical education resources now available to our constituent medical schools to the educational needs of medical students is a major challenge for which there are no simple solutions. In September 1985, the Association will hold a 2-day conference funded by the Division of Medicine of the Health Resources and Services Administration on clinical education for medical students. It is anticipated that conferees will be able to identify many of the problems institutions are having with clinical clerkships, but finding solutions may be difficult. It is probably inevitable that developing a satisfactory environment for the initial clinical education of medical students will impinge upon policies directed toward reducing medical service costs and increasing the efficiency of hospital and clinic operations.

As a beginning, the Association could establish a task force to plan a program to assist the medical schools to assess the problems that must be solved to adapt clinical settings for medical student education. During this effort, strategies could be evolved to influence national and local policy makers to consider the resource allocations needed for medical student education when modifying health care financing.

#### Questions for Discussion:

1. Would an AAMC task force on the clinical education of medical students be a useful method for identifying the problems that changes in the teaching hospital environment are causing?
2. Could such a task force recommend solutions that would be applicable to the diverse institutions in the AAMC constituency?
3. Are there other approaches that the AAMC should take to assess the need for improvement in medical students' clinical education?

#### Admission to Graduate Medical Education

Growing competition for admission to graduate medical education programs is causing students to concentrate prematurely on gaining residency positions at the expense of accomplishing their general professional education. The GPEP Panel recommended that:

"Medical faculties should encourage their students to concentrate their elective programs on the advancement of their general professional education rather than on the pursuit of a residency position."

The Panel added:

"Discussions within institutions and among certifying boards, residency review committees, medical specialty societies, and graduate program directors are needed to ensure that medical students are provided opportunities to complete their general professional education without undue stress in planning their graduate medical education."

The deleterious effects on students' general professional education induced by their desires to gain residency positions in the specialties of their choice are enhanced by the recruiting policies and practices of graduate program directors. Five specialties that admit students in their second or third post-graduate year are now using matching programs that require senior students to submit applications several months in advance of the date set for the National Residency Matching Program.

Many program directors are now informing students that they must come to their institutions and spend an elective period in their program if they want to be considered for a residency position. Instances of students taking an elective in the specialty in which they hope to do their graduate training at four or more institutions are reported. Forcing early decisions for residency positions and encouraging repetitive elective clerkships in the same specialty are not consistent with accomplishing a general professional education during medical school.

Achieving productive discussions that will eliminate the distorting effect of the pursuit of graduate medical education upon medical students' general professional education is complicated by the amorphous nature of the leadership of graduate medical education. Twenty-four specialty boards and 24 residency review committees establish the policies that must be followed by over 4,000 program directors. There is no single agency with hegemony over graduate medical education, and despite almost two decades of discussion, little progress has been accomplished in achieving institutional responsibility for graduate medical education at the local level. The American Board of Medical Specialties provides a forum for certifying boards to discuss issues, but it has little authority. The Accreditation Council for Graduate Medical Education, with its accrediting authority, has power, but the Council and its sponsoring organizations have been loathe to impose restrictions on the recruiting activities of program directors. For example, a clause that would have made programs use the National Resident Matching Program for the selection of medical school graduates for their PGY1 positions as a condition of accreditation was not accepted when the General Requirements of the Essentials of Accredited Residencies were revised.

The AAMC and its constituent members of the Council of Teaching Hospitals have relatively little influence on the recruiting policies of program directors as well. In the 1981 Task Force Report on Graduate Medical Education, it was recommended that deans letters and transcripts should not be requested by program directors before October 1 of a student's senior year. This year, at the Annual Meeting, there were numerous reports of earlier and earlier demands for letters and transcripts by program directors. For over a year the Association has attempted to convince program directors in ophthalmology, otolaryngology, neurology, and neurosurgery that a separate match four months before the NRMP match is both undesirable and unnecessary. There is little evidence that these specialties will abandon their early match. They are more concerned with their own prerogatives than with the educational needs of medical

students.

Discussions to influence graduate medical education policy bodies and program directors will have to begin at the highest level. The Association could initiate discussion at the Council for Medical Affairs, urging the other members of the Council to give a high priority to ameliorating the detrimental effects of competition for admission to graduate medical education on students' general professional education. Once discussions have begun, strategies to extend these to involve the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, residency review committees, specialty boards, and associations of program directors could be developed. In addition, annual examinations of progress, or lack thereof, could be included in the programs of the interim meetings of the CAS, COD, and COTH for the next several years. These Councils are representative of the vast majority of the institutions and specialties that provide graduate medical education programs in the United States.

#### Questions for Discussion:

1. Should the AAMC initiate discussions among sponsoring members of the ACGME and others involved in graduate medical education directed toward reducing the effect of competition for residency positions on medical students' general professional education?
2. Are there other strategies that will reduce the distortion of medical students' general professional education by the recruiting policies and practices of residency program directors?

#### Other Activities

The activities described above could be undertaken during this year and carried on simultaneously. The Educational Advancement Program might continue for several years. The MCAT program would be a continuing effort. The negotiations with NBME could probably be completed in two years. The work of the task force on clinical education would probably result in additional program developments that cannot be precisely described at this time. The effort to reduce the distortion of general professional education by graduate medical education will have to be sustained over a prolonged period, but it will not absorb a large amount of staff time.

#### Questions for Discussion:

1. Are there other activities that the AAMC should undertake to assist its constituents to accomplish the recommendations of the GPEP Panel report?
2. Should any of these displace or be in addition to those described?

## GRADUATE MEDICAL EDUCATION

The documents which follow reflect a wide range of issues impinging on graduate medical education that are of current concern to the AAMC. Foremost among these is the financing of graduate medical education, a topic to be addressed by Dr. J. Robert Buchanan, chairman of the AAMC Task Force. The document appearing on page 52 is a description of issues addressed by the task force and provides a background for Dr. Buchanan's remarks. A second issue is the action of the ACGME on Clinical Skills Evaluation reported in Dr. Swanson's memorandum to the record appearing on page 68. This issue will be brought to the Executive Council for action on April 4, 1985. The third document reflects a concern raised by Dr. Sutnick and Luginbuhl regarding the actions of several residency review committees. They are particularly concerned with the move toward increasingly detailed specifications which may make it difficult for certain smaller medical centers to be in compliance. This matter is addressed on page 70. The fourth issue relates to the intrusion of the residency selection process in several specialties into the undergraduate curriculum. The Executive Council action on September 24, 1985 appears on page 71. Dr. Stoneman's concern with another dimension of the problem appears on page 72. Finally, on page 74 and following, there is a description of a new phenomenon on the scene of the so-called National Medical Researcher Matching Program, which appears to be a commercial enterprise designed to take advantage of the aspirations of individuals unfamiliar with the standard process.



**association of american  
medical colleges**

AAMC COMMITTEE ON  
FINANCING GRADUATE MEDICAL EDUCATION

Statement of Issues

March, 1985

In the last five years, the AAMC has completed comprehensive reviews of both graduate and undergraduate medical education.\* Among the common themes of these reports is the conclusion that a contemporary medical education requires completion of both medical school and residency training in order to be prepared for independent medical practice. Medical schools provide the general professional education which is the foundation of all medical practice. Residency training or graduate medical education provides the formal clinical education that develops the skills and experience necessary for independent practice. Residency programs are accredited by the Residency Review Committees under the supervision of the Accreditation Council for Graduate Medical Education.

Graduate medical education is not focused on the university campus. It takes place primarily in teaching hospitals. Residents, working under supervision, learn clinical medicine by hands-on participation in the care of hospital patients. Patients are being treated and residents are being trained through the same activities. In effect, both products -- patient care and education -- are being simultaneously, or jointly, produced in the teaching hospital.

The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs -- education is not simply a by-product. Adding the educational role involves additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. These costs are real. If graduate medical education is to continue, these costs cannot be avoided. Therefore, the growing debate about financing graduate medical education should

\*Graduate Medical Education: Proposals for the Eighties (1981) and Physicians for the Twenty-First Century (1984).

not be one about paying or not paying these costs. Rather, the debate should be about the most appropriate method of paying for the costs of residency training.

For the past several decades, the teaching hospital's added costs for residency training have been financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984 survey of stipends paid to housestaff show 81% of the stipends and benefits are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes patient service revenue has been and continues to be the primary source for supporting the total costs of graduate medical education.

The AAMC has had a long-standing policy on financing graduate medical education which was reaffirmed in 1980 when the AAMC published the report of its Task Force on Graduate Medical Education. This three-year task force recommended that:

Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospital (p. 94, emphasis added).

The recommendation was consistent with private payer practices and with Congressional intent for the Medicare program. Many Blue Cross agreements throughout the country explicitly provide for payment of these costs. Congress clearly established payments for residents in training as a legitimate Part A Medicare expense in the original Medicare statute.

The AAMC continues to believe patient charges and reimbursements are an appropriate method of financing graduate medical education. In fact, if all, or most, of the nation's hospitals participated in graduate medical education, patient service financing of residency training could survive in the face of the increasingly competitive hospital marketplace. However, only 2 percent (125) of the nation's 5,900 community general hospitals provide 50 percent of the nation's residency training. Another 1,100 hospitals provide the remaining half of residency training. These 1,225 hospitals bear the cost of training the nation's entire supply of residents. The remaining 4,600 community hospitals -- as well as health maintenance organizations, competitive medical plans, and preferred provider organizations -- obtain the benefits of fully trained physicians without sharing in the cost of the training itself. This gives the non-teaching hospital an advantage in setting its charges and negotiating contracts. In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded.

The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and explore future alternatives for financing residency training. The Committee is chaired by J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and the members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the Committee were held in November, January and February and alternatives for financing graduate medical

education were explored. This paper has been prepared to summarize the discussions of the Committee and to explain the competing views on the issues of financing graduate medical education reviewed by the Committee.

The Committee's discussions have focused on five topics:

- o the need for special funding for graduate medical education in the patient care payment environment that is evolving;
- o the advisability of creating a societal funding mechanism for graduate medical education rather than having each payer establish its own policies;
- o the number of training years to be financed with any separate funding and the resulting manpower controls that accompany various alternatives;
- o the increasing use of non-hospital sites, especially ambulatory care settings, for residency training; and
- o the responsibility for training physicians educated in foreign medical schools.

The remainder of this report explores each of these topics in some detail in order to provide AAMC members, physicians and hospitals, third party payers, and public policy analysts with an understanding of the conflicting viewpoints within the medical education community.

## The Need for Separate Funding

Patient care financing of graduate medical education has well served teaching hospitals, physicians-in-training, and society for several decades. Hospitals have been able to expand positions available to meet the increasing number of medical school graduates, specialties have upgraded their basic clinical training requirements, new subspecialties in medicine and surgery have developed, and new technologies have been widely disseminated.

Some Committee members and some AAMC members believe that teaching hospitals may be able to compete in the new environment without separate funding for the higher costs that result from graduate medical education. Until evidence to the contrary is clear, they believe that it would be unwise for the AAMC to advocate alternate financing arrangements which may jeopardize some of the benefits of the current system. These benefits include the freedom of medical students to elect to train in the specialty of their choice and the ability of teaching hospitals to offer a variety of residency programs.

The competing view, held by the majority of the Committee and many AAMC members, is that patient revenues in the future price-competitive market may be insufficient to support financing of graduate medical education and that alternatives must be found or at least explored. This group believes payers will withdraw their explicit support and/or cut back on their implicit support for graduate medical education. As a result, teaching hospitals will be forced either to limit other hospital programs and services to support the educational mission or to reduce the numbers of residents and faculty they support. Other missions also may increasingly draw on the resources of the teaching hospitals. For example, many teaching hospitals are being asked to provide increasing amounts of care to the indigent without concomitant increases in state or local

support. Thus, institutional resources are being stretched substantially and may be unable to support educational programs at current levels.

In substantial part, this dichotomy of viewpoints reflects different member experiences and points of reference. Those who advocate continuing to finance graduate medical education with patient service revenues present their viewpoint with reference to a payment system based on negotiated prices. They believe the teaching hospital has a marketable resource in its educational activities. They see education providing a quality-enhancing benefit not available from non-teaching hospitals. Moreover, in a negotiated market, a hospital is free to reject a price which does not enable it to meet its patient care and educational costs.

Those who advocate establishing separate financing for graduate medical education present their view with reference to a payment system based either on administered prices set by an external entity or on a payment system dominated simply by lowest price. For example, Medicare's basic prospective payment formulas are designed to pay a fixed price for a given patient irrespective of whether the hospital does or does not offer residency training. Unless separate funding is added, such as Medicare's current medical education passthrough, the teaching hospital must provide two products (i.e., patient care and education) for the same price the non-teaching hospital must provide only patient care. For non-Medicare payers, if price is the only selection criteria, there will not be additional funding for graduate medical education.

Given these differing reference points and perspectives, the AAMC faces two fundamental but conflicting assumptions:

public and private payers will recognize the unique contributions and benefits of teaching hospitals and be willing to pay teaching hospitals higher payments. As a result, the AAMC need not explore alternative arrangements for financing graduate medical education;

or

public and private payers of hospital services are becoming increasingly resistant to including adequate funding for the support of graduate medical education in their general patient care payments. As a result, the AAMC must explore options to provide support for this essential mission of teaching hospitals.

Resolution of this fundamental difference in working assumptions must precede discussions about the methodologies and structures for financing graduate medical education.

The Committee premised its development of alternative financing arrangements on the latter assumption cited above. This does not imply that it is inappropriate to finance GME with the general operating revenues of teaching hospitals. It does recognize, however, that in the future new payment systems for patient services may not provide teaching hospitals with sufficient funds to finance both their patient care and educational missions. Therefore, the Committee has explored alternatives and identified conflicting issues that must be resolved.

#### Scope of Proposals

Health care financing arrangements, both public and private, are undergoing substantial changes:

- o payers are increasingly interested in paying only for the immediate services used by their beneficiaries,
- o predetermined payments are replacing retrospective cost reimbursement, and
- o low price is replacing access as a criteria for selecting hospitals.

In this environment, each payer has an economic advantage in behaving as a marginal price purchaser paying only the incremental costs arising from services provided to its patients. This behavioral incentive, however, is in conflict with the broader societal interest in maintaining and supporting commonweal services benefiting all collectively but no payer individually.

Adequate financing for graduate medical education requires each payer to subordinate some of its economic self-interest to the broader social interest of adequately training new physicians. This subordination of self interest can be achieved in two ways: (1) society can impose a tax to support the costs of residency training or (2) payers can individually be persuaded for social, ethical, or public image reasons to share in financing residency training.

The Committee recognizes advantages and disadvantages to each approach. The taxation approach is the most likely to provide comprehensive financing and to avoid conflicting health manpower policies across payers. However, requiring a Federal tax, administered by Federal officials, seems to be contradictory to the present political climate. Moreover, it would make residency training dependent on a single source of funds and subject it to annual debates in the Federal budget. Such fiscal control could lead to massive intervention in medical education. Similar reservations exist for state-administered taxes. In addition, a state tax approach could lead to conflicting manpower policies across the nation.

The individual payer approach does not require major Federal legislation or a new bureaucracy and it permits manpower training decisions to remain at the institutional level. It is not clear, however, whether payers will subordinate their economic self interest. Some may; others may not. As a result, the revenue base for residency training may be incomplete and constantly changing.

The preferred course is unclear. Should the AAMC seek a comprehensive, national tax or should the AAMC concentrate on national payers (e.g., Medicare) while individual members work with their state and with individual payers? Each choice has major risks.

#### The Training Period To Be Funded

If separate funding is provided to support graduate medical education, the amount of that funding could be set by determining the number of residents to be financed and the number of training years to be supported. Three options on the length of training which would be supported by separate funding are available: (1) fund residents for a fixed number of years (e.g., 3, 4, or 5) regardless of the specialty in which the resident is training; (2) fund residents only for the period of time necessary to obtain initial board eligibility; or (3) fund residents in all accredited programs for initial and subspecialty training.

Option one provides separate funding for a fixed number of years per resident. Residents in programs which can be completed in the fixed number of years are supported throughout their training. Residents in the longer programs would receive funding for the fixed number of years but they, the hospital and the staff physicians would have to support the remaining years with patient service revenues, grants, appropriations, contracts, or philanthropy. For example, if the separate funding were provided for the first three years of residency training, residents in three year programs would be supported for all training years. Residents in programs lasting four or more years would receive separate funding only for the first three years of their program. Thus, under the three year example, residents in family practice, pediatrics, and internal medicine would receive funding throughout their basic training. Residents in all other specialties and subspecialties would receive funding only for the first three years of their program. Advocates of fixed year funding emphasize two

advantages to the approach. First, it minimizes external regulation. It does not require an external entity to allocate residency positions by specialty or across hospitals because payment is made based solely on the number of residents at or below the fixed years of training. Secondly, the advocates generally believe it will increase the proportion of residents training in the primary care specialties and decrease the proportion of residents undertaking subspecialty training. Detractors are concerned that the fixed year funding creates instability and uncertainty for residency programs lasting beyond the fixed year threshold. They note that strong training programs are built across time and need stability of financing and personnel. Detractors are also concerned that funding less than the years required for certification may lead to: inappropriate efforts to shorten training time, residents who drop out of training programs before completing them, or fee-for-service billing for residents who have not completed their training programs.

A second alternative varies the number of years of separate funding with the number of years of specialty training required for initial board certification. Residents in internal medicine would be supported for the three years of internal medicine with no separate funding provided for subspecialty training. Residents in surgery would be supported for the five years required for general surgery with no additional separate funding provided for the extra years required for thoracic, plastic, or colon and rectal surgery. The principal advantage of this alternative is its explicit recognition of the variation in the time required for initial board certification in different specialties. Some Committee members are concerned that separate funding which varies with the training required for initial board eligibility may lead to the development of a manpower planning entity which designates the number of approved positions in each specialty. The majority of the Committee believes, however, that a manpower planning entity is not necessary if separate funding is limited to the initial training program.

The majority also believes their position would be strengthened if the number of years of support for each specialty is limited to the present requirement. The major disadvantage of this alternative is its limitation to initial board eligibility. In many specialties -- including internal medicine, pediatrics, and surgery -- some residents undertake subspecialty training after they have completed, or could have completed, the initial residency. This alternative would not provide separate funding for residents in subspecialty training. Other sources of financing would be needed to support subspecialty programs.

The third alternative provides separate funding for all residents training in approved training programs. This approach provides separate funding for full specialty and subspecialty training in all disciplines. Advocates of this approach emphasize that it provides full funding for the period of time that the physician-in-training is subject to the direction and supervision of faculty. It does not provide an economic disincentive to developing or pursuing the longer training programs. Detractors note the open-endedness of this approach. They believe the funding entity is likely to limit its financial exposure under this option by developing explicit manpower training policies. The detractors are concerned that some entity may determine how many positions in each type of training will be offered and which hospitals will be approved for funding.

The three funding options are dramatically different. They vary in terms of ease of administration, financial comprehensiveness, and likely manpower regulation. Each approach has supporters. Selection of any one approach will bring fundamental change to residency training.

### Non-Hospital Training Sites

Increasingly, acute care hospitals are being used only for the most intensive portion of a patient's illness or procedure. This has changed both the kinds of cases admitted to inpatient units and shortened the length of time the patient is in the hospital. As a result, several specialties are now trying to incorporate non-hospital experiences in their residency programs. This creates problems because hospital patient care revenue has been the predominate source of support for residency training. While hospital charges and costs presently include expenses for graduate medical education programs, ambulatory care providers do not have such costs in their present charges. Increasing charges in ambulatory or long-term care settings to support residency training would disadvantage some providers as price competition in all areas of medical care increases. Innovative financing approaches must be developed and evaluated for both long-term care and ambulatory settings.

### Residency Positions To Be Supported

The United States has 127 medical schools accredited by the Liaison Committee on Medical Education (LCME) and 15 accredited osteopathic schools from which there are a total of approximately 16,200 graduates. The AAMC Committee believes that the United States has an obligation to provide the resources necessary to train these graduates. The Committee believes society has no similar obligation to provide and financially underwrite graduate medical education for graduates of non-accredited medical schools or schools outside the U.S. At the present time 18% of residency training positions are occupied by physicians graduating from foreign medical schools. While some U.S. hospitals may wish to continue training foreign graduates, the Committee believes such training need not be supported by funding arrangements designed to support graduate medical education. Because almost twenty percent of current residents

are foreign medical graduates, adoption by payers of the Committee's position would substantially reduce the funding needed for graduate medical education.

### Conclusion

This statement of issues is focused on five major topics surrounding the future financing of graduate medical education. The Committee recognizes that numerous secondary issues have not been addressed. For example, approaches which increase the uncertainty of residency support may discourage economically-disadvantaged individuals from choosing a medical career. Eliminating funding for foreign medical graduates may pose special transition problems for patient services in some hospitals. The Committee is aware of these and other secondary concerns but chose to omit them in order to address the primary topics in a more tightly focused way.

During the last two decades, hospitals have operated for the most part in a cost reimbursement era with substantial autonomy. They have competed with each other on the basis of quality and scope of services; there was minimal competition on the basis of price. The Committee recognizes that the environment of the mid-80's and beyond is different and that hospitals must improve the efficiency of all their services. Price per unit of service is becoming the basis of competition. Even efficient teaching hospitals are disadvantaged in the price competitive market for a variety of reasons including:

- o the provision of a disproportionately large share of care to the indigent;
- o the treatment of the most severely ill patients;

- o the provision of regional stand-by services, such as burn centers, pediatric and adult open-heart surgery centers, and transplant centers;
- o the presence of clinical research efforts to advance diagnostic and treatment capabilities; and
- o the provision of graduate medical education to maintain the supply of physicians for this country.

All of these functions are important to the missions of teaching hospitals, and all make teaching hospitals more expensive to operate than non-teaching hospitals. The Committee's task is to examine only changes in the financing of graduate medical education, but it clearly recognizes that even if separate funding for graduate medical education is adopted, teaching hospitals will continue to require special consideration in any hospital financing scheme for the other functions that distinguish them from non-teaching hospitals. While financial support for graduate medical education will not eliminate the teaching hospital's problems, support for GME will contribute to a more equitable market in which teaching hospitals are less disadvantaged.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COMMITTEE ON FINANCING GRADUATE  
MEDICAL EDUCATION

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New York, New York

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Executive Director  
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School at Houston  
Houston, Texas

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Professor of Family Medicine  
School of Medicine  
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Columbia, Missouri

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Dean, School of Medicine  
University of California, San Diego  
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Albert Einstein College of Medicine  
of Yeshiva University  
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Winston-Salem, North Carolina

W. DONALD WESTON, M.D.  
Dean  
College of Human Medicine  
Michigan State University  
East Lansing, Michigan

FRANK C. WILSON, JR., M.D.  
Chairman, Division of Orthopaedics  
School of Medicine  
University of North Carolina  
Chapel Hill, North Carolina



# association of american medical colleges

February 15, 1985

## MEMORANDUM

TO: The Record

FROM: August G. Swanson, M.D.

SUBJECT: Action of the ACGME on Clinical Skills Evaluation

At the February 11-12, 1985 meeting of the Accreditation Council for Graduate Medical Education, the Council approved the addition of the following paragraph to the General Requirements of the Essentials of Accredited Residencies.

Each accredited residency program is responsible for assessing the clinical skills of each resident entering the first year of the program. Those residents found deficient in clinical skills are to be assisted, where appropriate, in remedying such deficiencies and this assistance is to be offered in the early part of the PGY-1 year. Those residents who have not satisfied the program faculty by improvement in clinical skills will be dismissed from the program before completion of the first year.

This action was engineered by Frank Riddick (AMA representative), Chairman of the Structure and Function Committee, and Dick Reitemeier (ABMS representative). It occurred in the context of a discussion by the committee on the issues surrounding the evaluation of the clinical skills of foreign medical graduates. Reitemeier feels strongly that the clinical skills of all first-year residents (graduates of LCME-accredited schools as well as foreign medical graduates) should be evaluated by program directors. He extolled the program of the American Board of Internal Medicine, which now requires that program directors certify to the Board that the clinical skills of the residents they are recommending for certification merit their becoming certified internists. In the committee meeting I pointed out that if the ACGME has concerns about the clinical skills of graduates of LCME-accredited schools, this should be discussed with the Liaison Committee on Medical Education before action by the ACGME. Reitemeier called this a delaying tactic and the paragraph was placed upon the plenary session agenda of the ACGME. D. Kay Clawson introduced a motion to table action until there could be consultation between the ACGME and the LCME. The motion was defeated, and the motion to include the paragraph in the General Requirements passed with only the

AAMC representatives and the resident representative voting negative.

Subsequently, Robert Ginsberg, public member, rose to speak strongly in favor of the initiation of discussions between LCME and ACGME on this issue and any others of mutual concern. He pointed out that the concept of the continuum of medical education could be enhanced if the voluntary accrediting bodies for both undergraduate and graduate medical education work together. No formal action was taken, but there was general support for having the ACGME initiate discussions. Bruce McFadden (AHA representative), Chairman of the ACGME, asked me after the meeting what the AAMC posture would be on ratification of this change in the General Requirements. I told him I thought that unless there were efforts by the ACGME to initiate discussions with LCME, the Executive Council was likely to take a negative position. I also pointed out that the Structure and Functions document is in its final stages of revision and that discussions between LCME and ACGME should be initiated as soon as possible.

In the course of these discussions, the acceptance by ACGME of an examination of clinical skills for graduates seeking its certification was left in abeyance. Although the tenor of discussions indicated that the acceptance of the concept of such an examination by ECFMG was positive.

Should the ACGME/LCME discussions evolve, another item for the agenda could be the recruiting practices of graduate medical education programs that are disrupting the general professional education of medical students.

cc: Executive Staff  
DAA Directors  
James R. Schofield, M.D.

February 26, 1985

MEMORANDUM TO: Council of Deans

SUBJECT: Graduate Medical Education in Academic Medical Centers

Over the past several years there has been an increasing emphasis on quality control in residency programs. The Residency Review Committees are more and more inclined to establish stricter criteria and to provide approvals on a probationary basis. There are often requirements for research activities of residents and faculty, and at times the need for teaching in basic sciences as well as in the clinical discipline. Even relatively small programs based in medical school hospitals can provide this type of academic structure to the program.

It is our understanding that some Residency Review Committees are considering additional guidelines that might provide a threat to residency programs in some academic institutions. An example is the proposed guideline by the Residency Review Committee in Pediatrics for an average daily census of 20 medical pediatric inpatients for a program that would qualify for accreditation, a requirement which several medical school hospital pediatric residency programs could not meet.

Because of the educational mission and academic goals of medical schools and their hospitals, and the close interaction of graduate medical education with undergraduate medical education, we would like to raise the question with the Council of Deans as to whether or not a joint approach should be made to addressing this general issue.

Alton I. Sutnick, M.D.  
William H. Luginbuhl, M.D.

## Matching Medical Students for Advanced Residency Positions

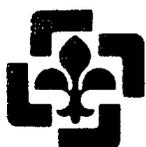
Last year the Executive Committee had met with representatives of specialties which matched in the second postgraduate year to determine the special needs of those specialties and whether they could be met by participation in the NRMP. One of the outcomes of that meeting had been the establishment of a specialty advisory board by the NRMP. The Executive Council remained concerned about pressures to provide student evaluations early in the senior year and the premature career decisions that often accompany early application deadlines. The Council wished to continue its discussions with these specialties on the issue of timing of the application process as well as the issue of participation in the NRMP. As a basis for these discussions the Executive Council adopted a resolution supporting later release of student evaluations and endorsing the NRMP as the appropriate organization for matching students in internships and residencies.

**ACTION:** On motion, seconded, and carried, the Executive Council adopted the following resolution:

The educational needs of medical students are best served if they are not forced to make premature decisions about career specialization. Their time in medical school should be devoted, as much as possible, to completing their general professional education, obtaining in-depth training in basic disciplines, and breadth in elective experiences.

To achieve these educational goals and contain the pressures toward premature specialization, medical schools should release their summary reports of student achievement (Deans' letters, transcripts) as late as possible in the senior year as recommended by the AAMC Task Force on Graduate Medical Education in 1981. Specialty program directors should moderate their pressures for early specialty selection, and students should support efforts to conduct residency selection as late in the senior year as possible. This timing allows students to complete the basic clerkship cycle as well as some elective experiences before choosing a post-graduate career track and affords time for the school to evaluate and summarize the achievements of that senior class.

Optimal career selection is further enhanced by coordinating applications and interview trips, integrating selection of internship and residency programs which require dual applications, and maximizing the ability of medical student couples to obtain desired residency choices in the same geographic area. All of these desired outcomes are achieved by the National Resident Matching Program which has a long and distinguished record in coordinating the yearly placement of the majority of American medical students in residency programs. We propose that all internship (PGY-1) and residency (PGY-2 and beyond) positions offered to medical students be offered only through NRMP.



St. Louis University  
Medical Center

School of Medicine

1402 S. Grand Blvd., St. Louis, Mo. 63104  
314/664-9800

Office of the Dean

October 17, 1984

Mr. Joseph A Keyes, Jr.  
Director, Department of  
Institutional Development  
AAMC  
One Dupont Circle, N.W.  
Washington, DC 20036

Dear Joe:

I am writing at the suggestion of Ed Stemmler with whom I discussed the following matter on the telephone yesterday. It is his suggestion that you attempt to provide space on the Council of Dean's Agenda under New Business for this subject.

Subject -- Encroachment by specialty residency program directors on the undergraduate clerkships.

Background -- With increasing competition by medical students for positions in desirable specialty residencies, including, but not limited to the surgical subspecialties, program directors are increasingly requesting candidates to spend an elective clerkship at their institutions prior to graduation. In the past it has been possible to accommodate this during elective time in the senior year subsequent to completion of the junior year core clerkships. However, with more and more of these specialties working outside the NRMP match, increasing pressure is being placed on student candidates to visit during their junior year. This problem is growing rapidly and will require concerted action by medical schools, the LCME, and an appropriate strategic approach to the other entities who are a part of the problem (among them many of our own department chairmen). It would seem imperative that medical schools assume a unified position in this matter.

Action -- Between now and the time of the Chicago meeting, I will have sought advice from a variety of sources on actions



Mr. Keyes  
October 17, 1984  
Page Two

which might be taken outside the AAMC in addition to action by the Council of Deans. Certainly the Section on Medical Schools of the AMA should consider taking a position. I believe the problem is very widespread and will be prepared to suggest a strategic course. I would presume that the action of the Council would be to refer the problem to the Administrative Board.

Sincerely,

William Stoneman III, M.D.  
Dean

WS:jb

cc: Dr. Edward J. Stemmler

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DEPARTMENT OF PHYSIOLOGY  
SCHOOL OF MEDICINE  
PHONE: 415-666-1751

SAN FRANCISCO, CALIFORNIA 94143

January 29, 1985

Dr. Elizabeth Short  
AAMC  
Department of Academic Affairs  
One Dupont Circle, N.W., Suite 200  
Washington, D.C. 20036

Dear Libby:

Following up our telephone conversation, I enclose a copy of the unsolicited letter I got from the National Medical Research Matching Program, Inc. with the attached resumes, and one sample of the type of letters that have been pouring into my office since then. As I told you, I am not sure where they got the information that we were looking for postdoctoral fellows. We are always in the market for good candidates, but have not advertised recently and as far as I know the only place our training program is listed is in the Journal of Clinical Endocrinology and Metabolism. As I also mentioned, Zena Werb at our institution received a similar mailing that I believe was unsolicited, and it may well be that others on our faculty were similarly "honored".

I hope the AAMC will look into this situation and, if the National Medical Research Matching Program, Inc. is really the very borderline operation that it seems to be, see if its activities can be stopped.

All best wishes.

Sincerely,

William F. Ganong, M.D.  
Lange Professor of Physiology  
Chairman, Dept. of Physiology

WFG:jlf



NATIONAL MEDICAL RESEARCHER MATCHING PROGRAM, INC.

1109 MAIN STREET—SUITE C  
BOISE, IDAHO 83702

(208) 336-7387  
(208) 336-7397

December 28, 1984

Dr. William F. Ganong  
Department of Physiology  
University of California, San Francisco  
S 762  
San Francisco, CA 94143

Dear Dr. Ganong:

Enclosed are applications for the position opening of your research program. The applicants are required to communicate directly with you to initiate the particular application procedures for the above mentioned position.

We did not verify the information contained in the applications. Where appropriate, we confirmed that any medical school described in applications is listed in The World Directory of Medical Schools published by the World Health Organization. Because we are only an information service, we recommend that as part of your application procedure you verify the information contained in the applications.

Each applicant certified to us that the information provided in his or her application is true and correct.

The National Medical Researcher Matching Program provides a "nationwide link" between research institutions seeking qualified applicants and those eligible individuals looking for medical research positions. Your courtesy and cooperation is greatly appreciated.

Very truly yours,

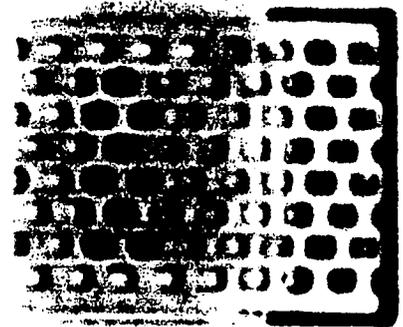
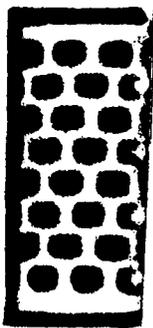
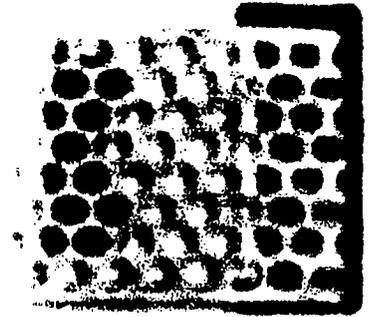
*Jean K. Swanke*  
Jean K. Swanke,  
Executive Secretary  
National Medical Researcher  
Matching Program

JKS/LLT

Enclosure



National  
Medical  
Researcher  
Matching Program



Provided by  
NATIONAL MEDICAL RESEARCHER  
MATCHING PROGRAM, INC.  
Boise, Idaho

1109 Main Street, Suite C  
P.O. Box 2079  
Boise, Idaho 83702  
Telephone: (208) 336-7387  
(208) 336-7397

Telex: 3717411 NMRMP  
Telecopier: (208) 336-1471 NMRMP  
Toll Free: (800) 245-1886

THIS IS AN INFORMATIONAL BROCHURE AND  
NOT A SOLICITATION OF ANY KIND

The National Medical Researcher Matching Program, Inc. was incorporated in Idaho in 1984 and it maintains its new offices at:

1109 Main Street, Suite C  
P.O. Box 2079  
Boise, Idaho 83702  
Telephone: (208) 336-7387  
(208) 336-7397

Telex: 3717411 NMRMP  
Telecopier: (208) 336-1471 NMRMP  
Toll Free: (800) 245-1886

The **National Medical Researcher Matching Program<sup>SM</sup>** is a specially-designed, privately-operated computerized information service that attempts to match professional opportunities in post-doctoral medical research to senior medical students and medical graduates seeking alternatives to clinical positions. Those eligible to register for the program include senior students in medical schools accredited by the AMA's Liaison Committee on Medical Education who are enrolled in schools in the United States and Canada, physicians who have graduated from programs accredited by the Liaison Committee on Medical Education, graduates of foreign medical schools recognized by the World Health Organization, and United States citizens who are in fifth pathway programs.

Many of the eligible individuals apply for clinical positions in the United States. Unfortunately, the number of such clinical positions in each year is **limited**, and some of the eligible individuals are not accepted by a clinical program. Unless these eligible individuals work in a different medical capacity, their training and special expertise may be wasted while they are waiting.

Some of the eligible individuals turn to medical research as an **alternative career**. Although medical research experience can **not** be used to satisfy the post-graduate training requirements for licensure, it provides a unique opportunity for an eligible individual to utilize his or her medical training. However, finding a suitable medical research position can be difficult. Because medical research openings are typically publicized only locally, an individual with limited time and resources may not learn of the research position in his or her specialization and preferred geographic location.

The National Medical Researcher Matching Program is designed to provide a **nationwide** link between research institutions seeking qualified applicants and those eligible individuals looking for medical research positions. We do **not** guarantee employment. Instead, we assist applicants to overcome their geographical and informational limitations by attempting to match each applicant with the available research positions in the applicant's preferred specialization and designated locale, mailing information about the position to the applicant, and providing information about the applicant to the research director of the institution having the research opening.

The specific terms and conditions regarding each research opening vary widely and it is each applicant's responsibility to inquire about salary, term of employment, interviews and other requirements directly from each research director.

Some eligible individuals applying for clinical positions are also hampered by the schedule of the clinical programs, which invariably commence on July 1st and last a full year. Missing the application deadlines or rejections by all the clinical programs in one year often means that an individual must wait a full year for another opportunity to apply. In con-

trast, research positions become available continuously. Our program provides each applicant with information regarding at least three research opportunities every three months for a year. Each time, it is the applicant's responsibility to use the information to pursue each opportunity.

We plan to conduct research to determine and better specify the needs of the group of eligible individuals. By examining these needs, we can hopefully design our program to assist eligible individuals to become contributing members of the medical researcher community, either in the United States or in the individual's home country.

Foreign medical graduates and students who obtain research experience may return to their home countries and apply the advanced knowledge, improved techniques, and invaluable experience gained from a research position in their specialization. Perhaps more importantly, they may also teach the advanced knowledge and improved techniques in medical research to young doctors in their home countries, thereby improving the medical standards of each country to which they return.

The National Medical Researcher Matching Program, Inc. expressly notifies all applicants in writing that it is not affiliated with the American Medical Association (AMA) or any of the AMA's programs, including the National Resident Matching Program, or with any medical institution, and that research experience may **not** be used to satisfy the postgraduate training requirements for licensure. Since our program is merely an information service, we also expressly advise, in writing, each research director to verify the qualifications of each applicant.

All applicants are strongly urged to use the information provided by our program to actively pursue the available research positions.

Garcia-Maldonado Maurilio  
1251 Fulton Ave. #12  
Sacramento, CA 95825  
(916)-453-3735

MEDICAL EDUCATION

Univ. Autonoma Guadalajara, Mexico  
Degree: Physician & Surgeon 1979

GRADUATE EDUCATION

Univ. Autonoma Guadalajara, Mexico  
Area of Study: Med. Surgery  
Degree: M.D. & Surgeon 1972-1976

CLINICAL EXPERIENCE

Univ. California-Davis Sacramento Med. Ctr., CA  
Major: Gastroenterology  
Position: Fellow PGY 4 1982-1983

20 Noviembre Hosp., Mexico  
Major: Intern. Medicine  
Position: Resident PGY1-3 1980-1982

Hospital Regponal Tssste, Mexico  
Major: Rotating  
Position: Resident 1979-1980

Angel Leano Hospital, Mexico  
Major: Nephrology  
Position: Fellow 1978-1979

Regionl Military Hospital, Mexico  
Major: Rotating Intern.  
Position: Intern. 1977-1977

RESEARCH EXPERIENCE

University Of California Davis, Sacramento, CA  
Area of Study: Nephrology-Uremic Toxins  
Position: Research Fellow PGY 4 1983-1985

MEDICAL EXAMINATIONS PASSED

FLEX  
ECFMG/FMGEMS

REFERENCE

Neville Pimstone, M.D., Chief Of Gastroenterology  
University Of California Davis-UCDMC  
4301 X St., Sacramento, CA 95817

Paul F. Gulyassy, M.D., Chief Of Nephrology  
University Of California Davis-UCDMC  
4301 X St., Sacramento, CA 95817

Thomas A. Depner, M.D., Head Dialysin Dept.  
Univ. Of California Davis-UCDMC  
4301 X St., Sacramento, CA 95817

Dr. Arturo Aguillon-Luna, Chief Of Surg.  
Hospital Regional Issste  
Fray Diego Magdalena 555, San Luis Potosi, Slp., Mexico

Kahlon Maninder Singh  
22 Fortuna West  
Irvine, CA 92714

MEDICAL EDUCATION

Patliputra Medical College, India 1980  
Degree: M.B.B.S.

CLINICAL EXPERIENCE

Rajendra Hospital Patiala, India 1983-1984  
Major: Ophthalmology  
Position: Jr. Resident

Pajenda Hospital, India 1982-1982  
Major: Ophthalmology, Intern. Med.  
Position: House Physician

General Hospital, India 1981-1981  
Major: Rotating Intern.  
Position: Intern.

RESEARCH EXPERIENCE

Govt. Medical College, India 1983-1984  
Area of Study: Ophthalmology  
Position: Post Graduate Student

REFERENCE

Dr. Ravinder S. Arora, M.D., Family Practice  
Laguna Hills Medical Arts Center  
24953 Paseo De Valencia Bldg. #5, Laguna Hills, CA 92653

Dr. Davinder Singh, M.D., Gastroenterologist  
Fountain Valley Cardiology Clinic Inc.  
11100 Warner Ave, #268 Fountain Valley, CA 92708

Dr. Ravinder Singh, M.D., Psychiatrist  
Doctor's Hospital  
1905 North College Ave, Santa Ana, CA 92706

Banez Eulogio Brillantes  
55 Carrizal St.  
San Francisco, CA 94134  
(415)-558-3975

MEDICAL EDUCATION

University Of Santo Tomas, Philippines 1971  
Degree: M.D.

CLINICAL EXPERIENCE

Univ. Of Santo Tomas Hosp., Philippines 1977-1979  
Major: Anesthesia  
Position: Affiliate Faculty

Quezon City General Hosp., Philippines 1976-1979  
Major: Anesthesia  
Position: Consultant

Clinica Arellano, Philippines 1974-1979  
Major: Ob, Pediatrics, Medicine  
Position: House Staff

Univ. Of Santo Tomas Hospital, Philippines 1972-1973  
Major: Anesthesia  
Position: Resident Physician

REFERENCE

Luisita Reyes De Castro, M.D., Section Head-Anesthesia  
Univ. Of Santo Tomas  
España St., Sampaloc, Manila, Philippines

Fe Villanueva-Fernandez, M.D., Hospital Director  
Quezon City General Hospital  
Seminary Rd., Quezon City, Philippines

Ernesto G. Moreno, M.D., Clerkship Prog. Director  
Univ. Of Santo Tomas  
España St., Sampaloc, Manila, Philippines

Prado Fabiola  
6704 Wooster Ave  
Los Angeles, CA 90056  
(213)-410-0517

MEDICAL EDUCATION

Univ. Of San Carlos Of Guatemala, Central America 1984  
Degree: M.D.

CLINICAL EXPERIENCE

Roosevelt Hospital, Guatemala 1983-1983  
Position: Internship

National Hospital-Escuintla, Guatemala 1982-1982  
Major: Gyn/Ob.

Roosevelt Hospital, Guatemala 1981-1982  
Major: Traumatology, Pediatrics

General Hospital, Guatemala 1981-1981  
Major: Intern. Med., Surgery

REFERENCE

Dr. Carlos De La Riva, Chief Of Neurosurg.  
General Hospital  
Ave La Reforma, 3-43 Zona 10, Guatemala City, C.A.

Dr. Edgar Berganza, Pediatrics Dept.  
Roosevelt Hospital  
1 Ave., 8-67 Zona 9, Guatemala City, C.A.

Dr. Rodolfo Duran Ayala  
Roosevelt Hospital  
4 Ave, 16-64 Zona 14, Guatemala City, C.A.

Dr. Carlos Roldan  
2208 Bellefontaine, Houston, TX 77030

Frenkel Helen Vladimirovna  
15622 Pasadena Ave.  
Tustin, CA 92680  
(714)-838-3250

MEDICAL EDUCATION

First Leningrad Medical Institute, U.S.S.R. 1955  
Degree: M.D.

GRADUATE EDUCATION

First Leningrad Medical Institute, U.S.S.R. 1961-1964  
Area of Study: Ob/Gyn  
Degree: Ph.D.

CLINICAL EXPERIENCE

First Leningrad Med. Institute, U.S.S.R. 1964-1980  
Major: Ob/Gyn  
Position: Asst. Prof. In Ob/Gyn

First Leningrad Med. Institute, U.S.S.R. 1961-1964  
Major: Ob/Gyn  
Position: Postgraduate Student

Clinic N 17 Of Hospital N 3, U.S.S.R. 1959-1961  
Major: Ob/Gyn  
Position: Resident

Clinic N 9, U.S.S.R. 1955-1959  
Major: Ob/Gyn  
Position: Intern. Of Ob/Gyn

RESEARCH EXPERIENCE

First Leningrad Med. Institute, U.S.S.R. 1975-1980  
Area of Study: Toxemia Of Pregnancy & Renal Diseases  
Position: Asst. Prof. In Ob/Gyn

First Leningrad Med. Institute, U.S.S.R. 1970-1975  
Area of Study: Electrolites: Ionisir. Calcium  
Position: Asst. Prof. In Ob/Gyn

First Leningrad Med. Institute, U.S.S.R. 1961-1964  
Area of Study: Erythrodoesis & Iron Metabolism  
Position: Postgraduate Student

REFERENCE

Leo L. Levinson, M.D., Ph.D.  
Kaiser Permanente Medical Center, Dept. Of Ob/Gyn  
9961 Sierra Ave., Fontana, CA 92335

Arye Lev-Ran, M.D., Ph.D., Director  
City Of Hope National Medical Center  
Duarte, CA 91010

Tapia-Camacho Juan  
368 Heather Heights  
Monrovia, CA 91016  
(818)-358-0655

MEDICAL EDUCATION

School Of Medicine, Mexico  
Degree: M.D. 1952

CLINICAL EXPERIENCE

Los Angeles Hospital, L.A., CA  
Position: Intern. 1954-1955

St. Joseph's Hospital, Kansas, MO  
Major: Surgery  
Position: Surgical Resident 1952-1953

St. Joseph's Hospital, Kansas, MO  
Position: Intern. 1951-1952

REFERENCE

Florence Rhudy  
The California Hospital  
1414 Hope St., Los Angeles, CA

Gifford John  
The California Hospital  
1414 Hope St., Los Angeles, CA

Tapia-Camacho Juan  
368 Heather Heights  
Monrovia, CA 91016  
(818)-358-0655

MEDICAL EDUCATION

School Of Medicine, Mexico  
Degree: M.D.

1952

CLINICAL EXPERIENCE

Los Angeles Hospital, L.A., CA  
Position: Intern.

1954-1955

St. Joseph's Hospital, Kansas, MO  
Major: Surgery  
Position: Surgical Resident

1952-1953

St. Joseph's Hospital, Kansas, MO  
Position: Intern.

1951-1952

REFERENCE

Florence Rhudy  
The California Hospital  
1414 Hope St., Los Angeles, CA

Gifford John  
The California Hospital  
1414 Hope St., Los Angeles, CA





# association of american medical colleges

MEMORANDUM

November 19, 1984

TO: A. G. Swanson

FROM: Richard R. Randlett *RRR*

SUBJECT: National Medical Researcher Matching Program (NMRMP)

In response to "Dr. Zylar's request", we have obtained current registration materials for the "NMRMP". These are attached.

It is interesting to note that while the telegraphed request was sent to 690 Market Street in San Francisco, the response did not originate from there; the operation has apparently been moved to 1109 Main Street in Boise, Idaho.

The Conditions, Restrictions and Limitations, although pertaining to the 1984-1985 processing season, have been modified from those we originally received when the operation was located in California. All dates have been moved forward approximately one month. In addition, the wording has changed from a positive stance to one that is less positive. For example, the "NMRMP" was described as a program which matched. It now is described as a program which attempts to match.

If you have any questions, or if we can assist in any additional follow-up, please give me a call.

RRR/pj

Enclosures



GRADUATE MEDICAL EDUCATION

**APPLICATION FOR  
MEDICAL RESEARCH POSITION**

PROVIDED BY

**NATIONAL MEDICAL RESEARCHER  
MATCHING PROGRAM**

BOISE IDAHO

APPLICATION FOR MEDICAL RESEARCH POSITION

NAME (LAST) (FIRST) (MIDDLE)				
SOCIAL SECURITY NUMBER (IF ANY)				
PRESENT ADDRESS (STREET)		(CITY)		(STATE) (ZIP)
PRESENT PHONE NOS				
DAY ( )		EVENING ( )		
PERMANENT ADDRESS (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)				
C/O (STREET)		(CITY)		(STATE) (ZIP)
PERMANENT PHONE NO			7 NUMBER OF DEPENDENTS	

OPTIONAL  
  
 ATTACH RECENT  
 PHOTOGRAPH  
  
 (2" X 2")

CITIZENSHIP		9 VISA STATUS (IF APPLICABLE)		
<input type="checkbox"/> U.S. <input type="checkbox"/> OTHER ( )		<input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY (SPECIFY <input type="checkbox"/> J-1 <input type="checkbox"/> H-1 <input type="checkbox"/> F-1 <input type="checkbox"/> OTHERS)		

MEDICAL EDUCATION			
1 MEDICAL SCHOOL(S)		(NAME)	(CITY) (STATE)
MONTH/YEAR OF MATRICULATION AT MEDICAL SCHOOL		MONTH/YEAR OF (ANTICIPATED) GRADUATION	
TITLE OF DEGREE		DATE CONFERRED (OR TO BE CONFERRED)	
M.D., M.B., B.S. OR OTHER		MONTH _____ YEAR _____	

UNDERGRADUATE EDUCATION				
UNDERGRADUATE COLLEGE(S)	DATES ATTENDED		MAJOR	DEGREE (IF ANY)
	FROM (MO./YR.)	TO (MO./YR.)		
NAME				
STATE				
NAME				
STATE				

GRADUATE EDUCATION (IF ANY)				
GRADUATE SCHOOL(S)	DATES ATTENDED		AREA OF STUDY	GRADUATE DEGREE (IF ANY)
	FROM (MO./YR.)	TO (MO./YR.)		
NAME				
STATE				
NAME				
STATE				

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13 CLINICAL EXPERIENCE				
HOSPITAL(S)	DATES ATTENDED		MAJOR	POSITION
	FROM (MO/YR)	TO (MO/YR)		
NAME A				
CITY STATE				
NAME B				
CITY STATE				
NAME C				
CITY STATE				
NAME D				
CITY STATE				

14 I HAVE ALREADY PASSED THE EXAMINATIONS CHECKED BELOW ON THE DATES INDICATED \*

<input type="checkbox"/> NBME PART I	(DATE)	<input type="checkbox"/> NBME PART II	(DATE)
<input type="checkbox"/> FLEX	(DATE)	(STATE(S) OF LICENSURE)	
ECFMG / FMGEMS (DATE)			
* NOT REQUIRED FOR MOST RESEARCH POSITIONS			

15 RESEARCH EXPERIENCE (IF ANY)				
INSTITUTION(S)	DATES ATTENDED		AREA OF STUDY	POSITION
	FROM (MO/YR)	TO (MO/YR)		
NAME A				
CITY STATE				
NAME B				
CITY STATE				
NAME C				
CITY STATE				

16

## GEOGRAPHICAL PREFERENCE

CHOOSE 3 STATES IN WHICH YOU WOULD LIKE TO WORK, MARKING THEM 1, 2 AND 3 TO INDICATE YOUR ORDER OF PREFERENCE. (IF THERE ARE NO OPENINGS IN YOUR SUBJECT AREA IN ANY OF THOSE THREE STATES, WE WILL MATCH YOU WITH OPPORTUNITIES IN STATES AS CLOSE TO YOUR PREFERRED STATES AS POSSIBLE.)

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> ALABAMA     | <input type="checkbox"/> LOUISIANA      | <input type="checkbox"/> OHIO             |
| <input type="checkbox"/> ALASKA      | <input type="checkbox"/> MAINE          | <input type="checkbox"/> OKLAHOMA         |
| <input type="checkbox"/> ARIZONA     | <input type="checkbox"/> MARYLAND       | <input type="checkbox"/> OREGON           |
| <input type="checkbox"/> ARKANSAS    | <input type="checkbox"/> MASSACHUSETTS  | <input type="checkbox"/> PENNSYLVANIA     |
| <input type="checkbox"/> CALIFORNIA  | <input type="checkbox"/> MICHIGAN       | <input type="checkbox"/> RHODE ISLAND     |
| <input type="checkbox"/> COLORADO    | <input type="checkbox"/> MINNESOTA      | <input type="checkbox"/> SOUTH CAROLINA   |
| <input type="checkbox"/> CONNECTICUT | <input type="checkbox"/> MISSISSIPPI    | <input type="checkbox"/> SOUTH DAKOTA     |
| <input type="checkbox"/> DELAWARE    | <input type="checkbox"/> MISSOURI       | <input type="checkbox"/> TENNESSE         |
| <input type="checkbox"/> FLORIDA     | <input type="checkbox"/> MONTANA        | <input type="checkbox"/> TEXAS            |
| <input type="checkbox"/> GEORGIA     | <input type="checkbox"/> NEBRASKA       | <input type="checkbox"/> UTAH             |
| <input type="checkbox"/> HAWAII      | <input type="checkbox"/> NEVADA         | <input type="checkbox"/> VERMONT          |
| <input type="checkbox"/> IDAHO       | <input type="checkbox"/> NEW HAMPSHIRE  | <input type="checkbox"/> VIRGINIA         |
| <input type="checkbox"/> ILLINOIS    | <input type="checkbox"/> NEW JERSEY     | <input type="checkbox"/> WASHINGTON       |
| <input type="checkbox"/> INDIANA     | <input type="checkbox"/> NEW MEXICO     | <input type="checkbox"/> WEST VIRGINIA    |
| <input type="checkbox"/> IOWA        | <input type="checkbox"/> NEW YORK       | <input type="checkbox"/> WISCONSIN        |
| <input type="checkbox"/> KANSAS      | <input type="checkbox"/> NORTH CAROLINA | <input type="checkbox"/> WYOMING          |
| <input type="checkbox"/> KENTUCKY    | <input type="checkbox"/> NORTH DAKOTA   | <input type="checkbox"/> WASHINGTON, D.C. |

17

## SUBJECT PREFERENCE

CHOOSE 3 FIELDS IN WHICH YOU WOULD LIKE TO WORK, MARKING THEM 1, 2 AND 3 TO INDICATE YOUR ORDER OF PREFERENCE. (IF THERE ARE NO RESEARCH OPPORTUNITIES IN YOUR PREFERRED SUBJECTS, WE WILL MATCH YOU WITH OPPORTUNITIES IN FIELDS AS CLOSELY RELATED TO YOUR PREFERENCES AS POSSIBLE.)

- |   |  |
|---|--|
| <input type="checkbox"/> ANATOMY                      | <input type="checkbox"/> PHYSIOLOGY                        |
| <input type="checkbox"/> BEHAVIORAL SCIENCES          | <input type="checkbox"/> ENDOCRINOLOGY                     |
| <input type="checkbox"/> BIOCHEMISTRY                 | <input type="checkbox"/> PREVENTIVE MEDICINE/PUBLIC HEALTH |
| <input type="checkbox"/> MICROBIOLOGY                 | <input type="checkbox"/> INTERNAL MEDICINE                 |
| <input type="checkbox"/> IMMUNOLOGY                   | <input type="checkbox"/> OBSTETRICS AND GYNECOLOGY         |
| <input type="checkbox"/> PARASITOLOGY                 | <input type="checkbox"/> PEDIATRICS                        |
| <input type="checkbox"/> PATHOLOGY                    | <input type="checkbox"/> PSYCHIATRY                        |
| <input type="checkbox"/> PHARMACOLOGY                 | <input type="checkbox"/> SURGERY                           |
| <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ |  |

18. THE FOLLOWING INDIVIDUALS, WHO KNOW MY QUALIFICATIONS WELL, HAVE BEEN ASKED TO WRITE REFERENCES FOR ME UPON REQUEST:

A. NAME AND TITLE

INSTITUTION

ADDRESS

B. NAME AND TITLE

INSTITUTION

ADDRESS

C. NAME AND TITLE

INSTITUTION

ADDRESS

D. NAME AND TITLE

INSTITUTION

ADDRESS

I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THE POSITION

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE \_\_\_\_\_

# NATIONAL MEDICAL RESEARCHER MATCHING PROGRAM

1984-1985

## CONDITIONS, RESTRICTIONS AND LIMITATIONS

The National Medical Researcher Matching Program (NMRMP) is a specially designed computerized information service which attempts to match professional opportunities in medical research to senior medical students and medical graduates seeking alternatives to clinical positions. NMRMP also attempts to match applicants to available research positions in major medical institutions nationwide.

NMRMP was established to assist the increasing number of M.D.'s who are turning from clinical to research work because of the greater number of career opportunities in research and the greater challenge to apply what they have learned in their chosen field's research frontiers. Despite the existence of research opportunities, however, many qualified senior medical students and medical graduates are unable to find positions—for example, more than ten thousand foreign-trained M.D.'s in the U.S. are currently working in neither medicine nor medicine-related fields. NMRMP's goal is to match the existing opportunities to the position-seeking senior medical students and medical graduates. NMRMP provides each applicant with information regarding twelve or more position openings in four separate matches in one program year. The openings will be geared to the applicant's preferred field and locale, and each opening will be an opportunity for the applicant to follow up. The process provides the information to allow the applicant to know about and have the opportunity to apply for a research position when the position is available.

NMRMP is not affiliated with the American Medical Association (or National Resident Matching Program) or any medical institution. NMRMP does, however, work with major medical institutions throughout the United States in referring applicants for research openings geared to the applicant's fields of interest and geographic preferences. (Please note: by registering with NMRMP, the applicant authorizes NMRMP to refer the applicant's information to the directors of research programs.)

Conditions of employment vary markedly depending on the particular available position. The applicant should, therefore, inquire about the conditions of employment as part of the applicant's direct communication with the research program directors.

Most research experience may not be used to satisfy the postgraduate training requirement for licensing, and it is desirable but not necessary for the medical research applicant to have passed the various licensing examinations.

The eligibility of applicants for registering with NMRMP is defined as follows:

- senior students in medical schools accredited by the Liaison Committee on Medical Education, enrolled in programs leading to a M.D. degree in the United States and Canada;
- physicians who have graduated from programs accredited by the Liaison Committee on Medical Education;
- graduates of foreign medical schools which are not accredited by the Liaison Committee on Medical Education but listed in the W.H.O. Directory of Medical Schools; and
- U.S. citizens who are in a fifth pathway program.

The NMRMP relies on the applicant's absolute compliance with NMRMP's deadline dates in the following program sequence. To participate, adhere to the following precisely:

**I. BY NOVEMBER 30, 1984:**

The NMRMP must have received in its office from each applicant the completed and executed Application for Medical Research Position, the completed and executed Applicant Agreement and the non-refundable fee of \$220.

NMRMP requires that applicants include the postcard provided in this packet—stamped and self-addressed—with the application materials and fee so that NMRMP can verify receipt.

**II. BETWEEN DECEMBER 1, 1984 AND JANUARY 31, 1985:**

Based on the information received by NMRMP from applicants and from major medical institutions, NMRMP will conduct a computer analysis of applicant qualifications and preferences as well as requirements of research positions available throughout the country.

**III. BY JANUARY 31, 1985:**

NMRMP will attempt the first match by sending the research program directors the information provided by prospective applicants who meet the qualification requirements and, simultaneously, notifying each qualified applicant of three or more position openings.

THE APPLICANT IS THEN REQUIRED TO IMMEDIATELY COMMUNICATE DIRECTLY WITH THE RESEARCH PROGRAM DIRECTORS TO INITIATE THE PARTICULAR APPLICATION PROCEDURES FOR THE POSITIONS PRESENTED.

**IV. POSTMARKED NO LATER THAN MARCH 22, 1985:**

The applicant is required and honor-bound to notify NMRMP in writing of the status of his or her applications for the research positions from the first attempted match.

**V. BY APRIL 5, 1985:**

Using the same procedures, NMRMP will attempt the second match for each applicant who timely notified NMRMP that he or she failed to secure any of the positions presented to him or her in the first attempt.

**VI. POSTMARKED NO LATER THAN MAY 24, 1985:**

The applicant is required and honor-bound to notify NMRMP in writing of the status of his or her applications for the research positions from the second attempted match.

**VII. BY JUNE 7, 1985:**

Using the same procedures, NMRMP will attempt the third match for each applicant who notified NMRMP that he or she failed to secure any of the positions presented to him or her in the second attempt.

**VIII. POSTMARKED NO LATER THAN JULY 24, 1985:**

The applicant is required and honor-bound to notify NMRMP in writing of the status of his or her applications for the research positions from the third attempted match.

**IX. BY AUGUST 9, 1985:**

Using the same procedures, NMRMP will attempt the fourth and final match for each applicant who notified NMRMP that he or she failed to secure any of the positions presented to him or her in the third attempted match.

**X. BY SEPTEMBER 27, 1985:**

The applicant is required and honor-bound to notify NMRMP in writing of the status of his or her applications for the research positions from the fourth attempted match.

For more information or additional application forms contact  
NATIONAL MEDICAL RESEARCHER MATCHING PROGRAM, INC.  
1109 Main Street, Suite C  
Boise, Idaho 83702  
(208) 336-7387  
(208) 336-7397

INVESTOR OWNED TEACHING HOSPITAL MEMBERSHIP IN THE  
COUNCIL OF TEACHING HOSPITALS

The attached letter from John Gaffney, Executive Director, St. Joseph Hospital in Omaha directly raises the issue of investor owned hospital participation in COTH/AAMC. Under the current rules for determining membership in the Council of Teaching Hospitals, a hospital must qualify as a public hospital or a not-for-profit institution. Thus, hospitals owned or leased by investor owned corporations such as Humana Hospital University (leased) and St. Joseph Hospital in Omaha (recently acquired by AMI) are excluded from membership in COTH. Hospitals managed by an investor owned corporation, such as the hospital of the University of Mississippi and the University of Medicine and Dentistry of New Jersey, are eligible to continue membership. Those attending the COTH Spring Meeting in Baltimore this past May heard descriptions of the situations at the University of Louisville, McLean Hospital in Boston, and The George Washington University Hospital. The matter of investor owned hospital membership in COTH was discussed at the Baltimore Spring Meeting, and once again, at the request of the COTH Administrative Board, at the COTH Business Meeting this past November. The following points were made in these discussions (the attached letter from John Ives, Executive Vice President, Shands Hospital, is an excellent example of a thoughtful COTH constituent viewpoint.):

- o The arguments for participation of investor owned hospitals in COTH are logical and to some degree persuasive. However, there are strong and emotional views on each side of the issue that need to be considered;
- o Inviting investor owned hospital participation could be a very divisive move at this point since there is not clear consensus in the COTH constituency;
- o Inviting such organizations to participate would be one more step toward legitimizing them as an acceptable and productive component of the health care industry;
- o Bringing for-profit institutions into the COTH would dilute the ability of the organization to develop the type of public perception necessary for effective advocacy in public policy forums;
- o One of the objectives of COTH is information sharing among member hospitals. Investor owned organizations are reluctant to share basic data and information, particularly concerning financial matters;
- o Is the purpose of COTH to bring together teaching hospitals or those with common profit missions? In other words, should ownership be a factor in COTH membership;
- o If an organization supports our goals and is interested in participation, perhaps it should be given the opportunity to do so;
- o If these investor owned hospitals are not invited to participate another organization could develop representing teaching hospitals; and

- o The principal teaching hospitals at which two medical schools (Louisville and Creighton) conduct their undergraduate medical education programs are not eligible for membership. Others may soon follow a similar pattern.

Application of current policy is represented by the letter of September 24 to the Women's Hospital in Las Vegas. Also attached is a letter from Association counsel relating to membership of such hospitals in the AAMC.

Questions for Discussion:

1. Is it appropriate for the COTH/AAMC to represent broadly the community of medical education, and yet exclude some organizations participating in medical education because of their ownership status?
2. Are there other positive or negative points that need to be raised in the debate?
3. What is the process the Board would recommend to address and reach a conclusion on this issue?



**Saint Joseph  
Hospital**

*Life...is our business*

801 North 30th Street • Omaha, Nebraska 68131-2197  
402/449-4000

December 10, 1984

Richard M. Knapp, Ph.D.  
Director/Department of Teaching Hospitals  
Council of Teaching Hospitals  
One Dupont Circle, N. W.  
Washington, D.C. 20036

Dear Dick:

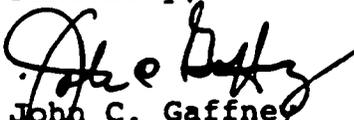
As you are aware, Saint Joseph Hospital and American Medical International have had ongoing discussions about the potential merger of our hospital into the AMI organization. On November 19, this merger was accomplished.

As I understand the COTH bylaws, they preclude an investor-owned hospital being a member. We are respectfully requesting that the Saint Joseph Hospital membership under AMI be continued. This will undoubtedly necessitate a bylaws change for the Council of Teaching Hospitals.

Dick, as I mentioned to you before, it is the intention of AMI and certainly the management of Saint Joseph Hospital to continue to be the primary teaching facility for the health science schools of Creighton University. The necessary contractual commitments between the hospital and AMI are in place to insure our continued role as an academic medical center. We hope the Board of Directors of the Council of Teaching Hospitals will look favorably upon our request for a bylaws change.

I look forward to hearing from you soon.

Sincerely,

  
John C. Gaffney  
Executive Director

JCG/ljs

cc: Dr. O'Brien  
Creighton University

# CREIGHTON UNIVERSITY

Vice President  
For Health Sciences

December 14, 1984

Richard M. Knapp, Ph.D.  
Director/Department of Teaching Hospitals  
Council of Teaching Hospitals  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Dick:

As you know Creighton University's interest and involvement with the AAMC and the Council of Teaching Hospitals is very important to us. I am aware that the recent acquisition of St. Joseph Hospital, our primary teaching hospital and a member of COTH, by American Medical International jeopardizes its membership in COTH. I am also aware that John Gaffney has written to you requesting that St. Joseph Hospital's membership be continued. I wish to endorse this request and to urge strongly that COTH take whatever steps are necessary to revise its by-laws so that we may continue to participate in COTH affairs.

I believe it important for the Council of Teaching Hospitals to recognize that St. Joseph is going to continue to function as a full-service teaching hospital dedicated to all the health science schools of Creighton University and that AMI has made a very strong commitment to enhance the teaching programs conducted at and supported by the Hospital. To exclude St. Joseph from membership simply because it is investor-owned seems to me to be basing membership on an irrelevant factor. Surely the standard for judging a teaching hospital, and its membership in the most important organization of teaching hospitals, should be how well it defines and attains its educational goals, not who owns it.

You may be assured that AMI will continue in its educational mission because of the contractual relationships it has with the Creighton Omaha Regional HealthCare Corp., from whom it acquired the hospital, and the affiliation agreements with Creighton University and the Boys Town National Institute. AMI has not only made their voluntary commitment to our academic missions, but it has contractually agreed to it in legally binding documents.

I sincerely hope that the Council of Teaching Hospitals will find it possible to accommodate St. Joseph and will be able to affect the appropriate change in its by-laws.

If I can help you in this matter in any way, please let me know.

Sincerely yours,



RICHARD L. O'BRIEN, M.D.  
Acting Vice President for  
Health Sciences and Dean,  
School of Medicine

RLO/sn

California at 24th Street Omaha, Nebraska

-101-

(402) 280-2973 Telex: 910-622-9287

# SHANDS HOSPITAL

at the University of Florida  
Gainesville, Florida 32610

John E. Ives  
Executive Vice President  
Box J-326  
(904) 392-3771

November 6, 1984

Mr. Sheldon King  
Executive Vice President  
Stanford University  
Stanford, California 94305

Dear Sheldon:

I have thought more about the short discussion at the COTH meeting regarding membership of investor-owned hospitals as members of the AAMC and COTH. I am putting my view of the matter in writing as there are a couple of other points I wish to make beyond those I made at the meeting.

First, I had a question in my mind as to whether a not-for-profit 501(c)(3) or 501(c)(6) organization could have for-profit members. This question has been researched for the Florida Hospital Association in the past. A discussion with the President of that organization discloses that their best legal advice regarding the tax situation is that there is no threat to their not-for-profit status as a result of having for-profit members.

One way of looking at this question is to look at the way many of us perceive the AAMC/COTH mission. I for one, and I think others agree, see the mission as educational, the dissemination of information to the membership, and representation with the federal government and other agencies.

If we agree on the above and look at the three areas, I can explain some of my questions about having investor-owned hospitals as members.

With regard to education, I would find their participation in educational activities of the COTH perfectly acceptable, as most of the activities deal with matters that are not controversial between for-profits and not-for-profits. In this arena, the viewpoint of the for-profits might occasionally be useful.

On the matter of dissemination of information, I would make several different points. The first point is that much of the information which is disseminated by COTH is information collected from its membership. Our experience in Florida is that the information which will be proffered on a voluntary

November 6, 1984

Page 2

basis by the for-profits is limited. Historically, they do not like to provide basic information about the finances or other material regarding their operations which might offer others a competitive advantage. It is clear that some of this reluctance is mitigated by the fact that Medicare cost reports are public documents and, in our case, state reports required by cost containment boards and other such state agencies are also public information. I do not know how this lack of response would affect the ability of COTH to respond to its membership's desire for information regarding fellow members.

Many of us see the most important present activity of the COTH as representation with the federal government. Some of us have been concerned with the already diverse membership that the COTH is trying to represent. It is clear that the community teaching hospital's needs, desires, and wants vis-a-vis the federal government are often at odds with the needs, wants, and desires of the university teaching hospitals. Some of us feel that the needs of the university teaching hospitals are being subordinated to the larger membership of community hospitals. Whether this is the case or not is not terribly important, as that is the perception. It seems to many of us who have observed associations which serve both profit and not-for-profit hospitals that this representation tends to be very weak and often presents the association in a light which is unfavorable to all. It is simply impossible on many occasions to represent those who have profit as a primary motive and those who have other missions, such as education and service, as a primary motive. Legislators are quick to perceive the weakness in the arguments of those who attempt to represent both and, as a result, over time, tend to disregard or even hold with some contempt the individuals and views representing and represented by those organizations.

There will be a percentage of so-called university teaching hospitals which are owned by for-profit companies. This number will increase over the number that we see today. Personally, I do not believe that a majority of the teaching hospitals will be included, but a significant number may. Therefore, I do not believe that we should hide our heads in the sand about these hospitals. However, I also believe that there is no rush to welcome with open arms these institutions which have chosen to sell to investor-owned chains. We have time to wait to see what direction they take. I do not believe that the association will lose influence over the near term if it does not accept these members. I believe that to defer any change would enable us to get a clearer picture of what is going to happen, and perhaps give us a clearer impression of what we ought to do.

I have three other random thoughts bearing on this subject, one of which is that the College of Medicine associated with these institutions is already a member of the AAMC and most of the correspondence from the AAMC is addressed to at least the Dean. As a result, the Dean can share whatever information is sent with the Hospital Director.

Dick Knapp has proposed the possibility of a corresponding membership for these institutions, one which would allow them to be on mailing lists, allow them to participate in certain activities, but would not afford them a seat at the table (a vote). I would assume that if such a membership were offered it would be with a clear understanding that representation of that institution with the federal government and others would not be included as part of the arrangement. This should not be a problem as they all have their strong lobbyists in Washington already.

Finally, I believe that the perception that there were "ten votes for, ten votes against, and 300 people who did not understand the question" is accurate. Most of the country has not been involved with the for-profit hospitals, particularly the large chains. They tend to prevail across the south; therefore, a large number of our members have not had any opportunity to learn what they are about, to understand their mode of operation, or to really clearly have exposed to them the goals of these for-profit institutions. If I am correct in this thought, it will be very difficult for the COTH to come to any real conclusion regarding this matter until there is further exposure, which might argue for my suggestion that we do nothing at the present time.

Sincerely yours,

  
John E. Ives  
Executive Vice President

JEI:nh

cc: ✓ Richard M. Knapp, Ph.D.  
Mr. Robert Baker

association of american  
medical colleges

September 24, 1984

Ms. Willa J. Stone  
Administrator  
Women's Hospital  
2025 East Sahara Avenue  
Las Vegas, Nevada 89116

Dear Ms. Stone:

On July 11, 1984 I notified you that the COTH Administrative Board and AAMC Executive Council had endorsed Women's Hospital's application for corresponding membership in the Council of Teaching Hospitals (Attachment A). The final step in COTH membership is approval for membership by the AAMC Assembly at its Annual Meeting. Recently, I have learned that Women's Hospital is a for-profit corporation. As stated in the membership application materials sent to you and on the face of the application completed by Women's Hospital (Attachment B), COTH is limited to 501(c)(3) and publicly (i.e., governmentally) owned hospitals. As a for-profit hospital, Women's Hospital is not eligible for membership in COTH, and the application will not be presented to the AAMC Assembly.

I apologize for any misunderstanding this matter may have caused. Because no dues invoice was mailed, no dues have been paid and, thus, there is no need for a refund.

The issue of investor owned hospital participation in the Council of Teaching Hospitals was discussed and debated at the COTH Spring Meeting last May, and will be discussed once again at the institutional membership meeting in Chicago. I've enclosed a copy of the spring meeting program and the Chicago agenda for your review. This issue has also been raised in the attached publication, "New Challenges ..." on page 9.

If there are ways in which we can be helpful to you, I hope you will call upon us. However, I do request that Women's Hospital not identify itself as a member of either the Association of American Medical Colleges or its Council of Teaching hospitals.

Thank you.

Sincerely,

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

RMK/mrl  
Attachments

cc: Robert M. Daugherty, Jr., M.D., Ph.D.  
Dean, University of Nevada  
School of Medicine

WILLIAMS, MYERS AND QUIGGLE  
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SUSAN L. FLAHERTY

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EDMUND B. C.  
1192-1193  
PAUL FOREST  
1192-1193

September 7, 1983

Joseph A. Keyes, Esquire  
Staff Counsel  
Association of American  
Medical Colleges  
One Dupont Circle, N. W.  
Washington, D. C. 20036

Dear Mr. Keyes:

Under AAMC's Articles of Incorporation and Bylaws voting membership in the Association of American Medical Colleges is limited to educational and scientific organizations described in IRC Section 501(c)(3) which are public charities described in Section 509(a)(1) or (2) of the Internal Revenue Code. They include medical schools, certain hospitals involved in medical education and certain academic societies active in the field of medicine and biomedical sciences.

You have asked us to review the possibility of AAMC's extending membership eligibility to certain proprietary institutions which do not meet these tests.

This question has been raised with us by organizations similar to AAMC and has been an issue during the processing of applications for exemption of such similar organizations.

In our opinion, such a step should not be taken without obtaining from the Internal Revenue Service an advance ruling that expansion of your membership in such a fashion will not affect AAMC's exemption from Federal income tax as a 501(c)(3) educational and charitable institution.

The basic Service position is set forth in Revenue Ruling 69-633, 1969-2 C.B. 121. Revenue Ruling 69-633 dealt with the question of whether contributions by the member hospitals or other organizations to a taxable cooperative hospital service organization providing laundry services to its member institutions would affect the tax exempt status of "contributing" organizations. The holding was that it would not,

provided all of the member organizations were exempt under Section 501(c)(3) as charitable, educational or scientific. However, if the laundry included members not exempt from tax and the member exempt 501(c)(3) hospitals made contributions to the laundry in excess of their proportionate share based upon benefits derived, exemptions of the 501(c)(3) members might be adversely affected. "Similarly, a contribution by any other exempt organization might also inure to the benefit of the proprietary hospital and adversely affect the contributing organization's exempt status."

If the Internal Revenue Service should determine that the services provided to the proprietary members were not merely incidental to the exempt purposes of the contributing organization, the exemption of the contributing organizations could be subject to challenge as violating the private inurement provisions of Section 501(c)(3).

The Internal Revenue Service has taken such a position with respect to associations of colleges and universities similar to AAMC. Over a number of years, we have converted a number of associations of colleges and universities into 501(c)(3) entities. In each case the Internal Revenue Service required that all of the active voting members be entities exempt under Section 501(c)(3).

The import of the one ruling in which the Service has acted favorably in this regard is not clear. Revenue Ruling 74-146, 1974-1 C.B. 129, dealt with an exempt organization which accredits colleges and universities which included some nonexempt members (proprietary schools). The Internal Revenue Service found that the accrediting program was "designed to foster excellence in education, and develop criteria and guidelines for assessing educational effectiveness \* \* \* It assures the educational community, the general public, and other agencies or organizations that an accredited educational institution has clearly defined and appropriate educational objectives, has established conditions under which their achievement can reasonably be expected, appears in fact to be accomplishing them substantially, and is so organized, staffed, and supported that it can be expected to continue to do so." Two factors were noted. The first was that proprietary schools represented a small minority of the members of the organization (accreditation resulted in membership in such cases). Secondly, it held that any private benefit that may accrue to the few proprietary members because of their accreditation was incidental to the exempt purpose of improving the quality of education.

The Service would probably apply similar criteria in this case. However, depending upon the facts, the Service might hold that the benefits accruing to proprietary members of AAMC are not merely incidental and, therefore, the exemption under 501(c)(3) might be in jeopardy. Even if the "incidental benefits" test were met, the Internal Revenue Service might hold that inclusion of any significant number of such entities

would endanger AAMC's 501(c)(3) status. It is possible that the Service might take a different position if only the educational components of the proprietary institutions were admitted to membership.

If AAMC were to lose its exempt status under Section 501(c)(3), it should qualify for exemption from taxation under Section 501(c)(4) (social welfare) and/or Section 501(c)(6) (trade association). However, there are a number of important benefits which are available to Section 501(c)(3) organizations which are not available to Section 501(c)(4) or (c)(6) organizations. Among these are the following:

1. Contributions and bequests by individuals and corporations to 501(c)(3) entities are deductible by the donors for Federal income tax purposes.
2. 501(c)(3) entities need not have qualified pension plans under Section 401 but may make payments towards annuities of their employees which are basically limited only to 20-percent of includible compensation with provisions for past benefits. (Section 403(b).) As in qualified plans, the payments are not taxable to the employees until they receive pension distributions after retirement. Moreover, under Section 403(b) (as interpreted by the Internal Revenue Service regulations), employees may elect to take a reduction in taxable wages and have the amount applied by the 501(c)(3) employer to the purchase of an additional Section 403(b) annuity without being taxed on the amount (i.e., salary/annuity option-"tax sheltered annuities"). This, of course, is the TIAA-CREF program.
3. The restrictions imposed upon private foundations by the Tax Reform Act of 1969 with respect to grants made by it are such that few, if any, private foundations will make substantial grants to any entities other than 501(c)(3) exempt organizations.
4. As a 501(c)(4) or (c)(6) organization, AAMC might not be eligible for certain Federal and state grants.
5. Section 501(c)(3) status usually entitles an organization to state and local tax exemption as an educational or charitable entity.
6. AAMC would not be eligible for exemption from Federal excise taxes. For example, exemption from the communications tax is granted to nonprofit operating educational institutions described in Section 170(b)(1)(A)(ii) as well as nonprofit hospitals described in Section 170(b)(1)(A)(iii). (See Sections 4253(j) and 4253(h).) The Internal Revenue Service has extended this exemption to an association made up entirely of nonprofit operating educational institutions described in Section 170(b)(1)(A)(vi) even though the association was not itself a nonprofit operating educational organization because "the function of [the organization] is to carry out activities of [its] member institutions, each of which is a nonprofit educational organization." As a

September 7, 1983

result, "the facilities or services furnished to the association are deemed to be for the exclusive use of their member institutions." (Revenue Ruling 63-15, 1963-1 C.B. 187.) In a recent private letter ruling, the Service has held that the similar exemption from Federal excise tax imposed on gasoline under IRC Sections 4041(g)(4) and 4221(a)(5) does not apply to an association of operating educational organizations if the association has one or more proprietary members. (Private Letter Ruling 8132103 issued May 15, 1981.)

I would note that, if AAMC was forced to give up its exemption under 501(c)(3) and became exempt under 501(c)(4) or 501(c)(6), it could form an exempt subsidiary to perform its exclusively educational and charitable functions which could be qualified as a "public" charity under Section 509(a)(3). However, such a change might significantly affect your operations.

In our opinion, the Internal Revenue Service, based upon the rulings and actions cited above, has a very negative attitude towards the inclusion of proprietary members in an exempt 501(c)(3) organization such as AAMC unless the benefits accruing to such members are not material and further the exempt purposes of the organization. Revenue Ruling 74-146, cited above, does indicate that under certain unusual circumstances the Service will recognize the possibility of such an organization including for-profit entities in membership. However, the ruling is very narrow in its scope and cannot be relied upon. In our opinion, if AAMC does wish to consider including in its membership proprietary institutions (other than as affiliated nonvoting "contributors" receiving no material benefits), a ruling from the Internal Revenue Service should be sought in advance of any such change.

We hope this is responsive to your inquiry. If you have any other questions, please call them to our attention.

With best regards,

Very truly yours,

WILLIAMS, MYERS AND QUIGGLE

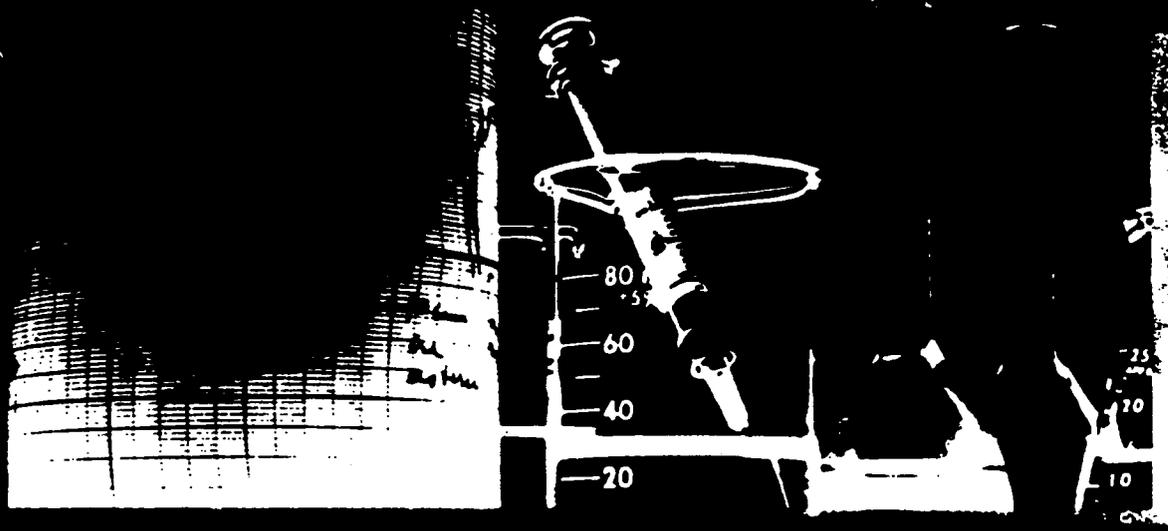
By: *Mark Dinger*

By: *J. L. G. [unclear]*

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**The Ad Hoc Group for Medical Research Funding**

**Health Research USA 20c**



Copyright 1984 United States Postal Service

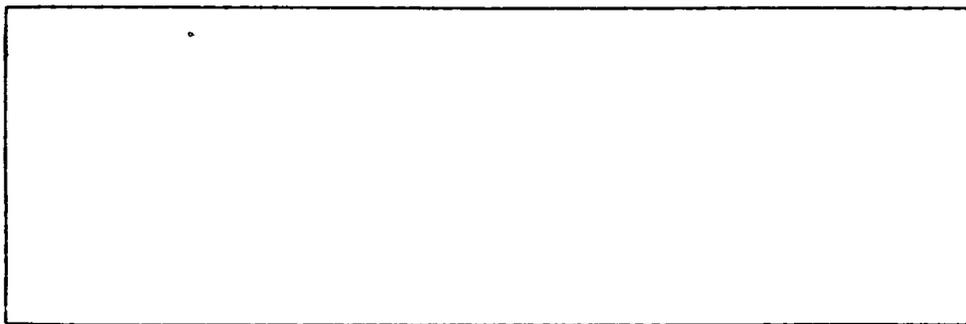
# **A Proposal for Fiscal Year 1986**

"Until this century, young and old alike have lived in fear of diseases such as polio, small pox, and yellow fever. Today, thanks to the work of dedicated health research professionals, these diseases are no longer incurable, and people around the world now lead more productive, happier, and healthier lives."

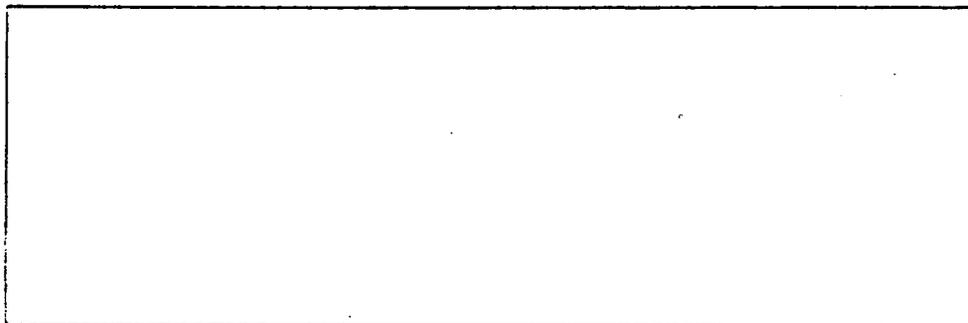
Dr. John F. Nermann  
National Medical Director  
United States Postal Service

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**DIABETIC RETINOPATHY**



Diabetes can cause harmful changes in the blood vessels of the retina. In people who have had the disease for a long time, a network of fine abnormal vessels may appear, (A) then deteriorate and hemorrhage, causing blurriness of vision or even blindness.



A National Eye Institute (NEI) study showed that treatment of diabetic retinopathy with a laser (called photocoagulation) cuts in half the risk of severe vision loss from this disease, which is a leading cause for blindness among adult Americans. In photocoagulation, powerful beams of light produce hundreds or thousands of tiny burn spots (B), a relatively painless method for coagulating abnormal vessels and destroying diseased retinal tissue.

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COVER: Stamp commemorating the 100th anniversary of Memorial Sloan-Kettering Cancer Center, issued May 17, 1984 in New York by the United States Postal Service.

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The Ad Hoc Group for Medical Research Funding

United by their concern for the vitality of the biomedical and behavioral research enterprise, a large and diverse group of organizations recommends that appropriations for health science be increased reasonably in the coming fiscal year. This document is an analysis of the President's FY 1986 budget for the National Institutes of Health (NIH) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) and a rationale for this group's substitute proposal.

Congress has demonstrated, through support of the NIH and ADAMHA, an acute understanding of the needs of research and the importance of a balanced research program. Today, because there is a direct causal relationship between the work done in the nation's research centers and better health care, and because the Congress has recognized the benefits of increased investment in research, there is a revolution in the biological and medical sciences that is leading to the prevention and cure of countless previously intractable conditions. The pace of progress has placed the United States at the forefront of biomedical and behavioral research.

In addition, the spinoffs of medical research are promising dramatic economic growth with concomitant benefit to the federal budget, the foreign trade balance, and the employment outlook. Biotechnology provides advances in human health, extraordinary possibilities for the industrial community, and the promise of reduced health care costs.

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## In Recent Years Medical Research Has:

- o Discovered a genetic marker for Huntington's disease, bringing us closer to the day when we will have a diagnostic test for this devastating illness.
- o Discovered that in cases of Alzheimer's disease the brain tissue has less than half of the normal amount of RNA, a finding that may provide further insight into the underlying mechanisms of this tragic illness, which affects about 2 million older Americans.
- o Developed methods to transplant insulin-producing islet cells into humans, making possible further advances in therapy of juvenile diabetes.
- o Extended the effectiveness of bone-marrow transplantation from a treatment for acute leukemias of children and adults to use in aplastic anemia, severe immuno-deficiency diseases of childhood, and genetic disorders.
- o Developed a mouse-human monoclonal antibody which halts an experimentally-induced form of multiple sclerosis in mice and will soon be tested in humans.
- o Identified a series of oncogenes which may be the key components in the onset of human cancer in response to a variety of stimuli. Understanding the role of oncogenes in the origins of cancer could lead to new approaches in cancer control.
- o Discovered that there is a genetic predisposition to alcoholism in up to 40 percent of afflicted individuals, allowing researchers to distinguish between alcohol tolerance based on genetics and that based on learning and environment.
- o Identified the agent that causes AIDS as HTLV-III, a newly discovered member of the family of human T-Cell leukemia-lymphoma viruses. NIH scientists are working on a number of approaches to develop a vaccine against AIDS.
- o Cloned the gene for the major antigen of the human malaria parasite. This technique will enable researchers to prepare quantities of the antigen for testing its potential use in a vaccine to protect against malaria, which is a serious health problem in most tropical countries.
- o Discovered that potassium citrate reduces the rate of kidney stone formation or stops stone production in certain classes of patients. Approximately 200,000 Americans who suffer from calcium-containing kidney stones may benefit from this treatment, now awaiting FDA approval.
- o Created artificial intelligence-based expert computer consulting systems for physicians. Such systems can provide the latest information on cancer therapy and aid in the diagnosis and management of neurologic disorders, genetic diseases, bleeding disorders, and rheumatologic diseases.
- o Developed acyclovir, a medication to reduce the pain and limit the duration of outbreaks of genital herpes in some victims, and developed a vaccine which in mice almost totally protects against lethal inoculation of Herpes simplex virus. This discovery offers hope of developing a vaccine for humans.

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- o Developed recombinant DNA technology, which permits large scale biosynthetic production of interferon, human insulin, growth hormones, new vaccines, natural pain-killing endorphins and other new products which have the potential to make a broad impact on our economy.
- o Discovered cyclosporine, a drug which can greatly reduce bodily rejection of transplanted organs. This drug also seems to reduce eye inflammation in patients with posterior uveitis, a disease that can lead to visual impairment.
- o Gained the capacity, through techniques such as positron emission tomography (PET) and magnetic resonance imaging (MRI), to observe biochemical activity in the conscious brain and define discrete areas of brain that may be defective in certain illnesses, and to investigate the functional and structural changes produced in the brain over time by drug abuse.
- o Cloned antihemophilic factor, the substance lacking in hemophiliacs that helps blood to clot.
- o Verified the existence of a genetic component of some psychoses, and determined that environmental events may trigger one's inherited risk or predisposition for a given disorder.

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## Economics of Medical Research at a Glance

### Some Costs of Diseases

- o Total health care costs in the US for 1985 are estimated at \$456.4 billion; federal investment in medical research is only 1.2% of this figure. Health care now consumes 10.8% of the GNP.
- o The annual expenditure on health care in the United States is \$2000 per person. The annual Federal investment in medical research to reduce this cost is only \$25 per person.
- o Neurological and communicative disorders annually cost our society \$114 billion.
- o Psychiatric disorders, other than those associated with substance abuse, cost society \$20.3 billion in 1980 alone.
- o In 1980 the nation spent over \$37.3 billion on medical and social costs of cancer treatment.
- o Over \$25 billion is spent each year in treatment for Alzheimer victims.
- o Eye diseases cost our society \$16 billion a year.

### Return on Federal Investment in Medical Research

- o Studies show that the rate of return on every \$1 invested in medical research is \$13. Between 1900 and 1975, benefits exceeded the federal investment by some \$300 billion (adjusted for inflation), a seven-fold return.
- o In 1982 alone, \$7.7 billion was saved because of a reduction in the death rate from coronary heart diseases, and \$5.2 billion was saved because of reduced death rate from strokes.
- o \$5 billion annually is saved because medical research developed a vaccine for polio. Over \$10 was returned for every \$1 invested in research, development, and application of the vaccination against measles -- a \$4.48 billion dollar return.
- o Estimates indicate that the introduction of lithium treatment for manic-depressive illness has saved \$6.5 billion, far exceeding the total federal investment in National Institutes of Mental Health (NIMH) research.
- o Over \$40 billion is contributed annually to the GNP from medical research discoveries that are now used in non-health related products. This is more than the total Federal investment in basic research over the past 50 years.
- o Over \$1 billion in private sector investment was made in the emerging biotechnology industry in 1983 as a result of discoveries in medical research.

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Why Federal Investment in Medical Research Must Be Increased

- o 855,000 Americans are diagnosed each year as having some form of cancer; about half will die of the disease.
- o 3.5 million Americans are disabled by stroke or other injuries to the central nervous system.
- o 2 million elderly Americans are afflicted by Alzheimer's disease.
- o 60 million people suffer from cardiovascular disease.
- o 16 million Americans suffer from osteoarthritis.
- o 11 million people are diagnosed as having diabetes.
- o 100 million Americans suffer from some form of digestive disorder each year.
- o 300 million people worldwide are afflicted with malaria; each year 1 million will die of the disease.
- o One of three babies born in 1985 will develop cancer during its lifetime.
- o 100,000 people will die this year as a result of allergic and infectious diseases.
- o 2.5 million new cases of gonorrhea and over 80,000 new cases of syphilis develop each year in the United States.
- o 62,000 people each year become blind. At any one time there are over a half a million blind people in America.
- o 24 million people in any given month are afflicted by psychiatric disorders, other than those connected with substance abuse.
- o 4,000 infants died in 1981 as a result of respiratory distress syndrome.
- o 7 million visits to physicians' offices due to blood diseases were made in 1979 alone.
- o 15 million Americans suffer from chronic lung disease.
- o 232 million Americans suffer from some type of oral dental disease.
- o About two million children have mental disorders so severe they require immediate care.
- o 7 million hearing impaired persons live in the United States.

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## Impact of President's Request on Health Research

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	FY 1985 Appropriations	President's FY 1986 Request	Percent Changes
<b>NIH</b>			
Total	\$5.149 billion	\$4.852 billion	-6%
<b>ADAMHA</b>			
Research, Research Training, & Direct Operations	\$392.5 million	\$388.9 million	-1%

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Health problems are pervasive and costly. The research programs of the Public Health Service provide tremendous opportunities for advances in medical science that can reduce these burdensome problems. Despite this, the President's FY 1986 budget requests a decrease of 6 percent below the FY 1985 appropriation level for the National Institutes of Health (NIH) and 1 percent for the research programs of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Adoption of the President's budget would:

- o allow merely 29 percent of approved projects at NIH and 33 percent at ADAMHA to be funded, resulting in the rejection of proposals rated by peers at high levels of excellence.
- o support very few of the approved pending clinical trials, which will impede the application of new therapies for patient care.
- o preclude renovation of badly deteriorating physical plants and animal labs across the nation, slowing the discovery of new knowledge.
- o reduce, by more than 753 Full Time Equivalent (FTE), the research, services, and support staffs at NIH and ADAMHA with serious adverse consequences, particularly for the intramural research programs.
- o reduce the number of research centers supported by NIH & ADAMHA from a level of 568 to 535 in FY 1986.
- o disband some of the multi-disciplinary research teams directed at specific disease disorders.
- o maintain the same level of research trainees -- 9,891 for NIH and 984 for ADAMHA -- despite the growing shortages of well-trained investigators.

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## Ad Hoc Group for Medical Research Funding A Proposal for the National Institutes of Health

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FY 1985 Appropriation	President's FY 1986 Request	FY 1986 Current Services Budget	Ad Hoc Group FY 1986 Recommendation
\$5.149 billion	\$4.852 billion	\$5.626 billion	\$5.701 billion

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This proposal brings the increase for the NIH into line with those requested by the President for science support in other agencies. (See Figure 1) It provides very modest program growth of about \$75 million or 1% over a current services budget.

In contrast to the President's request, our proposal provides:

- o funds sufficient to make awards to a minimum scientific priority score of 180 or at least 38% of approved research grant applications, although higher levels may be necessary in some Institutes. This request would fund approximately 6500 competing research grants, the same level supported by the Congress in its FY '85 appropriation. Even this request will not fund approximately 2400 high quality research grants (to 50 percent of approved applications) which represent important lost research opportunities. (+ 363 million over FY 1985)
- o modest growth in research centers -- specialized/comprehensive, general clinical, and biotechnology research. In addition, money is provided for the rehabilitation and renovation of animal laboratories. (+ \$58 million over FY 1985)
- o opportunities to continue high priority major clinical trials, and to allow some growth in the research career programs, clinical education and other research related programs. (+ \$35 million over FY 1985)
- o research training to raise the current number of trainees from 9,891 to 10,154, near the level recommended by the National Academy of Sciences (10,518). (+ \$14.1 million over FY 1985)

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- o an increase in research facility construction funds to help begin to address the great need to update, renovate and rehabilitate some of our outmoded and inefficient research facilities, and additional funds for shared instrumentation programs. (+ \$20 million over FY 1985)
- o provide for the expansion of the communication and education programs of the National Library of Medicine. (+ \$8 million over FY 1985)
- o Maintenance levels for the remainder of the research programs to meet the current services levels as set forth in the FY 1985 appropriation. Some of these basic programs include contracts, minority biomedical research support, intramural research, and elimination of the proposal to cut NIH personnel. (+ \$53 million over 1985)

Total: \$75 million over current services  
\$552 million over FY 1985  
\$849 million over the President's FY 1986 request

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## Ad Hoc Group for Medical Research Funding: A Proposal for the Alcohol, Drug Abuse, and Mental Health Administration Research, Research Training and Direct Operations Activities

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FY 1985 Appropriation	President's FY 1986 Request	FY 1986 Current Services Budget	Ad Hoc Group FY 1986 Recommendation
\$392.5 million	\$389.0 million	\$447.7 million	\$499.0 million

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The Ad Hoc Group proposal begins to address the urgent research needs and priorities of ADAMHA as set forth in the recent Institute of Medicine (IOM) report.

In contrast to the President's request, our proposal provides:

- o a level of continuation grants consistent with the enacted FY '85 appropriation with realistic average cost. (+ \$41 million over FY 1985)
- o funds sufficient to award at realistic average cost new and competing investigator-initiated project grants to a minimum scientific priority score of 180. This request would fund approximately 650 new and competing grants. Even this request would not fund approximately 125 grants (to 50 percent of approved applications) which represent excellent research opportunities. (+ 14 million over FY 1985)
- o restoration of proposed reductions in and enhancement of the intramural program, revitalization and acquisition of essential equipment and initial planning for renovation and construction of clinical and laboratory facilities. (+ \$18 million over FY 1985)
- o support for approximately 1300 research trainees, a necessary step to assure future availability of well-trained research manpower. Stipends would be increased to more generous levels. (+ \$7 million over FY 1985)

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- o enhancement of field-initiated research other than that supported through research grants -- i.e. Centers, Research Scientists, Cooperative Agreements, Contracts, and Small Grants. (+ \$18 million over FY 1985)
- o restoration of proposed cuts in direct operations activities with addition of new positions where workload is rapidly increasing. (+ \$8 million over FY 1985)

TOTAL: \$51.3 million over current services  
\$107 million over the fiscal 1985 appropriation  
\$110 million over the President's FY 1986 request

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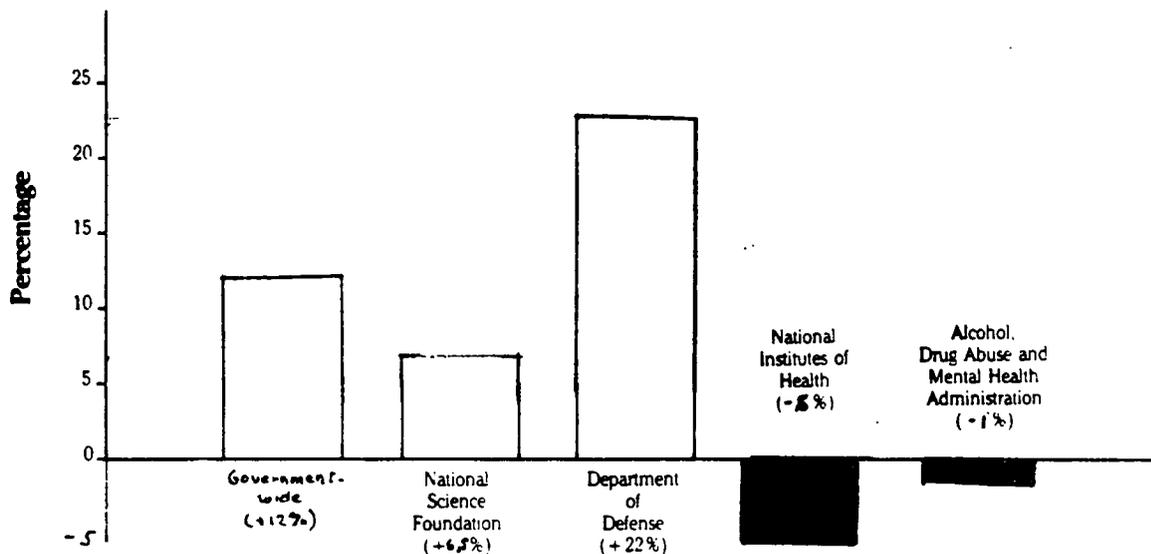
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Figure 1

## Federal Support for Research and Development Percentage Increases

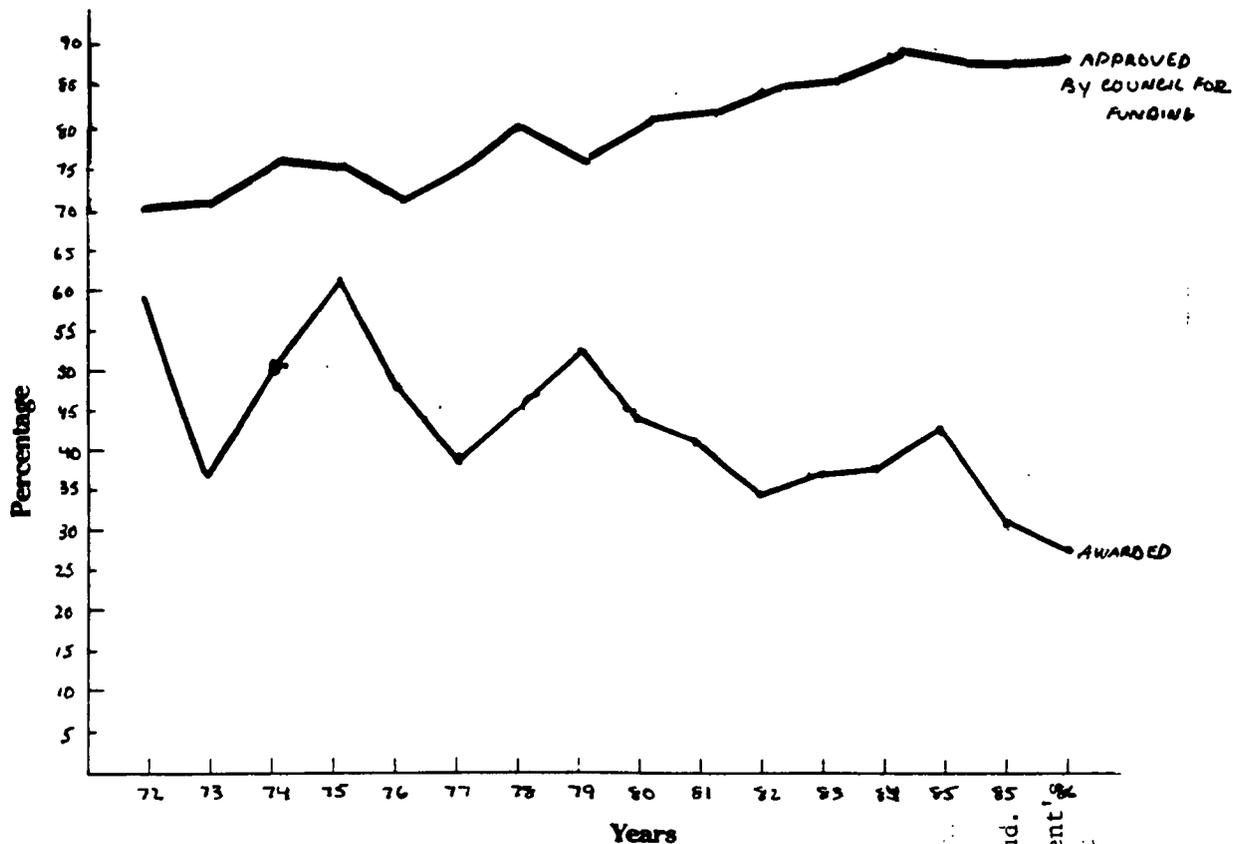
Fiscal Year 1986 vs. 1985  
Obligations



Source: Budget of the U.S. Government, FY 1986, Special Analysis K, ADMAHA data adjusted to exclude Community Programs in accordance with stated congressional preference.

## PERCENTAGE OF GRANT APPLICATIONS RECOMMENDED FOR APPROVAL BY COUNCIL AND PERCENT AWARDED, NIH, 1972-1986

Figure 2



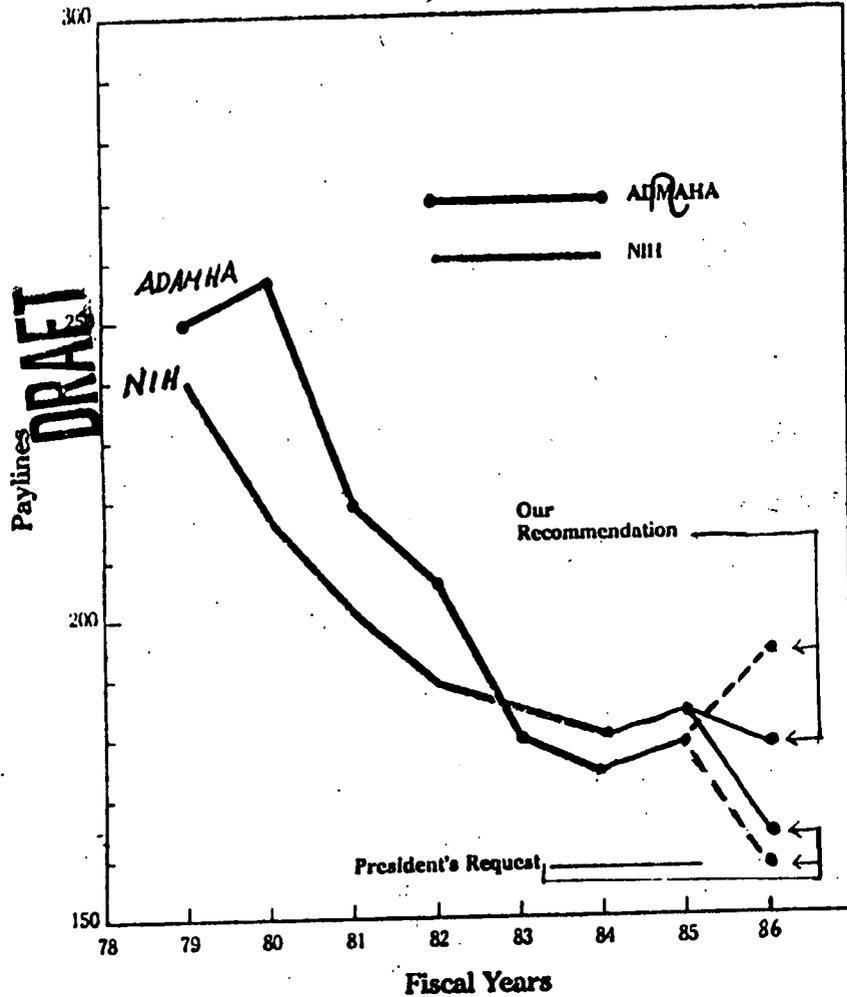
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Figure 3  
Paylines\* for Funding Approved New and Competing Research Projects

FYs 1979-1985  
1986

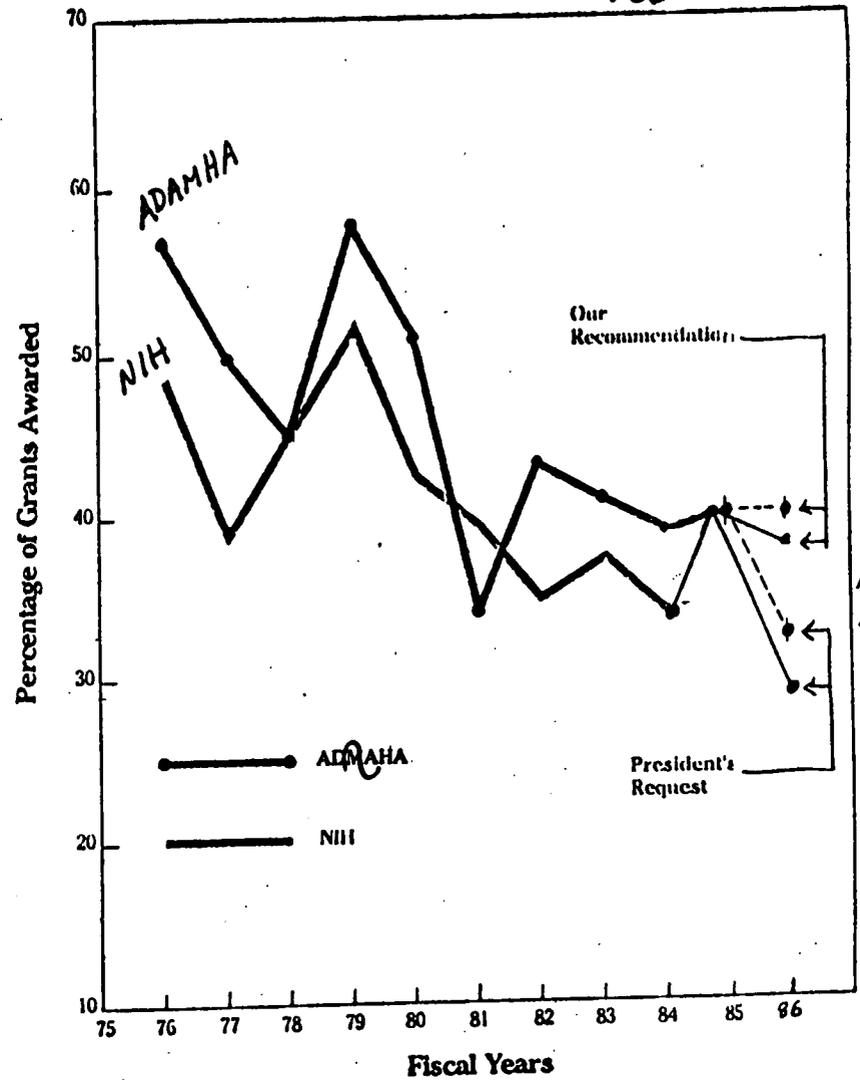


\*In the NIH and ADMAHA merit review systems, the best proposals receive the lowest scores, and funds are awarded based on these priority scores. The "Payline" is the cut-off score or ceiling at which funds available for the fiscal year are exhausted.

Figure 4

Award Rates\* for Funding New and Competing Research Projects

FYs 1976-1986



\*Award rates are the number of projects actually funded as a percentage of those approved and therefore eligible for funding.

*△ charts to reflect new #'s - Fred and Kevin*

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## Reasonable funding of medical research would enable pursuit of opportunities such as:

- o Further study of the body's main defense mechanism against disease, the immune system. Disorders of the immune system occur in allergic diseases, certain forms of arthritis, multiple sclerosis, chronic infections, blood disorders, and other diseases, and are believed to occur in over 30 million people at some time during their lives.
- o New advances in the neurosciences, especially in degenerative diseases such as Alzheimer's, stroke and chronic neurological disorders, and in our ability to understand nerve cell dysfunction, which is the root cause of all neurological and communicative disorders.
- o Heart, lung and vascular research in such areas as childhood asthma and occupational hazards, as well as programs to continue high blood pressure education and treatment.
- o Research to identify biologic clues in depression and mania, disorders which affect between 10 to 14 million people at any one time. Biological clues are potential keys to explaining causes of depression, distinguishing among depressive patients, and selecting treatments best suited to their needs.
- o Development of antibodies against the principal bacteria responsible for dental plaque and tooth decay. Although the incidence of tooth decay is declining, the average American child develops 11 cavities by age 17.
- o Continued long-term testing of hundreds of new drugs and chemicals introduced into our bodies and the environment annually.
- o Further study in endocrinology, where research in hormones, their secretions, and metabolism, will improve our ability to influence growth, reproduction, and brain function.
- o Development of a vaccine for malaria.
- o Development of a vaccine for AIDS.
- o Identification of the mode of genetic transmission in the schizophrenias and affective disorders.
- o Understanding why white blood cells sometimes do not go to the site of a wound to fight life-threatening infections. Understanding why the cells do not behave in an expected fashion may lead to methods to correct this malfunction.
- o Refinement and improvement of immunosuppressant drugs now being used with increased regularity in organ transplants to prevent rejection.
- o Understanding the role of allergic mechanisms in cardiac dysfunction, sudden death and myocardial infarction.
- o Understanding how the clotting enzyme, thrombin, interacts with platelets, which would provide important information on how the early events in clotting take place. This work has important implications for heart attacks, stroke and other abnormal clotting situations.

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- o Identification of the biological mechanisms involved in susceptibility to alcohol problems.
- o Development of drugs that might interfere with the release of cholesterol into the blood stream, thus reducing coronary atherosclerosis and the risk of heart attacks.
- o Understanding how embryonic development is controlled genetically, which will provide valuable information on birth defects and malformations and perhaps how to prevent them.
- o Research on external eye infections and inflammatory disease including herpes simplex, the leading cause of corneal blindness and visual impairment in the United States.
- o Refinement of the variety of brain-imaging techniques needed to study the relationship between brain pathology and psychiatric disorders.
- o Development of genetically engineered endorphins, natural morphinelike compounds that control pain, and interleukins, proteins that regulate the body's immune system.
- o Development of a unified medical language system to link practical patient care decision-making with relevant health-care knowledge in computer systems and data bases.
- o Determination of sites in the brain at which drugs produce particular effects.
- o Development and testing of pharmacological adjuncts for use in the treatment of cocaine abuse.

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**AMERICA'S WORLD LEADERSHIP IN MEDICAL RESEARCH  
AND BIOTECHNOLOGY IS NO LONGER ASSURED:**

- o West Germany and Japan continue to have the highest percentage of GNP devoted to national civilian R&D expenditure. For 1983, the GNP/R&D ratio for both West Germany and Japan was 2.6 percent; the United States' ratio is 1.8 percent.

National Science Foundation  
Science and Technology  
Data Book, 1985

- o During the period 1979-1981, an estimated 49 percent of U.S. patents granted in the field of drugs and medicine went to foreign inventors.

National Science Board,  
Science Indicators-1982

- o Japan and West Germany have increased investment in R&D more rapidly than their economic growth.

International Science and  
Technology Data Update,  
NSF, January 1984

- o From 1973-1982, the U.S. proportion of science and technology in clinical medicine and biology steadily declined; its share of science and technology in biomedicine has remained constant.

National Science Foundation  
International Science and  
Technology Update,  
January 1985

- o The Japanese government has targeted biotechnology as a key technology of the future.

Congress of the United  
States, Office of Technology  
Assessment, January 1984

- o In 1983, the total number of scientists and engineers engaged in R&D in the U.S. was 750,000. This is estimated to be less than half the total number of scientists and engineers engaged in R&D in the Soviet Union.

International Science  
and Technology Update,  
NSF, January 1985

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- o "The current pattern of U.S. Government funding for basic and generic applied research in biotechnology in the United States may compromise the U.S. competitive position in the commercialization of biotechnology."

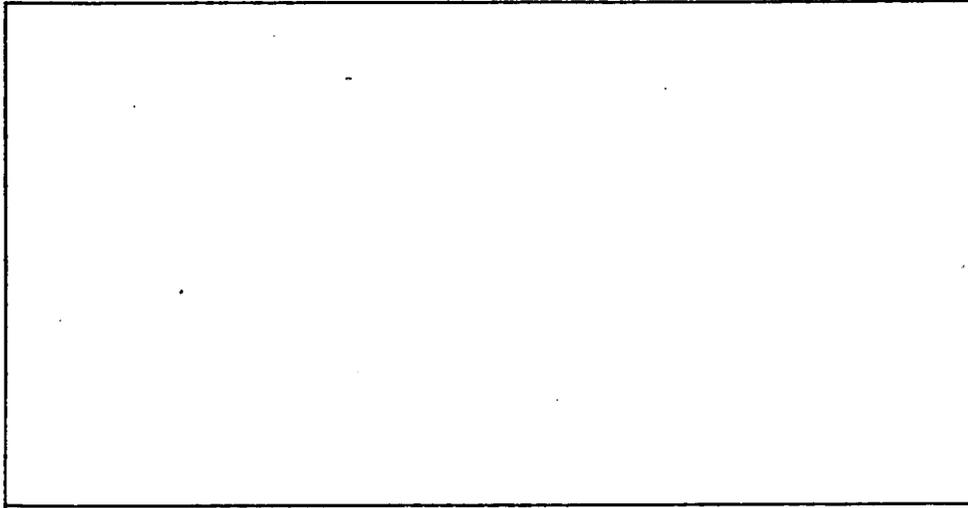
Office of Technology  
Assessment, Report on  
Commercial Biotechnology, 1983

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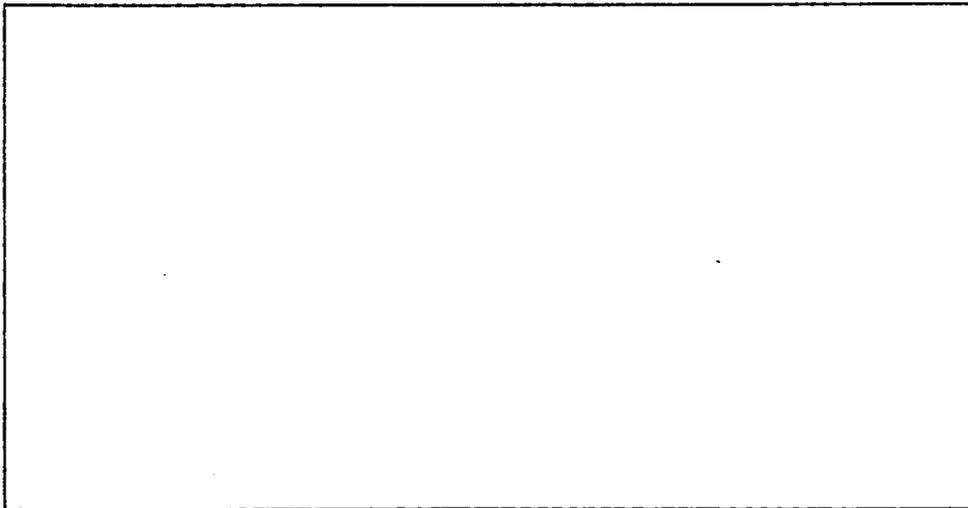
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MAGNETIC RESONANCE IMAGING



This is a transverse section of a chest of a healthy patient.



This is a transverse section of a chest of a patient who suffers from hypertrophic cardiomyopathy. An abnormal heart appears in the center. The left ventricular myocardium (in pink) is greatly thickened and increased in weight (mass). The blood-filled cavities are shown in bright red.

**DRAFT**

## THE AAMC CLINICAL EVALUATION PROGRAM

Division of Educational Measurement and Research

Xenia Tonesk, Ph.D.

The AAMC Clinical Evaluation Program is designed to assist clinical faculties in evaluating students during their undergraduate and graduate clinical education. The completion of Phase I of the program, during which participants identified general problems in the evaluation of clerks, was marked by the distribution of 7,000 copies of the booklet, "The Evaluation of Clerks: Perceptions of Clinical Faculty" (AAMC, 1983) and of the accompanying editorial, "Clinical Judgement of Faculties in Evaluating Clerks" (Journal of Medical Education, March 1983).

In Phase II of the program (in the Spring of 1983), the project on the self-assessment of clinical evaluation systems was initiated. The purpose of the project is to make available to interested medical schools a set of self-assessment materials which enables the schools to do the following:

1. Identify and describe components of their current evaluation system;
2. Assess the strengths and weaknesses of their current system in terms of whether it aids or hinders clinical faculty in the evaluation of all categories of students (i.e., superior, above average, adequate, presumed adequate, marginal, and failing);
3. Determine (or confirm) the degree to which clinical faculty accept the current system and level of their satisfaction with its effectiveness;
4. Make decisions concerning needed changes (e.g., minor modifications, major revisions, or new systems); and
5. Develop a strategy for implementing the desired improvements or changes.

Currently, clinical faculty and deans' office personnel in nine medical schools are pilot-testing the self-assessment materials using either a workshop model, discussion group model, or survey model. The nine schools include: University of California, Los Angeles; University of California, San Francisco; Jefferson;

LSU, New Orleans; McMaster; Oklahoma; Pennsylvania; Washington (Seattle); and Uniformed Services. Topics covered by the self-assessment materials include:

1. Obstacles to student evaluation;
2. Problem students with whom clinical faculty have particular difficulty;
3. Areas of knowledge, skills, and attitudes of clerks included in the evaluation;  
and
4. Evaluation policies and practices.

Preliminary findings from five of the schools indicate the following obstacles to student evaluation as commonly encountered by clinical faculty:

- o Lack of sufficient information about the clerks' strengths and weaknesses before they enter particular clerkships;
- o Insufficient opportunity to observe the clerks directly;
- o Lack of training of evaluators and inadequate guidelines for handling problem students;
- o Delays in feedback to students; and
- o Unwillingness to record, or to act upon, negative assessments.

As preliminary results show, certain categories of students offer a particular challenge to the clinical faculty: the bright student with poor interpersonal skills; the excessively shy, nonassertive clerk; and the unmotivated clerk. Less universally encountered but generally recognized as common problems are clerks who are hostile, untrustworthy, intellectually limited, manipulative, or clerks with psychiatric or substance abuse involvement.

Data collection is expected to be completed by all nine schools by early Summer 1985. Materials for use by all medical schools for the self-assessment of clinical evaluation systems are expected by the 1985 AAMC Annual Meeting.

The program is aided by an advisory group chaired by Dr. Daniel Federman of Harvard.

## SPECIAL SUPPLEMENT

### CLINICAL RESEARCH AND PROSPECTIVE PAYMENT

by Karen Pfordresher  
Staff Associate

The Medicare Prospective Payment System was initiated as part of the Social Security Amendments of 1983. This new reimbursement system rewards cost effective behavior by using pre-determined, per-case payments to hospitals for inpatient services. This system will not be fully implemented until 1986, thus allowing the Health Care Financing Administration (HCFA) to conduct studies of alternative methods of support for certain existing, essential costs of medical care. These studies will include reviews of how Medicare pays for capital costs, possible prospective payments for currently exempt specialty hospitals, an assessment of the feasibility of DRG-type (diagnosis-related group) payments for physician inpatient services, and the analysis of many other issues that together form the intricate framework of the current national medical care system.

Therefore, the many historical relationships fundamental to this framework are now under scrutiny and may be vulnerable to cost cutting measures. An issue which has not yet received the attention it deserves concerns the impact of the new payment incentives on clinical research. Reinforcing the belief that clinical research may be vulnerable to federal cost cutting is the debated assumption that patient participation in research is more costly than the standard care that the patient would have received. Upon initial consideration, this may appear to be a relatively straightforward issue. However, a more thoughtful review suggests analysis of the issue is fraught with difficulties.

#### Analysis Complexities

An analysis of the costs of clinical research should include a determination of the extent of its independence from and integration with the provision of routine care. No systematic body of knowledge has shown that services provided according to a research protocol cost more than care for the same diagnosis in the absence of a research protocol. Many elements confound the ability to conduct an acceptable study.

- Primarily, the issue's complexity relates to the difficulty of isolating procedures and therapies ordered and performed under research protocols from those that could occur under a routine or standard regimen, and identifying their specific costs. Also, standard treatment regimens vary from physician to physician and institution to institution. Since the standard regimen acts as the independent variable, care must be taken to be sure comparability is established.
- Identifying clinical trial patients and a matched control group for comparative purposes presents other dilemmas. In many diseases for which research is conducted there exists no generally accepted treatment. For some

problems, no recognized therapy has been found to be generally acceptable, nor has any procedure been found to be effective. Thus, a variety of palliative treatments which vary widely in terms of cost may be the alternative to the research protocol.

- Clinical trials vary in complexity, from testing the dosage and administration of drugs to the use of new technologies, therapies or invasive procedures.
- Involvement in clinical trials may be related to consideration of the complexity or stage of illness. In other words, research participation may be focused on the sicker patients. This would establish a further degree of difficulty in isolating research-related costs, due to the lack of agreement as to how severity measures can be imposed as evaluative criteria.
- There exists the question of how practice pattern variation may affect the cost of patient care. Individual physician reaction to patient pain, proclivity to either surgical or medical intervention, and other variables make it difficult to compare patients involved in research to those excluded. Once again, there exists no standard regimen of care. The treatment decision is often based on individual physician behavior, local protocol, and the availability of clinical research services. Therefore, any acceptable study must include participation from more than a few hospitals and physicians in different parts of the country.
- Care must be given as well to agreement on the time frame acceptable for comparison of research and non-research related costs of care. Clinical trial participation may be of short duration, extend over several years, require inpatient or outpatient follow-up, or extended or shortened nursing time due to drug administration.
- Finally, the outcome of the treatment provided should be included in the analysis. While treatment under the standard regimen may have been less costly, it also may have been less effective. Although admittedly difficult to measure, the quality of the outcome must be assessed as well.

Any analysis of the question, "Does it cost more to provide medical care under a research protocol?" must be multi-dimensional. With adequate separation of the attributes of accepted, routine regimens of care versus research protocol management, it may be possible to analyze the real cost of participation in clinical research, and determine whether or not it is indeed more expensive. However, much work remains to be done.

#### Current Medicare Policy

Prior to prospective payment, the *Medicare Provider Reimbursement Manual* stated in its introduction that "the basic rule applicable to a provider's research costs is such that expenditures, over and above those related to usual patient care, are excluded from allowable costs." Part I of the manual continues the definition of research versus routine, covered costs as follows:

"Research in the context of this principle means a sys-

tematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing, and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or preserving health." (Section 502.1)

"Where research is conducted in conjunction with or as a part of the care of patients, the costs of the usual patient care are reimbursable to providers to the extent that such costs are not met by research funds.

Usual patient care costs incurred in conjunction with the research must be specifically identified in those situations where a portion of the research funds is applicable to usual patient care costs. In these instances, providers must maintain statistics on research patients for each research project to identify the patients and the patient days and ancillary charges applicable to the usual patient care furnished by providers." (Section 504.2)

"In the context of this principle, extraordinary patient care is the care rendered [t]o research patients which is not medically reasonable, necessary, or ordinarily furnished to patients by providers. Such care is represented by additional patient care days and additional ancillary charges identified as non-Medicare in the patient care cost centers." (Section 502.3)

"Usual patient care is the care which is medically reasonable, necessary, and ordinarily furnished (absent any research programs) in the treatment of patients by providers under the supervision of physicians as indicated by the medical condition of the patients. Also, this definition intends that the appropriate level of care criteria must be met for the costs of this care to be reimbursable. Such care is represented by items and services (routine and ancillary) which may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing, and other related professional health services." (Section 502.2)

"Costs of research are not reimbursable to providers. Where, however, research is conducted in conjunction with or as part of the care of patients, the costs of usual patient care are reimbursable to the extent such costs are not met by research funds. The costs of extraordinary patient care based on research objectives are not reimbursable." (Section 504.2)

The implementation of prospective payments in 1984 dramatically altered Medicare's point of view regarding research-related, inpatient care. Under prospective payment, a hospital's production costs are irrelevant to the Medicare per-case reimbursement—an amount pre-determined, except for circumstances for which "outlier" payments apply. This payment system functionally addresses itself to the validity of the admission, rather than to justification of extraordinary care. In the January 3 final regulation, HCFA stated that:

"Specifically, Medicare's objective is to see whether, in cases where clearly noncovered services have been furnished to a beneficiary, there are nevertheless sufficient

covered services remaining so that payment of the DRG is appropriate."

Therefore, for hospitals to receive prospective payments for their patients involved in research protocols, they must show on their medical records, abstract, and Medicare bill that the patient would normally have been admitted for diagnosis or treatment even if the research protocol was not being used.

#### **Interest Shown in the Possible Impact of the Prospective Payment System on Clinical Research**

Many individuals have questioned the impact of prospective payments on research. Their questions and the different analyses currently underway are briefly described below. It is vitally important that any such analysis be done carefully and in a controlled, specific manner. Incorrect, invalid information will only further cloud a very important issue.

- Senator Robert Dole (R-KS), then Senate Finance Committee chairman, raised the question of whether HCFA had "deliberately ignored" the intent of Congress to allow wider extension of exceptions for community cancer centers than appears in the promulgated regulations (published September 1, 1983) implementing the prospective payment system. This issue was raised in a March 9, 1984 letter to the Department of Health and Human Services' Secretary Heckler from Senator Dole.
- The Association of Community Cancer Centers (ACCC) has initiated a campaign for the acceptance of DRG 471, currently not in the payment scheme, to cover research costs. To support this request, John Yarboro, chief of Hematology-Oncology at the University of Missouri Medical School and the new ACCC president, announced the initiation of a study to highlight the "difference in cost between those patients on clinical trials and those being managed conventionally." Although their methodology was called into question by the National Cancer Institute, the ACCC reported to the National Cancer Advisory Board Subcommittee on September 23, that preliminary data from four hospitals showed that costs per admission for research protocol patients exceeded those for non-protocol patients.
- The House of Representatives' Committee on Appropriations, during deliberation of the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, expressed concern regarding reports that "the new prospective payment system mandated by the Social Security Amendments may have an unintended and harmful effect on clinical trials." The Committee report states that "hospitals may now be unwilling to participate in clinical trials because of the extra expenses for patient care which are mandated by a research protocol."
- In response to this concern, the National Center for

Health Services Research (NCHSR) is now working with the National Cancer Institute to determine whether care rendered to patients involved in clinical trials is "more, less, or equally as expensive as nonclinical trial care." This study, coordinated by Dr. John Marshall, director of NCHSR, will measure hospital cost differences for patients participating and not participating in clinical research, controlled statistically and matched for patient diagnosis, stage of cancer, and age. Variables to be held constant include hospital teaching status, bed size, location, and other comparative factors. Cost data will be compared to the calculated prospective 1986 DRG payment (when the payment system is fully implemented) and therefore results of this study are not expected for two years.

- The National Institute of Mental Health (NIMH) is addressing the problem of establishing an adequate patient classification system for mental disorders, and is attempting to develop an alternative to DRGs, "based on such variables as age, marital status, and type of treatment as well as on diagnosis." Papers and studies on this and other issues relating to prospective payments for mental health services have been authored by Carl Taube, Ph.D., deputy director of the Division of Biometry and Epidemiology at NIMH, Paul Widem, A.C.S.W., assistant chief, mental health economics research branch of that division, and How-

ard H. Goldman, M.D., Ph.D., assistant director for Mental Health Financing at NIMH.

- The NCI Eastern Cooperative Oncology Group is conducting a pilot study to analyze the relative cost differences for comparable patients participating and not participating in clinical trials, and to determine relative cost differences within DRGs. Paul Carbone, M.D., chairman of the Eastern Cooperative Oncology Group stated that preliminary results show only 20 percent of the patients on study are over sixty-five, whereas the distribution was expected to be closer to 50 percent. In addition, when disaggregated to include only inpatient treatments, where DRG payments would apply, the possible impact of prospective payments would effect only three percent of the patients on study. Further analysis is being done to determine if a particular disease-specific subset of patients is more likely to be effected by the new payment system.

#### Too Soon for Conclusions

Until data from valid studies can be reviewed and interpreted, the question of whether or not the prospective payment system influences or adversely effects participation in clinical research remains unanswered. The AAMC would like to know more about this important issue; if you have concerns, suggestions, or data that would encourage a more thorough understanding, please call Karen Pfordresher of the Department of Teaching Hospitals at (202) 828-0496.



**association of american  
medical colleges**

The LCME's Use of NBME Examination Results

DRAFT

January 8, 1985

Staff Background Paper

Prepared by:

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Department of Institutional Development

## The LCME's Use of NBME Examination Results

### Introduction

The Liaison Committee on Medical Education (LCME) and its site visitors have, not infrequently, sought to review the performance of a school's students on the National Board of Medical Examiners (NBME) examinations and have, on occasion, used NBME scores or failure rates to support judgments of institutional effectiveness. This practice has always had its critics, but it is especially under fire at the present time at the confluence of two events: the publication of the Report of the Panel on the General Professional Education of the Physician (GPEP) and College Preparation for Medicine (AAMC, 1984) and the redrafting of the LCME's standards for accreditation. The purposes of this paper are to review the characteristics of the NBME examinations which bear on this issue, to separate out a number of considerations which often become entangled in discussions of whether a particular use of these examinations is appropriate or inappropriate, and to suggest circumstances under which the LCME might responsibly and usefully attend to examination results.

### Background

The original purpose of the NBME when founded in 1915 was to produce examinations of such high quality that they would become accepted by all the various state jurisdictions for use in physician licensing. The NBME achieved

that goal first with the development of comprehensive essay examinations and, during the 1950's, with the development of objective multiple choice examinations (Hubbard, 1978). Over time, the medical schools began to use the examinations for two other purposes: individual student evaluation and program (curriculum) evaluation. Currently, 47 percent of U.S. medical schools require students to achieve a passing total score on Part I for promotion and/or graduation, while 38 percent require a passing grade on Part II (Table 1). These figures have been stable over the past five years. Only 11-12 percent of medical schools use scores from Parts I and II in the determination of final course grades. This is a significant reduction from the number three years previously with respect to Part I but reflects stability with respect to Part II. Results of the NBME examinations are currently used by half of the medical schools in the U.S. for educational program evaluation, with no substantive change in this frequency of use over the past five years.

Critics argue that these uses by the schools of the NBME examinations have a deleterious effect on undergraduate medical education in two ways. First, a focus on the competencies assessed by the NBME examinations, notably the ability to recall information, may devalue other competencies of equal or greater importance. Second, the adoption of the NBME examinations, as a national standard for achievement in the various disciplines, may induce faculties to abandon their responsibility to exercise independent judgment in the design of the curriculum and the identification of important learning objectives.

The first concern must be viewed in the context of the range of competencies that comprise the goal of undergraduate medical education. In the planning and development of a new Comprehensive Qualifying Evaluation (CQE) Program, the NBME itself identified five abilities important in student evaluation; knowledge and understanding, problem-solving and judgment, technical skills, interpersonal skills, and work habits and attitudes. By applying these five abilities to ten

Table 1  
 USE OF NBME EXAMINATIONS BY  
 U.S. MEDICAL SCHOOLS - 1980-81 to 1984-85

	1980-81*		1981-82		1982-83		1983-84+		1984-85	
	No. (N=125)	Percent	No. (N=126)	Percent	No. (N=126)	Percent	No. (N=127)	Percent	No. (N=127)	Percent
<b>STUDENT EVALUATION</b>										
Use of the NBME exam, Part I										
Exam optional . . . . .	31	24.8	32	25.4	31	24.6	29	22.8	29	22.8
Student must record score . . . . .	35	28.0	33	26.2	34	27.0	35	27.6	35	27.6
Student must record total passing score . .	58	46.4	59	46.8	57	45.2	59	46.5	59	46.5
Student must record passing score in each section . . . . .			3	2.4	4	3.2	3	2.4	3	2.4
Scores used to determine final course grades	31	24.8	29	23.0	11	8.7	18	14.2	14	11.0
Use of selected sections of NBME exam, Part I, by departments to evaluate students										
Anatomy . . . . .	12	9.6	10	7.9	8	6.3	8	6.3	4	3.2
Behavioral sciences . . . . .	7	5.6	5	4.0	5	4.0	2	1.6	2	1.6
Biochemistry . . . . .	14	11.2	12	9.5	10	7.9	9	7.1	9	7.1
Microbiology . . . . .	23	18.4	20	15.9	15	11.9	12	9.5	9	7.1
Pathology . . . . .	21	16.8	17	13.5	12	9.5	11	8.7	10	7.9
Pharmacology . . . . .	19	15.2	16	12.7	10	7.9	9	7.1	6	4.7
Physiology . . . . .	18	14.4	15	11.9	11	8.7	8	6.3	4	3.2
Use of NBME exam, Part II										
Exam optional . . . . .	36	28.8	39	31.0	38	30.2	36	28.4	35	27.6
Student must record score . . . . .	37	30.4	36	28.6	42	33.3	41	32.3	41	32.3
Student must record passing score to graduate . . . . .	47	37.6	46	36.5	44	34.9	48	37.8	48	37.8
Scores used to determine final course grades	16	12.8	17	13.5	14	11.1	16	12.6	15	11.8
<b>CURRICULUM EVALUATION</b>										
Based in part on										
Results of the NBME exams . . . . .	65	52.0	67	53.2	61	48.4	62	48.8	63	49.6

\* This compilation includes 1978-79 data for Louisiana State-Shreveport and 1979-80 data for California-Los Angeles (UCLA)  
 † This compilation includes 1982-83 data for Georgetown.

FIGURE 1

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	CQE	CQE			
2. Performing a Physical Examination	CQE	CQE			
3. Using Diagnostic Aids	CQE	CQE			
4. Defining Problems	CQE	CQE			
5. Managing Therapy	CQE	CQE			
6. Keeping Records					
7. Employing Special Sources of Information					
8. Monitoring & Maintaining Health	CQE	CQE			
9. Assuming Community & Professional Responsibilities					
10. Maintaining Professional Competence					

\*Cells filled by "CQE" represent those areas currently assessed by NBME test questions.

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identified tasks, the NBME produced a 50-cell grid that comprises the areas of competence expected of M.D. graduates entering graduate medical education (Figure 1). Implicit adoption of this analytical framework by the AAMC is indicated by its appearance in an AAMC position statement on external examinations (AAMC, 1981). Only 12 of these 50 cells define areas amenable to assessment by current NBME test questions. The argument is made that focus by the school on NBME results tends to overemphasize the areas of competence that NBME examinations cover, at the expense of the other competencies. The evaluation method has also a concomitant effect on the teaching methods used. Information recall methods of evaluation tend to promote information transfer methods of teaching. These problems stem, in part, from the lack of objective measures available to assess the other areas of competence. NBME scores tend to fill a vacuum created by the absence of other types of assessments.<sup>1</sup>

Even within the sphere of competencies that the NBME examinations purport to address, a second concern has been expressed about its influence on the content of what is taught in the medical school curriculum. Decisions about the content of the curriculum have always been regarded, within very broad limits, the prerogative of the medical school faculty. Critics have charged that in seeking the approbation that high Board scores have come to represent, faculties have, in effect, delegated that authority to the NBME. "Teaching to the Boards" may have become more commonplace, resulting in a greater emphasis on the transfer of information useful for test performance at the expense of the learning of core concepts together with the development of problem-solving and self-directed

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<sup>1</sup>Comments made at an invitational conference sponsored by the Josiah Macy Foundation and Southern Illinois University School of Medicine (Barrows and Peters, 1984) suggest that the capability exists to develop and implement standardized methods to evaluate competencies not currently assessed by the NBME examinations. Arguably, many of the problems discussed in this paper will not be satisfactorily resolved until such methods are demonstrably effective and widely available.

learning skills. The dynamics of test construction itself may, in fact, lead away from core concepts because of the inclusion of more esoteric questions designed to produce the desired spread of scores.<sup>2</sup> Medical school proponents of the examinations have countered that the detailed information provided by the NBME on student performance has been useful in identifying gaps in the medical school curriculum. Relatively poor performance by students on one or another segment of the exam may highlight subject matter not taught or inadequately taught.<sup>3</sup>

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<sup>2</sup>The current scoring system in place for National Board examinations, which permits the medical schools to use the results for individual student and program evaluation, relates to this issue. Subscores are provided in the separate disciplines covered and discriminations are made using a 200-800 scale at as many levels of achievement as are statistically reliable. Neither of these aspects of the formal scoring system are required for licensing decisions nor for individual feedback to students who fail and are required to repeat. The demand for providing discriminations across a range of ability would seem to produce a tension in question development that results in many questions tapping peripheral and esoteric points that critics have charged distinguish the NBME examinations. The tension, common to all testing programs, results from the interplay of three factors: ability of the group, test content specifications and number of discriminations to be made. With the last of these fixed and a testing population of very able students, the necessity to make discriminations among the most knowledgeable of these students may force a movement away from core concepts.

Adoption of a simple pass/fail scoring system has been suggested as a means of reducing this tension. For pass/fail decisions, a question of medium difficulty is more useful than as a question of high difficulty. Questions most useful for pass/fail decisions are those of low to medium difficulty which tend to be most closely related to basic core concepts.

<sup>3</sup>Not directly relevant to the discussion is another use of NBME scores that has drawn the ire of some medical educators: that by residency program directors in the selection of house officers. The perception that this use is on the rise stems from two factors: a "buyers" market created by the increasing numbers of graduates coupled with the declining number of quality residency positions--the "jaws" effect (even specialties which only recently have had a reversal of fortunes and now have an abundance of applicants are markedly selective on the dimension of NBME performance); and, the use of pass/fail grading systems by a number of schools which make it difficult for program directors to discriminate among applicants in an easy and objective way. Concern is expressed that this is contributing to the replication in medical students of a set of behaviors in pre-medical students described as the "pre-med syndrome"--highly competitive and inappropriate focus on the acquisition of superficial credentials at the expense of mastery of more fundamental understanding, knowledge, skills and attitudes.

These two concerns provide much of the basis of the GPEP panel's criticisms of NBME examination use. To the extent that the LCME relies on NBME scores, it might be regarded as colluding with, and reinforcing the very aspects of the current system which, according to GPEP, require reformation if quality of undergraduate medical education is to be significantly improved. Thus, in commentary on the draft revision of the LCME standards for accreditation, there has been a push to discourage attention to NBME scores.<sup>4</sup>

#### The LCME's Interest in Using NBME Scores

The primary function of the LCME is to assure that minimum standards of contemporary medical education are being achieved by the schools. A second, but important function, and in most instances the chief value of an LCME evaluation, is to detect and highlight deficiencies in a school's program or resources which warrant attention by the school and to provide some impetus to the school's efforts to improve.

School characteristics examined by the LCME include those related to structure, process, and outcome. Structural variables include the various resources the school brings to bear on the educational program, for example, number, type, and credentials of faculty, library resources, physical facilities, and availability of teaching beds. Process variables are those observations gleaned by site visitors on the functioning of the various interdependent groups, within the school, for example, deans, department chairmen, faculty, hospital administrators, and students, in the conduct of the educational program. Outcome variables are measures of institutional effectiveness from the perspective of the quality of their products, or outputs of their programs.

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<sup>4</sup>cf. Barrows and Peters (1984) for a fuller discussion of these concerns that took place at the 1984 Macy/Southern Illinois Invitational Conference.

The focus of the debate centers on the LCME's use of NBME scores as outcome measures. The relevant part of the current draft (No. 11) of LCME Standards (LCME, 1984) reads as follows:

A committee of the faculty should establish principles and methods for the evaluation of student achievement and make decisions regarding promotion and graduation. The measures utilized should determine whether or not students have attained national standards of performance, as well as the school's standards. Each provisionally accredited program must utilize methods for determining the quality of its program and the level of achievement of its students compared to national norms (p. 23).

Note that the LCME appropriately places primary responsibility on the faculty for determining the principles and methods of student evaluation. This prerogative of faculties, however, is not regarded as absolute. The LCME requires some assurance that the faculty's standards do not fall below those recognized by the community of accredited schools. The reference to national standards or norms establishes this principle.

While the principle may be sound, the application of it creates difficulties both for the LCME and the medical schools. It presumes the availability of appropriate standardized assessments covering the range of competencies expected of graduating medical students. In reality, there is a paucity of such measures with the NBME examinations the most recognized and accessible. Because of this it is widely assumed that the reference in the Draft is tantamount to a requirement that the NBME examinations be used. While officials of the LCME deny that this is a necessary implication of the language or that this is their

intention,<sup>5</sup> they acknowledge the problems in applying the principle, problems which will persist until more, nationally standardized assessments, including those that extend the evaluation of medical student performance, are available.

Officials of the NBME have been among those who have expressed concern about the LCME's use of NBME examination scores as an outcome measure describing the quality of education (Levit, 1984). Since the NBME itself has recognized and attempted to facilitate the use of its examinations for purposes other than licensing (Hubbard, 1978), it must be concluded that their concern is with the care with which such uses need to be made. Individual schools can and do use the examination for purposes of individual student evaluation or curriculum evaluation, but the responsibility for that use rests with the school, and presumes a validation of such use. Establishing the validity of using NBME examinations for purposes of student and/or program evaluation requires at minimum a study of the congruence between examination objectives and school objectives. Low performance on the NBME examinations may reflect in part differences in those objectives and therefore may not be the most valid measure of educational program effectiveness for a particular school.<sup>6</sup>

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<sup>5</sup>The LCME has also examined results from the Federated Licensing Examination (FLEX), whose test questions are drawn from NBME material. Other external examinations, developed by various chairman groups (pathology, pharmacology, microbiology) independently of the NBME, could be used for this purpose. A further possibility is for schools to "borrow" examinations developed at established schools. While the results may not be referenced to national norms, the inter-school comparison would provide some external reference point for the LCME on the performance of a school's students.

<sup>6</sup>Wile (1978) reports such a validation project which led to discontinuing the use of Part I as a second year comprehensive examination. However, other studies (Kennedy et al., 1980; Garrard et al., 1978) have found widespread agreement between NBME examinations and school objectives. This agreement does not necessarily imply congruence. Schools tend to have as objectives areas of knowledge and spheres of competence beyond those of the examinations. In this case, NBME performance is an important but not sufficient criterion for evaluating student achievement or curriculum effectiveness.

The performance level of a school on the NBME examinations is also related to two other factors: the ability of students and their motivational set taking the examination. The latter is influenced by the school's policies regarding use of the examination scores. Those schools whose entering classes exhibit high MCAT scores and who require their students to pass the examinations for promotion and/or graduation are more likely to achieve high NBME scores (Anderson, 1983). Because of these variable factors, student ability, school examination policy, and the congruence of examination and learning objectives, interpretations from the scores as to educational program effectiveness must be made quite carefully.

In the discussion of LCME's use of NBME results, explicit recognition must be given two points and a distinction needs to be drawn between the use of failure rates and the use of mean scores. The first point is that NBME results are never used absolutely and independently of other aspects of the institutional evaluation. Low mean scores or high failure rates serve as a "red flag" for the LCME and the school, to highlight possible program deficiencies or other problems. The NBME results are interpreted by the LCME in the context of entering students' abilities, school examination policy, and school learning objectives vis-a-vis examination objectives.

The second point is that the weight ascribed to such outcome measures varies necessarily and appropriately from school to school. Such a variation reflects the interplay among structure, process, and outcome variables in the development of LCME judgment. To the extent to which a school has the necessary resources to provide a quality education and smoothly functioning processes to utilize those resources, the LCME has perceived little need to focus its attention on

outcome measures.<sup>7</sup>

New and developing schools, or schools adopting experimental approaches to medical education, tend to draw a more a definite LCME focus on outcome measures. Resources may be quite deviant from national norms, a temporary phenomenon related to the school's stage of growth or permanently by design of the new approach. In such instances, the LCME seeks to be reassured that the program, however unusual, is producing a satisfactory product. Exclusive focus by the LCME on structural variables would likely interfere with measured growth and development of the school or inhibit educational experimentation designed to do more with less resources or with resources in different configurations. Outcome measures referenced to national standards can provide some assurance to the LCME and the school in question that the level or configuration of resources is not impeding student learning.

LCME attention to failure rates on the NBME examinations can be justified on separate grounds than attention to mean scores. The charge that medical education has become a process of information transfer at the expense of skill development should not obscure the fact that medical students need to learn and understand core concepts in biomedical science and bring to patient care a basic fund of clinical information. While no absolute agreement may ever exist on the parameters of this core material, the NBME examination specifications, designed by test committees composed of medical school faculty, may be presumed to approximate well some national consensus. Passing the NBME examinations reflects therefore some level of mastery of basic and clinical science information deemed

<sup>7</sup>Historically, the LCME has been consistent with other accreditation agencies and bodies in putting much less weight on outcome measures than on the means to those outcomes, structure and process factors. This is in part a recognition of the limitations of currently available measures to describe adequately outcomes of the educational process. While the LCME presumably will remain consistent in its approach barring significant advances in evaluation methodology, it should be noted that currently in higher education there is sentiment for a greater focus on outcome measures in institutional evaluation (Kells, 1984).

relevant by a nationally representative group of faculty. In addition, passage of the NBME examinations is still a major pathway to licensure; by virtue of its segmentation and partial administration during medical school, it can serve a monitoring function that the other licensing exam, FLEX, cannot. Failure on Part I may be an early indication of potential problems in achieving licensure. It may also forecast problems later on in passing specialty board examinations to attain specialty board certification.

Against this background, attention to failure rates on NBME examinations seems clearly a legitimate and appropriate activity of the LCME. The LCME is involved with judging whether or not a school is meeting minimum requirements for the education of physicians. The extent to which the school's students meet minimum individual standards is one measure of the school's effectiveness. Incomplete congruence between examination and school objectives is not at issue here. It is reasonable to expect an overlap between the two sufficient to allow students to pass the examinations. Low ability of entering students, which may be related to the problem, is not a mitigating factor. Medical schools must be selective in their admissions at least to the degree that their students are capable of demonstrating the minimum level of knowledge and skills that passing the exam reflects. The LCME's attention to failure rates is justified also from the standpoint of the protection of enrolled, tuition-paying students. LCME approval should not be given to schools which are unsuccessful in producing

licensable graduates.<sup>8</sup>

The LCME does not limit itself to examination of failure rates but sometimes reviews mean scores as well. Its purpose here is often to highlight a disparity between expected performance based on perceptions of student ability and the richness of the school's resources, and actual performance. This involves an implicit comparison of schools or programs with each other, which requires care in interpretation. Subscore comparisons (of various disciplines) may reveal more easily matters of educational concern since student ability and school policy are constant. Any performance profiles uncovered may simply reflect differences in educational objectives, however, rather than departmental or teaching program deficiencies. A depressed score in behavioral science, for example, may simply reflect a studied and focused approach to that subject that departs from the areas emphasized by the examination. Once the discrepancy is observed, judgments

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<sup>8</sup>The use of failure rates has been criticized because of the procedures used in setting the pass/fail cutoff. Thus, a word about these procedures is in order. Historically, the pass/fail cutoff level was directly defined by the performance of each yearly examinee group, with a mandatory and predetermined percentage of examinees failing each year. This allowed the criterion level to fluctuate with ability differences of each yearly cohort. While the ability levels of each yearly cohort were presumed not to differ sharply (with a corresponding stability in the criterion level), the symbolism of this norm-referenced standard setting was not tenable. This was because it contained at least a theoretical prospect that a cohort of high performing examinees would force a failure on examinees whose individual performance in other years would have been quite satisfactory. Thus, in 1981 (Part I) and 1982 (Part II), the NBME modified its procedures. Currently, standards for passing are referenced to the performance of a selected group of examinees from the previous four years. While the criterion level therefore continues to be referenced to performance of a group, that group is relatively more fixed and independent of the current examinee group. Under the new system, it is theoretically possible for all examinees to pass or to fail, although in practice little change from previous failure rates can be expected. Since the new system was introduced, the number of failures on Part I has shown a slight reduction, while failures for Part II have not shown any trends in either direction (Kelley, 1984).

Other methods for setting the criterion level independent of group performance have been proposed, studied, and implemented in various certification programs over the last decade. These methods involve an item by item judgment of experts as to what a minimally competent person is expected to know. The NBME is currently studying some of these methods for their application to the NBME examinations.

are required as to the appropriateness or inappropriateness of the decision; the score itself throws no light on this issue.

If the LCME were to give great weight to NBME performance levels as reflected in mean scores, this would seem to run counter to the sense of the medical education community which is articulated by the GPEP Report. It may encourage faculties to maximize their schools' test performance, which, in some cases could hinder development of, and focus on, assessments of other skills, work habits and attitudes that are central to physician competence. In other cases, it might discourage faculty from taking responsibility for determining knowledge and problem-solving objectives and selecting appropriate evaluation methods for their courses. To the extent the LCME's actions effect these results, it may be complicit in the continuance of passive learning methods rather than serving as a force for the maintenance and enhancement of educational quality.

#### CONCLUSION

The preceding discussion leads to the following conclusions on an appropriate interpretation of LCME policy in the use of NBME examination scores.

The LCME reserves the right to assure itself that medical students within an institution have attained standards of achievement that do not fall below those recognized by the community of accredited schools. This principle must be maintained. The few measures available and their limited scope currently hinder the LCME from applying this principle in relation to the complete spectrum of competencies that comprise medical student performance. However, when available, NBME examinations results provide important information on a subset of these competencies, that is appropriate for the LCME to consider. The LCME's principal focus here is properly on the school's failure rate. A relatively high failure

rate signifies a potential problem for the school in producing licensible graduates. It also indicates that a significant number of students do not possess a minimal fund of basic and clinical science information deemed relevant by a nationally representative group of faculty. Mean scores on the NBME may receive a secondary focus. The interpretation of this information should be approached cautiously, mindful of the various factors related to test performance.

In certain cases, NBME examination results are not available nor are substitute measures referenced to national norms. In these instances, the LCME, noting the paucity of available measures and wishing to avoid unduly intruding into the faculty's basic prerogative to determine the academic program, has the discretion to infer fulfillment of this standard indirectly through their examination of structural and process characteristics. In cases where this examination is not sufficiently reassuring, instances frequently characteristic of new and developing schools but which may describe others as well, the LCME should be able to demand more direct evidence that national standards of performance are being attained. For the present, this may be seen as tantamount to an NBME requirement. However, as more and different measures become available, the perceived restriction of freedom on the school's academic program should ease.

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