

1985 SPRING MEETING of the COUNCIL OF DEANS

March 20-23, 1985
The Cottonwoods

Wednesday, March 20th

1:00-5:00 pm, Hotel Lobby

ARRIVAL & REGISTRATION

SESSION I

5:30-7:00 pm, Ballroom

WELCOME & OVERVIEW

PRESIDENT'S REPORT

John A.D. Cooper, M.D.

7:00-8:00 pm, Poolside

RECEPTION

Thursday, March 21st

SESSION II

8:30-10:30 am, Ballroom

MONOCLONAL ANTIBODIES
AND CANCER

Hilary Koprowski, M.D.

Wistar Professor of Research Medicine

University of Pennsylvania

Director, Wistar Institute

Moderator: Donald W. King, M.D.

REVIEW OF BASIC SCIENCE TEACHING

Ernst Knobil, Ph.D.

H. Wayne Hightower Professor in the

Medical Sciences & Director of the

Laboratory for Neuroendocrinology

The University of Texas

Health Sciences Center at Houston

Moderator: D. Kay Clawson, M.D.

10:30-11:00 am, Ballroom

BREAK

SESSION III

11:00-1:00 pm, Ballroom

FUTURE DIRECTIONS FOR THE
ASSOCIATION OF AMERICAN MEDICAL
COLLEGES

Moderator: Arnold L. Brown, M.D.

Small Group Discussions

1:00 pm

UNSCHEDULED TIME

Friday, March 22nd

SESSION IV

8:30-10:30 am, Ballroom

FUTURE DIRECTIONS FOR THE
ASSOCIATION OF AMERICAN MEDICAL
COLLEGES

Moderator: Arnold L. Brown, M.D.

Reporter: Joseph A. Keyes, Jr.

FINANCING GRADUATE MEDICAL
EDUCATION

J. Robert Buchanan, M.D.

Chairman, AAMC Task Force on Financing

Graduate Medical Education

Moderator: Edward J. Stemmler, M.D.

10:30-11:00 am, Ballroom

BREAK

SESSION V

11:00-1:00 pm, Ballroom

TEACHING CLINICAL MEDICINE IN THE
AMBULATORY SETTING

Gerald T. Perkoff, M.D.

Professor of Family Medicine

University of Missouri

School of Medicine

Moderator: Richard H. Moy, M.D.

MCAT ESSAY PILOT PROJECT

Moderator: Robert Beran, Ph.D.

Edward White, Ph.D.

Former Director, Statewide

Calif. State University

English Equivalency Exam

Marliss Strange

Associate Director, Counseling

University of Oregon

Zen Camacho, Ph.D.

Associate Dean

Baylor College of Medicine

Terry Leigh, Ph.D.

Associate Dean, Student Affairs

& Admissions

University of Kentucky

1:00 pm

UNSCHEDULED TIME

Saturday, March 23rd

SESSION VI

8:30-12 noon, Ballroom

COD BUSINESS MEETING

12 Noon

ADJOURNMENT

RETURN BY February 11, 1985

RESERVATIONS
March 20-23, 1985

AAMC COUNCIL OF DEANS

THE COTTONWOODS
Scottsdale, Arizona

Name _____
Spouse's Name _____
School _____
Address _____
City _____ State _____ Zip _____
Office Telephone # _____

ARRIVAL/DEPARTURE

Arrival Date _____ Airline _____ # _____ Time _____
Departure Date _____ Airline _____ # _____ Time _____

THEME DINNER

Mexican Fiesta _____ # of tickets _____

Please make checks for the theme dinner payable to the AAMC.
Price includes: reception/dinner, entertainment, tax & gratuity.
Refunds will be given in the event of individual cancellations.

ACCOMMODATIONS:

Phoenix Suite (\$110) _____ Single _____ Double _____
Tucson Suite (\$165) _____ Single _____ Double _____
Flagstaff Suite (\$225) _____ Single _____ Double _____

SPECIAL BREAKFASTS

Midwest Deans _____
Southern Deans _____
Community Based Deans _____

Will Attend _____
Will Not Attend _____



PROGRAM PLANNING COMMITTEE

Richard E. Behrman, M.D.
Arnold L. Brown, M.D.
George T. Bryan, M.D.
D. Kay Clawson, M.D.
Donald W. King, M.D.
Richard S. Ross, M.D.
Edward J. Stemmler, M.D.

**ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES**

**COUNCIL OF DEANS
SPRING MEETING**

Program

March 20-23, 1985
The Cottonwoods
Scottsdale, Arizona

AN INVITATION

A New Deans' Orientation Program will be held in conjunction with this year's COD Spring Meeting on the evening of March 19th and the morning of March 20th. As a part of this program, there will be a reception at 6:30 pm on March 19th. Members of the Administrative Board and their spouses are cordially invited to join the staff and Council Chairman to welcome the new deans at this meeting.

Charles A. Dobry, M.D., Interim Dean, University of
Nebraska College of Medicine

Larry D. Edwards, M.D., Dean, Oral Roberts University
School of Medicine

Louis A. Faillace, M.D., Acting Dean, University of Texas
Medical School at Houston

Robert J. Joynt, M.D., Acting Dean, University of
Rochester School of Medicine & Dentistry

David Korn, M.D., Dean, Stanford University School of
Medicine

Richard M. Krause, M.D., Dean, Emory University School
of Medicine

Richard G. Lester, M.D., Dean, Eastern Virginia
Medical School

Raul A. Marcial-Rojas, M.D., Dean, Universidad Central
del Caribe Escuela de Medicina

Leon Rosenberg, M.D., Dean, Yale University School
of Medicine

Cecil O. Samuelson, M.D., Acting Dean, University of
Utah School of Medicine

Sol Sherry, M.D., Dean, Temple University School
of Medicine

Eugene M. Sigman, M.D., Interim Dean, University of
Connecticut School of Medicine

Joseph W. St. Geme, Jr., M.D., Dean, University of
Colorado School of Medicine

John F. Stapleton, M.D., Acting Dean, Georgetown
University School of Medicine

Paul D. Webster, III, M.D., Interim Dean, Medical
College of Georgia

Marjorie P. Wilson, M.D., Acting Dean, University of
Maryland School of Medicine

NEW DEANS' ORIENTATION

Tuesday, March 19

and

Wednesday, March 20

The Cottonwoods
Scottsdale, Arizona

TUESDAY, MARCH 19

Administrative Board

5:30 pm - 6:30 pm

Canyon Room A

Welcome and Introductions

Arnold L. Brown, M.D.
Chairman, Council of Deans

6:30 pm - 7:30 pm

Sonora Room &
Courtyard

RECEPTION

Open to new deans, participants in the orientation
session, COD Administrative Board members and spouses.

* * * * *

WEDNESDAY, MARCH 20

9:00 am - 12 Noon

Canyon Room A

Roundtable Discussions

* * * * *

AAMC Staff

John A. D. Cooper, M.D., President
John F. Sherman, Ph.D., Vice President
Thomas J. Kennedy, Jr., M.D., Director, Department of
Planning and Policy Development
Joseph A. Keyes, Jr., Director, Department of
Institutional Development
Richard M. Knapp, Ph.D., Director, Department of
Teaching Hospitals
August Swanson, M.D., Director, Department of Academic
Affairs

Arnold L. Brown, M.D., Dean, University of Wisconsin
Medical School

L. Thompson Bowles, M.D., Dean, Academic Affairs, George
Washington University School of Medicine

William Butler, M.D., President, Baylor College of Medicine

D. Kay Clawson, M.D., Executive Vice Chancellor, University
of Kansas School of Medicine

Robert Daniels, M.D., Dean, University of Cincinnati
College of Medicine

Louis J. Kettel, M.D., Dean, University of Arizona
College of Medicine

Walter F. Leavell, M.D., Dean, Meharry Medical College

Thomas H. Meikle, Jr., M.D., Dean, Cornell University
Medical College

Richard H. Moy, M.D., Dean and Provost, Southern Illinois
University School of Medicine

John Naughton, M.D., Dean, SUNY at Buffalo, School of
Medicine

Henry P. Russe, M.D., Dean, Rush Medical College

Edward J. Stemmler, M.D., Dean, University of Pennsylvania
School of Medicine

New Deans Invited

Henry H. Banks, M.D., Dean, Tufts University School
of Medicine

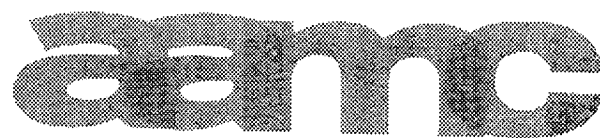
Henrik H. Bendixen, M.D., Dean, Columbia University
School of Medicine

William D. Bradshaw, M.D., Dean, University of Missouri
Columbia School of Medicine

David M. Brown, M.D., Dean, University of Minnesota
Medical School

Timothy Caris, M.D., Acting Dean, University of Texas
Medical School at San Antonio

Thomas Detre, M.D., Interim Dean, University of Pittsburgh
School of Medicine



FUTURE DIRECTIONS FOR THE AAMC

BACKGROUND MATERIALS FOR THE COUNCIL OF DEANS

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PREPARED FOR OFFICERS RETREAT

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- Council of Teaching Hospitals

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III. LETTERS SETTING OUT VIEWS OF BOARD MEMBERS AND OTHERS

- | | |
|----------------------|-------------------------|
| --Arnold L. Brown | --John Naughton |
| --Edward J. Stemmler | --Walter F. Leavell |
| --D. Kay Clawson | --Thomas H. Meikle |
| --William T. Butler | --Henry P. Russe |
| --L. Thompson Bowles | --David C. Dale |
| --Robert S. Daniels | --Hibbard E. Williams |
| --Louis J. Kettel | --Sherman M. Mellinkoff |
| --Richard H. Moy | |

IV. CHALLENGES IDENTIFIED BY THE ORGANIZATION OF STUDENT
REPRESENTATIVES

ISSUES FOR CONSIDERATION BY THE COUNCIL OF DEANS

The history of the COD issues paper is instructive of the deans' current thinking and perceptions of the AAMC. The paper was stimulated by the emergence of the COTH issues paper and was regarded at its inception as a potentially useful device to catalyze a discussion by the deans of their views, particularly with respect to the identification of matters which deserved greater or lesser programmatic emphasis. The initial effort was devoted to harvesting deans' views as to matters of contemporary significance--issues identification--and formulating questions regarding the adequacy of AAMC attention to them. Consequently, the document tended to be both terse and somewhat encyclopedic. Ultimately this configuration proved to inhibit the purpose of stimulating discussion. Apparently, successive iterations have served to assure that most of the major issues of a programmatic nature are included. On the other hand, despite several efforts, there has been little progress in developing a consensus regarding the need for changes in emphasis or new initiatives.

Two other events intervened and, in effect, took precedence over priority setting discussions. The first was the series of efforts undertaken by the COD chairman to improve communication among members of the Council and its leadership. The highlight of the Spring Meeting was a wide-ranging discussion of the Council on this topic which emphasized enhancing the sense of participation of the membership in the affairs of the AAMC. A number of suggestions emerged, some of which have already been effected:

- a new session at the Annual Meeting emphasizing dialogue and discussion in contrast to routine business, speeches and reports;
- a new sense of responsibility and accountability on the part of the Board for communication with the membership;
- a more active role for Board members in initiating new Council members into the society;
- a roster of deans which would provide Council members with greater insight into the background, interests and expertise of their colleagues;
- the exploration of modern information and communications technology to create more immediate and accessible channels of communications between the AAMC and its members and among the deans themselves.

The second intervening event was Dr. Cooper's announcement of his intention to retire in June 1986. This set in motion a series of discussions about the process of selecting his successor and speculations about the future of the AAMC after his departure. Thus, scheduled discussions of the Board in both September and October were diverted from the stated agenda of setting priorities regarding the matters set out in the issues paper to more broad ranging discussions regarding the mission of the AAMC. The scheduled COD business meeting at the Annual Meeting produced discussion, not of the

issues paper, but on the nature of the AAMC as symbolized by its name. A suggestion that the "Association of Academic Medical Centers (or American Medical Centers)" would more adequately symbolize the involvement of teaching hospitals and academic societies was met with intense discomfort in several quarters. Those who represent community based schools without "university-type hospitals" viewed the "medical center" designation as inapplicable to their own situation, and thus, as defining them out. Others suggested that it implied an aspiration to include responsibility for professions other than medicine which was overreaching, unnecessarily confrontational of other organizations and a diversion from the fundamental mission and strength of the AAMC-- advancing medical education. The proponents on the other hand, were concerned that too narrow a focus on undergraduate medical education would leave the AAMC powerless to deal with major forces that impinged on academic medicine, and would consign the teaching hospitals and academic societies to distinctly subordinate roles.

The last meeting of the COD Administrative board revealed little sentiment for an AAMC name change or a revision of the AAMC mission--the advancement of medical education--provided the mission is properly understood to imply a necessary and appropriate concern for preserving the scholarly environment and the search for new knowledge, and to imply a solicitude for the role of patient care and the settings in which clinical education is necessarily provided.

Several concerns were beginning to emerge regarding the implications for the AAMC of a new emphasis on undergraduate medical education by the deans. The first is the perception that the AAMC has underdeveloped mechanisms for involving the deans in the activities and deliberations of those concerned with educational matters in the AAMC, particularly the Group on Students Affairs and the Group on Medical Education. Second is the sense that the mechanisms for integrating the concerns of the three Councils are either underdeveloped or atrophied. Neither the Assembly nor the Executive Council has served in recent years as a deliberative body. Their affairs are limited to reports of limited interest and utility and to the ratification of actions already agreed to at Council or Board sessions, or, infrequently, negotiation of minor differences which remain.

At the last meeting of the Council of Deans Administrative Board, the members expressed an interest in having the staff undertake a synthesis of the three Councils' documents into a draft which would present a potential global picture of areas of consensus, areas of divergence and areas of conflict. In addition, the Board members volunteered to write short essays reflecting their aspirations for future directions for the AAMC. These, too, were to be collated and synthesized if possible into a document which might capture a consensus of the COD Board regarding priority matters to be attended. That process is now underway.

FUTURE CHALLENGES FOR THE COUNCIL OF ACADEMIC SOCIETIES

Development of the document:

During the past year, the Council of Academic Societies has been engaged in identifying and discussing the future challenges facing medical school faculties in the areas of medical education, research, and patient care. In addition, the Council has been examining its organizational structure to assess its continued effectiveness in developing strategies to meet these challenges.

The first stage of this process occurred during the CAS Spring Meeting in April. At that time, following the time-honored faculty tradition of full participatory democracy, the entire Council discussed a variety of issues that it considered important in the four areas highlighted above. Subsequent to these discussions, staff prepared a preliminary draft of the issues paper for consideration by the Administrative Board at its June and September meetings. During these deliberations, the Board concurred with the content and tone of the section concerning governance of the Administrative Board and the Council. The Board agreed that the strategies outlined within this section should focus on the interaction of the individual member societies and their representatives with the function of the Board and the entire Council.

The initial drafts of the paper identified a large number of issues of interest without making a serious effort to assign any priorities for action to each. Discussion was guided by the following three questions:

- (1) Have the major issues facing faculties been identified?
- (2) Are there significant issues that have been omitted?
- (3) Are the issues that have been identified germane to the CAS?

At the September meeting, the Board decided to enlist the aid of the Council representatives to answer these questions and to decide the priorities for the issues identified. In late September, the current draft of the paper was forwarded to the representatives from each society. The representatives also received a copy of a survey, which asked them to rate each of twenty-four possible action items identified within the paper on the basis of whether the item had a high, average, or low priority for the CAS. In addition, representatives were asked to rank the top five issues from among those that they considered to have a high priority.

Identification of key issues:

The results of the survey were made available during the Council's discussion of the document at the Annual Meeting of the CAS in Chicago on October 29. Fifty-six percent of the societies responded, with an equal proportion of basic science and clinical societies represented. The following items were given the highest priority most often in the survey:

- (1) The CAS should continue strong advocacy for biomedical research appropriations.
- (2) The CAS should continue efforts to achieve increased funding for research training.
- (3) The CAS should work with departmental chairmen to increase the institutional priority for medical student education.
- (4) The CAS should focus more attention on examining policies and initiatives for support of junior research faculty/new investigators.
- (5) The CAS should provide a forum for discussion and development of policies to balance competing interests in an atmosphere of constrained funding.
- (6) The CAS should undertake an examination of how medical student education programs are supported.
- (7) The CAS and individual academic societies should involve themselves in efforts to limit restrictions on the use of animals in research.

In addition, the following two items received attention from the basic scientists:

- (1) The CAS should provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences.
- (2) The CAS should examine how faculty involvement in planning and implementing improvements in medical education can be enhanced.

And these two items were well received by the clinicians:

- (1) The CAS should become involved in policy issues related to faculty practice efforts and their relation to the overall academic missions of faculty.
- (2) The CAS should support the establishment of an AAMC-wide Task Force to discuss proposed policies and funding for graduate medical education.

During Council discussion it was noted that most of the top priority issues centered on challenges to the faculty in their roles as biomedical investigators. One veteran Council member commented that this emphasis accorded with the role of the CAS in relation to the other two Councils as it had evolved over the last 15 years. He observed that while all members of the academic community were concerned about a wide range of issues, a tradition had developed that the COD took the lead in issues related to medical student education, the COTH led in issues of patient care, and the CAS led in the area of biomedical research.

The Council agreed that the next step is for the representatives to review this document and the identified priorities with their societies before any final action agenda is formulated.

COTH ISSUE PAPER

The paper "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" has been reviewed by the AAMC membership on a number of occasions:

November 1983	Approved for discussion by the COTH Administrative Board
December 1983	Reviewed and discussed at the AAMC Officers' Retreat
January 1984	Included on the agenda of the AAMC Executive Council (meeting cancelled)
April 1984	Included on the agenda of the AAMC Executive Council which recommended transmitting it to the AAMC Membership Presented and discussed at the Appalachian Council of Teaching Hospitals Mailed to all AAMC members
May 1984	Presented and discussed at the Western University Hospital Council Presented and discussed at the annual COTH Spring Meeting

A key observation in the COTH paper was the rise of special interest hospital organizations which may compete for member attention and interest. During the year, this trend has continued. The Consortium of State University Hospitals, which began as a small research interest group, has incorporated as the University Hospital Consortium (UHC) to offer shared service and joint venture economic activities to academic medical center hospitals. UHC currently has 23 members from the 115 academic medical center hospitals listed in the COTH paper and anticipates a major growth in membership in the next six months. Two other hospital alliances, Associated Healthcare Systems and United Healthcare, have merged to form American Healthcare Systems (AHS). They are planning to provide a Washington office for lobbying, a national preferred provider organization, and economic services. New organizations are also forming to represent clinical units or programs of the hospital. During the current year, hospitals with burn care units, as an example, began forming their own organization. Finally, during the year, a growing number of COTH members have retained Washington-based legal counsel to represent them. The relationship between these lawyers and the AAMC staff is unclear and often uncomfortable.

While the teaching hospital paper contained a number of recommendations, discussion during the year has focused primarily on three of them. First, with a few exceptions, COTH members and the members of other AAMC Councils have supported the position that COTH should include all types of teaching hospitals rather than be limited to 125-150 academic medical center hospitals. Secondly, COTH and other AAMC members have supported the recommendation not to develop and emphasize economic service programs (e.g., joint purchasing, fringe benefit insurance, consulting). This consensus may have contributed to the decision of the Consortium of State University Hospitals to reorganize. The third widely discussed position, the inclusion or exclusion of for-profit hospitals in COTH, has not led to a consensus. It is a separate item on this agenda.

A. MISSION

The AAMC . . . requires a mission statement which is concise, consistently contemporary and reflective of the organization's basic orientation. The current mission statement, without modification, meets these criteria.

Walter F. Leavell

It is hard for me to see why its function should be significantly changed.

L. Thompson Bowles

The primary concern of the AAMC should be medical education.

Arnold L. Brown

(w)e should reaffirm that our primary mission is medical education.

D. Kay Clawson

It is evident that the purpose of the organization is to improve the quality of medical education throughout the country.

William T. Butler

(The AAMC's) activities thus must center about the mission of advancing medical education in its broadest sense.

Louis J. Kettel

The focus of the Association should continue to be on medical student education with graduate education being an important variable in the continuum of this educational process.

Walter F. Leavell

It should be the job of the AAMC, and it has been, to continually remind those in the medical education establishment of what their basic and most important responsibility is.

Arnold L. Brown

The Association until the last two years has not emphasized sufficiently. . . its interest in medical education.

Robert S. Daniels

I strongly support the concept that medical schools are the prime focus of our organization and that it should be all medical schools.

Richard M. Moy.

We (should) maintain a narrow focus on the issues that relate to the functions of medical schools, hospitals and faculties.

Edward J. Stemmler

A. Mission, including identification of constituencies: options

A. Society for advancement of medical schools and teaching hospitals

1. more restrictive than AAHC, excluding other health professional schools, etc.
2. broader than present mission, as reflected in By-Laws.
3. reflects increased importance of teaching hospitals: co-equal.
4. president might be primarily experienced in hospital affairs.

B. Society for advancement of medical schools

1. broader mission than only medical education.
2. includes research, service in addition to education.
3. missions of teaching hospitals not comprehensively considered.

C. Society for advancement of medical education

1. represents current mission, statement which fails to reflect current activities and governance of AAMC.
2. might suggest person should be a known medical educator.

Thomas H. Meikle

I believe the mission of the AAMC is well described by the current mission statement.

Henry P. Russe

Any mission statement should be simple, short, general and capable of providing a long range view. I agree with those who have made the core mission of medical education a major emphasis.

John Naughton

There is a national preception that medical education has become subservient to other missions rather than the other way around. I think the other responses reflect that perception and concern.

John Naughton

My own bias is that somehow the AAMC became the principle spokesperson for the CAS and the NIH rather than for the schools as education entities. While the views of these constituencies are important and relevant, their dominance may have led to some of the voids in activity that are now receiving a larger amount of attention from the COD and COTH.

John Naughton

B. STRUCTURE

Assessment

It is extremely important that we maintain this organization as representing multiple constituencies and multiple institutions. The medical college, medical education, and the deans must be the first among equals. This primacy should not be exploited, however, and in no way should we de-emphasize or depreciate the other functions, agencies, or people. The strength and creativity of the AAMC has been its capacity to adapt to the socioeconomic circumstances of particular times and represent many viewpoints and many manpower interests. We cannot afford to fragment this organization. I believe that it would be very bad for everyone.

Robert S. Daniels

It would appear that the membership is not seeking a specific organizational change in structure, but wishes to be assured that the Association is truly representative of all participants, is dynamic, adaptable, maintains flexibility and is responsive to the input and concerns of its membership.

Walter F. Leavell

The current organizational structure appears to have the necessary flexibility to accommodate new constituent groups or constituent interests as the need identifies itself.

Walter F. Leavell

The Group on Student Affairs and the Group on Medical Education, as examples, are freestanding entities, essentially reporting to staff. There is no mechanism for regular dialogue or direct communication with these groups.

William T. Butler

While there are fairly frequent contacts between the three councils, just as there are locally, there seems to be little effort to integrate such bodies as the GME, GSA, or RIME into the general flow of information and contacts of the Association. This also is a reflection of the local situations.

Arnold L. Brown

Organizationally, too, I believe that it would be wise to articulate the groups interested in education in the AAMC with the policy making and governance structures. There should be clarity between the goals of most associations and the specific functions of education, research, and clinical care.

Robert S. Daniels

- COD: does the current structure foster and support interactions among medical schools with common interests
should the relationship of GSA, GME, OSR, etc. to the COD be defined better
should regional groups be actively encouraged and supported
Thomas H. Meikle

(T)here is no other home for the faculty medical educators...nor while there are fairly frequent contacts between the three councils, equivalent in the clinical arena to the hospital staff section of the AMA...(T)here is not a group of housestaff in the AAMC equivalent to the Organization of Student Representatives (OSR), (n)either is there a precise home for directors of licensing boards, housestaff program directors, and the like within the AAMC.

Louis J. Kettel

My impression is that (the CAS has) not represented education well nor represented the faculties well. However, their statement is balanced and comprehensive so perhaps they are modifying their historic position.... (their) interests and activities should include not only medical student education but graduate medical education as well (housestaff and fellows).

Robert S. Daniels

I suspect, for example, that there is relatively little active participation in the Council of Teaching Hospitals by the administrators of the hospitals affiliated with community-based medical schools for a variety of reasons, but in part because the COTH has been traditionally accommodated by and concerned with the problems of more traditional university owned and operated institutions.

Richard H. Moy

We should reexamine the relationships among the various components of our Association. The Council structure works well and is not an issue. What is an issue is the interface between the Councils. The relationship among Councils is presently not well served through the Executive Council but could be.

Edward J. Stemmler

Staff Organization

-do the departments and divisions of AAMC and their levels of staffing reflect the associations priorities.

Thomas H. Meikle

It is appropriate that the AAMC be composed of multiple constituencies. However, the relationship of these constituencies to the mission is important to define and establish.

John Naughton

The current structure of the AAMC neglects the vast differences that exist among the nation's medical schools. In my view, the AAMC behaves as if a single, national consensus exists for all issues. I think this accounts for some of the lack of commitment to the AAMC on the part of many deans: it seems as though the AAMC is made up of 127 medical schools which have as their common mission the education of physicians. From that point onward, a great deal of diversity exists.

John Naughton

Some schools are primarily research oriented, others primarily clinically oriented. The AAMC has been a good spokesperson for the former and a lousy spokesperson for the latter. There are also vast regional differences which affect a school's mission and behavior. As currently structured and administered, the AAMC is unable to deal with the issues of institutional diversity.

John Naughton

Recommendations

Serious consideration ought to be given to ways in which the various groups within the Association can communicate more effectively within the governance structure. This is not an argument to make groups part of the governing body but to establish more effective lines of communication.

Edward J. Stemmler

At the Administrative Board meeting, each of us has some understanding of the issues in our respective schools, but we may not understand collectively the problems and concerns of the GSA, for example, in the other 128 schools. Thus, a formal mechanism to integrate these functions would provide a more meaningful base of information for decision making by the respective councils.

William T. Butler

While simplistic, straightforward solutions lie in the formation of a faculty group equivalent to the Group on Student Affairs called the Group on Faculty Affairs (GFA) and an organization of housestaff representatives (OHR) equivalent to OSR. Within the Group on Medical Education a subset for program directors, CME directors, licensing directors, and the like, could be created. Representation on the Council of Deans Administrative Board could occur from the several groups and organizations within the AAMC parallel to the successful OSR membership on the Board.

Louis J. Kettel

I would like to have thought given to the substructures of the Association or, at least, the Council of Deans. Our only official substructures are the four geographic regions which, as we have observed, are not terribly functional with the current exception of the Southern deans. On the other hand, there are groups that appear to be functional and to be meeting needs. These are state groups. (For example, the New York deans and the Illinois deans which have active state organizations, met together in Chicago for the first time and found common interests which will prompt them to meet again.) There also is a group of free-standing schools and the community-based schools.

Richard H. Moy

The group, which was formerly known as The New and Developing Community-based Medical Schools, is choosing to drop the New and Developing and essentially commit itself to representing those medical schools, old or new, and those components which are community based and, thus, share unique concerns or unique variations of general concerns as compared to more traditional schools. At their meeting in Chicago, this group asked their new president, Bill Sawyer, to explore having official status within the Council of Deans or the AAMC.

Richard H. Moy

In my judgment, if the Association is to have credibility as it would relate to the implementation of the GPEP Report, focusing on our primary mission of medical education, the structure of the AAMC must be organizationally representative in a demonstrable manner.

Walter F. Leavell

I am skeptical and, for now, opposed to creating a new Council for faculty. I am also opposed to the AAMC taking on health science programs beyond those relating to the education of medical doctors.

L. Thompson Bowles

What I am proposing is the formation of standing committees comprised of a number of deans, faculty, COTH members, and students to meet on a regular basis. The majority of committee members would not be members of the Ad Boards although all Ad Boards would be represented, and one Ad Board member would serve as chairman. The committees would be advisory to each of the respective councils, and each council would benefit from the diversity of opinions, and each council would benefit from the diversity of opinions expressed in their deliberations. How many such standing committees would be needed or useful needs careful study.

William T. Butler

The COTH increasingly must examine its interfacing relationship with the medical school. This examination is not being done on a philosophical basis, since by definition COTH would not exist unless it is structured as an academic health care delivery system. However, it must also maintain its existence and competitiveness in the marketplace.

Walter F. Leavell

The structure of the AAMC is one which has allowed great flexibility representing all of its participants in a responsible and dynamic interactive whole. This was clearly evident to me during the year that I spent as a Scholar in Residence at the Association and the only suggested change that I make is that there be efforts to increase effective communication between the major councils.

Henry P. Russe

I do not believe there is any need for the creation of a new council for faculty affairs, although I might be persuaded in this direction.

Henry P. Russe

C. GOVERNANCE

Assessment

Recently, I have recognized that the Executive Council really was not the deliberative body that I had expected it to be and think that attention should be given to having far more open deliberations at that body, rather than a perfunctory approval of the actions that have been taken by the various Councils.

D. Kay Clawson

The function of the Executive Council as the governing body of the Association needs greater recognition during this period of transition. Council meetings have been rather pro-forma and there is little opportunity for the Council to function as a deliberative or governing body.

Edward J. Stemmler

It is important to recognize that many deans have felt disenfranchised and isolated from the process of deliberation on the issues and from other components of the organization. Admittedly, this is an extremely difficult problem, because the creation of a more deliberative process which involves many people may slow the machine down to the point that consensus cannot be attained before a critical vote in Congress or a final decision is required.

William T. Butler

The issues of governance are currently dominant, yet I am impressed that the present system has served us well.

D. Kay Clawson

There is some danger to the Association's operation if the Executive Council becomes too powerful a body. This issue of the balance in power between the President and Council is one to consider seriously. I am acquainted with other voluntary organizations in which the Council or Board structure has so much to say that the actions of the president are held in unreasonable check. On the other hand, there should be some awareness that lack of exercise of accountability by the Council may provide too much freedom for the President. John Cooper has managed this balance quite effectively.

Edward J. Stemmler

Governance:

- are COD, COTH, CAS co-equals; should they be equally represented on Executive Council
- COTH: should hospital CEO be representative of TH
is membership too broadly defined
is widespread constituent participation fostered
is regional representation balanced
- CAS: is CAS co-equal with COD and COTH
is CAS effective within AAMC
does CAS communicate adequately with constituent societies
Thomas H. Meikle

I think this area requires a great deal of review. While one can reasonably admire the way in which the AAMC functions, it is important to remember that it functions well because of John Cooper's dedication and personality. When an organization has become dependent on the leadership of a singular, strong personality, it oftentimes has problems when a transition comes.

John Naughton

In my opinion the AAMC is a self-sufficient organization designed to influence and speak on behalf of medical education.

John Naughton

Recommendations

We should be more concerned about the extent to which the Executive Council is really integrating the activities and developing policies of the various constituencies and functions of the AAMC. Currently, formal integration takes place only at the top when most issues are nearing the 'rubber stamp' level and apparently sometimes after many deans have gone home.

William T. Butler

Since (the Executive Council) does represent the point of accountability for the search and recruitment, and since it also represents the body which must approve any restatement of the mission and job description, the opportunity for more thoughtful meetings should be provided. This may require rescheduling of the Executive Council to a time when its members can attend and there may be other accommodations which the staff might consider and propose as well.

Edward J. Stemmler

Procedures could be developed to assist the Administrative Boards' members in having a better feel of the 'pulse' of the membership's thoughts on policy matters. This input may have to be actively sought because I believe that most non-Ad Board members tend to be somewhat passive participants. We need to discuss additional ways to enhance this functional representation, through involvement, participation and communication.

William T. Butler

I do not believe we should have more, different organizations inputting into the governance of the AAMC, but do believe that the various constituent bodies that are functioning should have a relationship with an appropriate Council in order to improve communications.

D. Kay Clawson

I believe that the Officers Retreat would benefit greatly by retaining the immediate past chairman as participants. I am struck by how much one learns during the course of the year as chairman...I admit that there is a risk of excessive intrusiveness on the part of a past leader, but the value of having an experienced perspective when one plans a future, surmounts the bad risk, in my opinion.

Edward J. Stemmler

I would second comments made by many of my colleagues that the importance of the Council of Deans be maintained in any considerations of governance or the reordering of the current governance structures.

Henry P. Russe

I would concur with comments by Ed Stemmler that John Cooper has managed to balance the governance of the Association extremely well during his tenure.

Henry P. Russe

I am pleased that Ed Stemmler and Bud Brown have sought to broaden the participation of the deans within the governance and feel that even as a new administrative board member, I am truly involved in matters of governance.

Henry P. Russe

IV. PROGRAM PRIORITIES

Assessment

The AAMC has performed very well the several functions of a service association. Its leadership has carefully sought the opinions of the members and based its advocacy upon them. As the legislative and executive branches of government, and the public generally, become even more concerned and involved in medical practice, reasoned and informed presentation of our views will become ever more important. The leadership of the Association must express these views from a reservoir of experience, accomplishment, and conviction that will provide the assurance that those arguments proceed from the basic precept of the organization--the concern for the quality of medical education.

Arnold L. Brown

The central purpose of the Council of Deans is to defend excellence in medical education and biomedical research.

Sherman M. Mellkinkoff

Both the COD and CAS express strong sentiments in their position papers concerning adequacy of research funding and the support that this traditionally has provided the academic institutions. The Council of Teaching Hospitals, likewise, are cognizant of the important role of research. However, they must also concern themselves with cost containment and have the need to be assured that research is paving its own way.

Walter F. Leavell

There are many issues surrounding research, such as, funding, industry-university relationships, and research fraud which deserve the attention of the AAMC. I realize that some of these topics have been dealt with in the past, but I believe more work needs to be done on a continuing basis.

Hibbard E. Williams

I continue to worry about the absence of any organized leadership by the Association in the area of medical practice plans. It is not just the mechanics of practice plans but the effective organization of health services for the purpose of medical education that should be addressed. By our silence we are losing our constituents.

Edward J. Stemmler

The COD, COTH and CAS are each equally concerned about the necessity and dependency on clinically derived income for supporting medical education and the consequences of this dependency, as it would relate to changes in policy by third party payers and legislative bodies.

Walter F. Leavell

There appears to be a uniformity of concern regarding the most appropriate means of funding medical education. The COD expresses an aggregate and comprehensive concern in terms of institutional support, as well as availability of loans and scholarships for students. The CAS similarly is concerned while the COTH expresses a need for identifying support for academic programs within its constituent environment.

Walter F. Leavell

I am becoming more and more discontented with the amount of time and effort that goes into the discussion of financial matters in the medical school. Somehow, we have to balance this with discussions and efforts in more scholarly things. The AAMC should lead the way in these kinds of activities.

Hibbard E. Williams

Should the Association and its members undertake to inform the public better about the extraordinary career opportunities which exist in medicine and to encourage young people to take more seriously the possibility of choosing this career? Further attention to the finance of tuition and living expenses is indicated and the need to promote low-interest loan funds in the service of improving the financial feasibility of medical education is important. Mention might also be made of the real experiences with women and minorities since the 1960's and the potential that the professional may be undergoing as restructuring in that more physicians will practice in large organizations, more will be employed and salaried, more will work fewer hours, and the life of a physician will be more regularized.

Robert S. Daniels

The AAMC must also concern itself with the quantity and quality of the applicant pool and, therefore, concern itself with some aspects of the undergraduate educational process. COD approaches the issue through strong support of the recommendations of the GPEP, while CAS added the dimension of accreditation, licensing and certifying authority.

Walter F. Leavell

The educational programs, at least for the COD, have been relevant, informative, and well conducted. This is an important activity of the AAMC and should be continued.

Arnold L. Brown

Thought should be given to renewing the courses in pedagogical technique for both deans and faculty.

Arnold L. Brown

In terms of providing the membership with timely information concerning our environment as well as gathering and analyzing a widerange of appropriate data, the Association has done very well.

Arnold L. Brown

For me, the critical program priorities are curricular reform, the funding of graduate medical education, and the continued emphasis on the identification and preservation of funding for research activities in the medical colleges.

Henry P. Russe

Additional high priority items are those which deal with the generation of flexible dollars, i.e., through medical practice plan activity for support of medical college budgets.

Henry P. Russe

I would agree with Don King and his comments at our last spring meeting that we might do well at some of our gatherings to focus somewhat more on the scientific aspects of medical education and the research that supports these activities.

Henry P. Russe

Program Areas = problems confronting constituents

A. Medical Schools

1. undergraduate medical education

- student selection; role of MCAT
- should enrollments be reduced; how to regulate supply/demand
- how to discourage study in inferior foreign medical schools
- will adequate numbers of qualified applicants be available
- how to broaden racial and socio-economic diversity
- how to encourage and finance needed changes in medical curriculum

- how to obtain increased financial aid for needy students
- how to avoid continuing large increases in tuition
- what is appropriate role of LCME; NBME

2. graduate medical education

- how to control quality and by whom
- how to finance
- should FMGs continue to be accommodated
- should supply of specialty positions be regulated
- how to attract graduates to underserved areas

3. continuing medical education

- is CME successful in improving the quality of health care

4. medical school financial support

- how to maintain fiscal stability in environment of change
- how to preserve appropriate balance of research/education with increased commercialization of medical service
- how to control faculty practice plans
- how to determine educational costs

B. Teaching Hospitals

1. patient care activities

- how to maintain physicians control of patient management
- how to evaluate quality of care in era of cost containment
- how to adapt to a competitive environment
- how to respond to investor-owned initiatives
- how to identify appropriate marketing strategies
- how to develop management/financial data
- how to fund the care of charity patients
- how to determine costs per case
- how to handle ethical problems

2. educational activities

- what are alternate methods of financing educational costs
- how to maintain reimbursement policies which support medical education and research

3. research activities

- how to maintain indirect support for clinical research

C. Faculty

1. educational activities

- how to improve quality of teaching
- how to increase teacher-student interaction
- how to increase importance of teaching and education in medical school environment
- how to support faculty for educational activities directly

2. research activities

- how to attract bright, creative young faculty in era of reduced or at least stabilized funding for research
- how to maintain graduate programs in research with decreased federal support
- how to make research careers attractive especially to MDs
- how to insure stable, adequate funding for biomedical/behavioral research and research training
- how to achieve balance between support for program projects and individual investigator-initiated projects
- how to improve funding for new equipment and the construction or renovation of research facilities
- how to achieve appropriate balance between direct and indirect support of research costs
- how to develop appropriate regulations for control of research wastes, animal and human subjects in research, and genetically engineered research products
- how to encourage and appropriately utilize research support from industry

D. Funding - support

- is the AAMC too dependent on MCAT revenues
- are the dues appropriate for each constituency
- should more support be sought from foundations and governments

E. Major activities or functions in support of programs

- advocacy of AAMC positions
- information for constituents
- education of constituents and others interested
- liaison with other organizations
- research on appropriate topics
- participation-communication among constituents

Thomas H. Meikle

I sense that this is an area that is coming under greater scrutiny. The program priorities must reflect the mission related to medical education.

John Naughton

It is my view that as we move into the new federalism the role of states and of individual institutions will assume greater importance in medical education. The time has come for the AAMC to adapt to an entire set of behaviors designed to maintain its credibility as the chief spokesperson for the nation's medical schools. To do so it must concern itself with the fabric of all medical schools, not just a few.

John Naughton

Thus, it must be ready to deal with all aspects of medical education including graduate medical education; alternate strategies for the teaching of medical education, i.e., more community and ambulatory settings; new forms of research, i.e., technological and service delivery; the importance of practice plans; and new forms of inter-institutional governance.

John Naughton

E. EXTERNAL RELATIONS

Assessment

Our external relationships...(our engage[ment] in the broad array of health policy organizations) deserve a more systematic evaluation.

Edward J. Stemmler

The environmental impact in relationships might be expanded and developed [in the COD Issues Paper]. Are we still respected and are we listened to by legislative and public administrative bodies? The collaborations with other bodies representing constituencies (the other associations) are also very important.

Robert S. Daniels

Do we need more interaction with outside organizations? I do not really have sufficient understanding of the working relationships which now exist to comment constructively. On the other hand, the development of appropriate coalitions may be essential if we are to be effective in bringing about change.

William T. Butler

Our interface with international medicine is not developed well enough at all. I do believe that we should provide more organized recognition of the common interest of medical education in the world.

Edward J. Stemmler

It is critical that we maintain our external relationships with other associations and particularly with the Congress of the United States as we seek to continue to be a voice for all of the component memberships of the Association.

Henry P. Russe

These are and will continue to be important. However, it will be more important for the leadership to pay attention to its internal constituents, particularly the medical schools and teaching hospitals.

John Naughton

F. COMMENTARY ON THE ISSUES PAPER

The 'Background' statement is a good one. I would expand it by including a statement on the multiple functions--education, research and clinical care. Comments on trends in each of these in terms of activity and financial support would be appropriate. The Association has such data in its recent testimonies to Congress. This information could be woven into 'The Issues' paragraph.

Robert S. Daniels

In the introduction it would be useful to make clear that this statement has as its purpose the posing of questions to which the Association and its member institutions should turn their attention. This statement attempts to address a three to five-year agenda for the rest of this decade (the 1980's).

Robert S. Daniels

The 'Foreign Medical Graduates' section should be moved to close proximity to the paragraph on size. It would be worthwhile to emphasize the importance of a comprehensive approach to manpower issues which assure adequate numbers; there should not be large over-population there must be assurances about quality; the decision should be made on quality bases and a good evaluation system.

Robert S. Daniels

In the 'Financing' paragraph there might be some further comment about the possible commercialization of the academic medical center, the need to evaluate new corporate forms, both for-profit and not-for-profit, and the possibilities of new and diverse functions.

Robert S. Daniels

I continue to believe that our statement is a useful one. Along with the other two papers, there could be generated a synthesized statement about which there could be a consensus. Such a statement would be very valuable. It should not, however, be focused on the answering of questions. It should concentrate, rather, on raising questions which then might direct the search by suggesting important functions and activities and necessary skills and strengths.

Robert S. Daniels

The three (3) position papers (COD, COTH, CAS) are concurrent on the mission. The COTH paper relates to the complexities of being a teaching hospital in support of the mission, while simultaneously maintaining competitiveness in a rapidly changing environment.

Walter F. Leavell

G. SELECTION OF THE NEW AAMC PRESIDENT

One central issue surrounds the definition of the role of the President...A specific job description should be written and approved by the Executive Council prior to the appointment of a new president.

Edward J. Stemmler

(T)here must be a stated policy on (the president's) term of office, the review process for performance, and the procedures which are to be used for continuation or termination...all of these issues are silent within our current bylaws but should not be.

Edward J. Stemmler

We can only be effective on a national scope by supporting and working with an intelligent, honorable, well-educated, altruistic, conscientious and talented president like John Cooper.

Sherman M. Mellkinkoff

The new president of the AAMC must be a distinguished medical educator.

Arnold L. Brown

More important, though, is to find the best and strongest person. I would be suspicious of a search focused too much...We need a strong generalist with broad interests and experience who can oversee and develop the many different aspects of the Association.

Robert S. Daniels

One of the great strengths of the Association has been the quality and continuity of the senior staff that John has brought together. It would be my hope that the process of the search, as well as its result, would maximize the likelihood of these people continuing with the organization and that when they must be replaced, it is by people of the same general caliber.

Richard H. Moy

The Association, in order to be effective nationally, needs a leader who is not a replacement for John A.D. Cooper but certainly one who has all of the same excellent characteristics which he has demonstrated for so long.

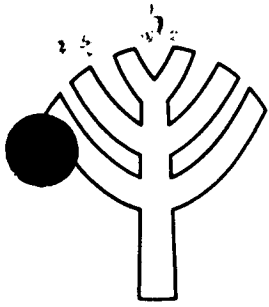
Henry P. Russe

I think the Search Committee is well underway. The next President must have the strength of John Cooper and be able to develop his authority while at the same time encouraging a greater participating role for the Executive Council. The Council will have to be more responsive to its constituent councils.

John Naughton

From my vantage point, the spirit of the AAMC seems good, and many well meaning deans, hospital administrators and specialty representatives are prepared to contribute to the organization's work. The new President will be able to capture this spirit if he is willing to encourage participatory management in an effective manner yet able to enunciate the organization's primary mission succinctly.

John Naughton



MEDICAL SCHOOL
University of Wisconsin—Madison

Center for Health Sciences

Medical Sciences Center
1300 University Avenue
Madison, Wisconsin 53706
Phone: 608-263-4900

Dean	263-4910
Registrar	263-4912
Admissions	263-4925
Student Services	263-4920

November 9, 1984

Joseph A. Keyes, Jr.
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Joe:

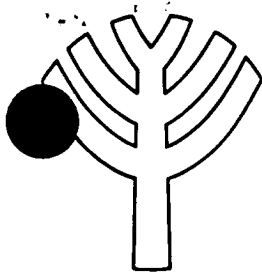
I apologize for the elliptical prose that characterizes the attached.
What I meant to say is:

- *the prime concern of the AAMC is medical education
- *medical education is the result of the integrated efforts of medical schools, teaching hospitals, and faculty
- *the ultimate responsibility for medical education is lodged in the medical schools
- *the new president of the AAMC must be a distinguished medical educator
- *the AAMC has done, and is doing, a good job but some improvements could be made.

Sincerely,

Arnold L. Brown, M.D.
Dean

Enclosure
0315J



MEDICAL SCHOOL
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November 9, 1984

Joseph A. Keyes, Jr.
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Joe:

Herewith my thoughts on the future of the AAMC:

The primary concern of the AAMC should be medical education. As obvious as such an assertion should be in regard to the AAMC, it is a notion easily forgotten in the frenzied movement from one crisis to the next that characterizes the medical care system. The inertia of medical education, the fact that it will go on, somehow, while attention is focused elsewhere, has given administrators, at least those who think about it, the rationale to avoid giving education the time and energy it so desperately requires. It should be the job of the AAMC, and it has been, to continually remind those in the medical education establishment of what their basic and most important responsibility is.

It would be naive to believe that matters such as DRG's, NIH authorizations, animal legislation, and Medicare assignment have nothing to do with medical education. They do. But such concerns should not divert the AAMC or its members from their preoccupation with the student in the classroom, the laboratory, or the clinic.

The premise that medical education is a continuum is widely acknowledged and accepted. The fact remains, however, that undergraduate education develops the foundation upon which the rest must build. The AAMC's concern with this phase of education has been appropriate and sustained. This must be continued.

Joseph Keyes, Jr.
November 9, 1984
Page 2

The transformation of undergraduate students into medical doctors and those into skilled physicians, requires a firm bond between medical schools and hospitals devoted to teaching. This partnership is maintained and the teaching mission of the hospital effected by the clinical faculties of the medical schools. Medical education rests, therefore, on a table supported by five legs--medical schools, teaching hospitals, faculty, students, and patients. Their interests are not always the same and at times diverge significantly. Four of these legs meet in the AAMC and all four share a concern for the fifth, present and future. The common interests of the schools, hospitals, faculties and students must be nurtured and emphasized by the only organization devoted to just those matters. None of those elements can exist apart from one another. Therefore, those issues that divide the components of medical education must be discussed, negotiated, and resolved. It is the AAMC that provides the forum, the opportunity, and the stimulus to maintain, and strengthen, the connections that bind together the corporate body of medical education.

The primacy of the academic mission of the integrated components of medical education is, or should be, acknowledged by all of them. The responsibility and accountability for this mission is centered upon the medical schools where, in the minds of the profession, the public, and the academic community, it will remain. This requires, however, great sensitivity on the part of the administration of the schools for the concerns, expectations, and aspirations of the teaching hospitals and faculties. We hang together or we hang separately.

The AAMC has performed very well the several functions of a service association. Its leadership has carefully sought the opinions of the members and based its advocacy upon them. As the legislative and executive branches of government, and the public generally, become even more concerned and involved in medical practice, reasoned and informed presentation of our views will become ever more important. The leadership of the Association must express these views from a reservoir of experience, accomplishment, and conviction that will provide the assurance that those arguments proceed from the basic precept of the organization--the concern for the quality of medical education.

In terms of providing the membership with timely information concerning our environment as well as gathering and analyzing a wide range of appropriate data, the Association has done very well. The educational programs, at least for the COD, have been relevant, informative, and well conducted. This is an important activity of the AAMC and should be continued. Thought should be given to renewing the courses in pedagogical technique for both deans and faculty.

Joseph Keyes, Jr.
November 9, 1984
Page 3

One of the essential functions of the AAMC is the development and nurture of relations with other organizations concerned with medical education. In the first instance, this is a responsibility of the President. Beyond that, however, it is necessary that there be wide participation by the membership. Also of importance are relations with the various constituencies within the AAMC. While there are fairly frequent contacts between the three councils, just as there are locally, there seems to be little effort to integrate such bodies as the GME, GSA, or RIME into the general flow of information and contacts of the Association. This also is a reflection of the local situations.

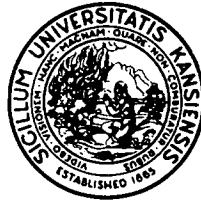
I believe that the AAMC has done its job well and generally reflects the concerns of its members. The essential mission for the future, as I believe it has been in the past, is a primary concern for the quality of medical education.

Sincerely,



Arnold L. Brown, M.D.
Dean

0311J



THE UNIVERSITY OF KANSAS

Office of the Executive Vice Chancellor
College of Health Sciences and Hospital
39th and Rainbow Blvd., Kansas City, Kansas 66103
(913) 588-1207

November 7, 1984

Joseph Keyes, J.D., Director
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, NW, Suite 200
Washington, DC 20036

Dear Joe:

Subject: Future Directions for AAMC
Position Paper, Council of Deans

The AAMC has made tremendous strides under John A. D. Cooper's direction and my own position is that we need to do some fine-tuning to repair some chinks in our armor, but should not look at wholesale change. I do believe it is appropriate to re-evaluate our areas of emphasis and think of the admonition in the book In Search of Excellence that a business should stick to the business it knows best to succeed. With that in mind, I believe we should re-affirm that our primary mission is medical education and try not to get distracted into areas that tangentially impact on medical education to the detriment of the primary thrust. With that in mind, I believe we should have liaison with organizations that impact upon the preparation of our students for medical school and encourage them in appropriate directions, but not to take this on as a primary mission.

Further, I recognize medical education as a continuum, but many other organizations are very much involved once the M.D. degree is granted. While I believe we should encourage our medical schools and the AAMC to try to assume primary responsibility for graduate medical education in the early years, I believe we must accept the fact that other organizations have vested interests in graduate medical education and we should work with them without striving for dominance in that arena. This is particularly true for continuing education, with the exception of providing continuing education for our primary constituents which include the administrators and faculty of our medical schools and primary teaching hospitals. As you know, I am very pleased with what we have accomplished in this area, and I think we should continue to expand our activities as the primary body for education of our constituent group.

I believe the AAMC is going to have to take leadership in addressing some serious internal problems in our medical schools which relate to a stable and aging faculty, and a real problem for the future in not having sufficient faculty positions available to recruit the bright young minds into medical education while we are retaining senior faculty that are past their prime. The whole issue of faculty education, re-education, re-tooling and its relationship to tenure is one of the top issues that no school independently can handle and should be a major thrust for the organization.

Student recruitment will increasingly become an issue as brighter students shy away from the long preparation for a medical career with increasing costs and decreasing rewards. I believe this society should take a national leadership role in coordinating the recruitment of the best students into careers in medicine. In this regard, I believe we must become more prominent as the educator of physicians for other countries. This will require us attempting to influence Congress and the State Department to the same degree we have done as it relates to NIH and research. I would also think we should form a closer liaison with international organizations, such as the Association of Medical Deans in Europe. I recognize there are a number of medical schools that are very entrepreneurial and are trying to sign good contracts with developing countries and I believe that our interests will best be served if this is handled through the AAMC, rather than a hundred-odd schools entrepreneuring on their own.

I think we clearly must be an education group as it relates to public education regarding the inseparability of quality medical education and research and patient care. It is not to say that we should take a leadership role in patient care issues or in financing of patient care, but only to ensure that our primary teaching institutions can maintain a sufficient patient base to carry out the necessary teaching and research so vital to the future of health care in this country.

Perhaps we also need to educate our own members that the teaching hospital of the past may have a lesser role in the education of medical students than we have known. Clearly, teaching must go beyond the hospital into private practice settings, public health units, nursing homes, long-care health facilities, etc.

From Page 9, Issues for Consideration

Advocacy. Obviously, we have to serve as a major advocate for our constituents of all segments of society. To do this, I think we must be a source of accurate information and have this readily disseminated to whatever constituent group we are trying to influence. I am totally convinced that in this day and age, the best way to influence people is with facts, not personal opinions. Therefore, I think we need to continue to build our internal information systems and hope that we can set up a mechanism that will allow for ease of transmission and on-line capabilities with our medical schools and other major constituents. Research in medical, or adult education, is extremely important and we should find mechanisms to stimulate and support this.

The issues of governance are currently dominant, yet I am impressed that the present system has served us well. I do believe that with a new CEO, it

November 7, 1984

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is appropriate to give that individual an opportunity to alter administrative organization. However, I do have my opinions and feel that we must preserve the powers of the president to operate the organization, but have a clear mechanism by which the executive board can review the president on a timely basis and allow the president term appointments rather than open-ended expectations. I do not believe we should have more, different organizations inputting into the governance of the AAMC, but do believe that the various constituent bodies that are functioning should have a relationship with an appropriate council in order to improve communication.

Recently, I have recognized that the executive committee really was not the deliberative body that I had expected it to be and think that attention should be given to having far more open deliberations at that body, rather than a perfunctory approval of the actions that have been taken by the various councils.

Joe, I am sure this is more than you wanted when you asked for something to be written. As you know, I am very pleased with the AAMC--what it is and what it does. When one looks at the questions posed on page 14 of our document, I would answer a resounding "Yes" to all but the last two. I think that the local, state, and regional issues are so varied that, other than being a repository for information, we would become overwhelmed if we attempted to monitor these activities.

In summary, I feel that we should concentrate on our primary responsibilities in medical education and work diligently with other organizations and their leadership.

Most sincerely,



D. Kay Clawson, M.D.
Executive Vice Chancellor

DKC/1h

UNIVERSITY of PENNSYLVANIA

SCHOOL OF MEDICINE

PHILADELPHIA 19104

EDWARD J. STEMMLER, M.D.

Robert G. Dunlop
Professor of Medicine

Office of the Dean
215-898-5181

November 8, 1984

Joseph A. Keyes, Jr., Esq.
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Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Joe:

I promised that I would write down my thoughts about the issues which confront the organization as it moves through the period of transition into the future. This note is not intended to be broad and comprehensive but to address those areas which, in my opinion, ought to be discussed during the forthcoming Officers Retreat.

One central issue surrounds the definition of the role of the President. The Association has functioned effectively in its present form and there may or may not be a need to adapt the job description of the President. Nonetheless the specific job description should be written and approved by the Executive Council prior to the appointment of a new president.

In addition to the job description there must be a stated policy on the term of office, the review process for performance, and the procedures which are to be used for continuation or termination. To my knowledge, all of these issues are silent within our current bylaws but should not be.

The function of the Executive Council as the governing body of the Association needs greater recognition during this period of transition. Council meetings have been rather pro-forma and there is little opportunity for the Council to function as a deliberative or governing body. Since it does represent the point of accountability for the search and recruitment, and since it also represents the body which must approve any restatement of the mission and of a job description, the opportunity for more thoughtful meetings should be provided. This may require rescheduling of the Executive Council to a time when its members can attend and there may be other accommodations which the staff might consider and propose as well.

I must point out that there is some danger to the Association's operation if the Executive Council become too powerful a body. This issue of the balance in power between the President and Council is one to consider seriously. I am acquainted with other voluntary organizations in which the council or board structure has so much to say that the actions of the president are held in unreasonable check. On the other hand, there should be some awareness that the lack of exercise of accountability by the Council may provide too much freedom for the President. John Cooper has managed this balance quite effectively and for the good of the Association. There is much to learn from the model which he has set in place.

I do believe that we should reexamine the relationships among the various components of our Association. The Council structure works well and is not an issue. What is an issue is the interface between the Councils. The relationship among Councils is presently not well served through the Executive Council but could be. Also, serious consideration ought to be given to ways in which the various Groups within the Association can communicate more effectively with the governance structure. This is not an argument to make groups part of the governing body but to establish more effective lines of communication. This is a very complex issue and will not lend itself to easy discussion at the retreat other than to be recognized as an area deserving of attention.

I tend to align myself with the remarks made by Charlie Sprague who recommended that we not attempt to broaden our focus too widely. In fact, Charlie put it the other way, that we maintain a narrow focus on the issues that relate to the functions of the medical schools, hospitals, and faculties. This choice between broadening and the maintenance of our current thrust represents one of the most important choices we will make at this point in our history. Charlie thought that we might need a new Coggeshall Committee to reformulate our scope of operations. Dick Janeway has envisioned the Search Committee as the means to serve that purpose. Either approach is satisfactory if the individuals draw on a broad view and listen to the important issues.

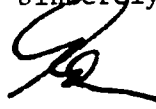
Our Association, like most voluntary organizations, has to deal with the delicate balance between the continuity or the early termination of elected leadership. I believe that the Officers Retreat would benefit greatly by retaining the immediate past Chairmen as participants in the Annual Retreat. I am struck by how much one learns during the course of the year as Chairman. Since it does not effect me personally, I would strongly recommend that future individuals in the role as immediate past Chairmen be participants in the retreat which should continue to include the Chairmen and the Chairmen elect. I admit that there is a risk of excessive intrusiveness on the part of a past leader but, the value of having an experienced perspective when one plans a future, surmounts the bad risk, in my opinion.

I continue to worry about the absence of any organized leadership by the Association in the area of medical practice plans. It is not just the mechanics of practice plans but the effective organization of health services for the purpose of medical education that should be addressed. By our silence we are losing our constituents. I recognize that this issue is moving toward the front burner but has not yet arrived.

Finally, we ought to be sure that our present external relationships are appropriately configured. I see no reason to question the present structure in that I do not believe that we are over or under engaged in the broad array of health policy organizations. Nonetheless, this area does deserve a more systematic examination. Also, our interface with international medicine is not developed well enough at all. I do believe that we should provide more organized recognition of the common interest of medical education in the world. This is an area that should be approached carefully and constructively. It certainly deserves to be thought out.

I hope these comments are helpful for discussions at the retreat and beyond. Warm personal regards.

Sincerely yours,



Edward J. Stemmler, M.D.
Dean

EJS/DSF

cc: Arnold L. Brown, M.D.
University of Wisconsin Medical School

D. Kay Clawson, M.D.
Chairman-elect



**BAYLOR
COLLEGE OF
MEDICINE**

Texas Medical Center
Houston, Texas 77030

William T. Butler, M.D.
President
(713) 799-4846

November 19, 1984

Mr. Joseph A. Keyes, Jr.
Director
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Joe:

This may be longer than you want, but I hope to express some personal observations about organizational issues as they relate to the recent Administrative Board's discussions in Chicago. In reflecting on my experiences and involvement with the AAMC, my first impression of the AAMC was that of a large, amorphous organization. It was difficult to understand. Even after 10 years, I'm not sure I understand the intricacies of all the internal and external relationships. On the other hand, I believe I am beginning to see how deans can and should exert leadership in bringing about change.

Let me describe three phases I have experienced in my involvement with the AAMC:

1. The Early Phase. In 1972, I was appointed Associate Dean of Admissions at Baylor. I attended the AAMC's GSA meetings to hear discussions about the admissions traffic rules; the GME meetings to learn what others were doing about students, admissions, and teaching methods; and the minority workshops to find out what was taking place in this area. At the time, I was not consciously aware of the AAMC's organizational structure, nor did I attend COD, CAS, or COTH business meetings because they usually conflicted with the above. Participation in GSA and GME, however, was extremely important to me. I benefited from interactions with colleagues from other schools who were coping with the same grass roots problems I was facing at Baylor. To that extent, the organization served me extremely well, providing a forum essential to that stage of my administrative education.

Mr. Joseph A. Keyes, Jr.

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2. The Mid Phase. Approximately five years later, when first appointed the Acting Dean at Baylor, I began to attend the AAMC's annual COD business meetings. In retrospect, these meetings were dull compared to the GSA meetings. I yearned for more interaction with the other deans (all of whom were "senior" to me), but no real forum was provided for discussion of the substantive issues I was concerned about at that stage --faculty appointment and promotion, faculty tenure issues, quality of educational programs, and so forth. I wanted to know how others were dealing with the same problems in their institutions. The annual COD meetings seemed to focus on business and legislatively oriented issues which, at that time, were new and not yet that interesting to me. I felt awkward in asking questions when everyone else seemed to know the answers. My subsequent experiences have shown the naivete of this assumption. The Spring meetings, on the other hand, were an improvement. The topics seemed more timely, but, even so, there was no real forum for interchange of thoughts and experiences. Basically, we listened to lectures followed by only limited discussion. It was difficult to get to know other deans. In the evenings, old friends would congregate, making it difficult for newcomers to get acquainted.

3. The More Recent Phase. I am now familiar with the broader organizational issues and relationships. Before my election to the Administrative Board, three specific events brought the AAMC into focus for me:
 - (a) Being chairman of the COD's Nominating Committee. This forced me to study and understand more clearly the representative governance of the AAMC and the relation of each Council to the total organization.
 - (b) Participating in meetings and group discussions with the 13 deans of the private, independent medical schools.
 - (c) Participating in meetings of the Southern Council of Deans.

The common denominator of these events was involvement and communication. Sharing of concerns as well as accomplishments built confidence as well as friendships and relationships which have grown over time.

In the framework of the foregoing, let me move to discussion of the goals for the AAMC's current organization. It is evident that the purpose of the organization is to improve the quality of medical education throughout the country. Thus, the AAMC's organizational structure should be

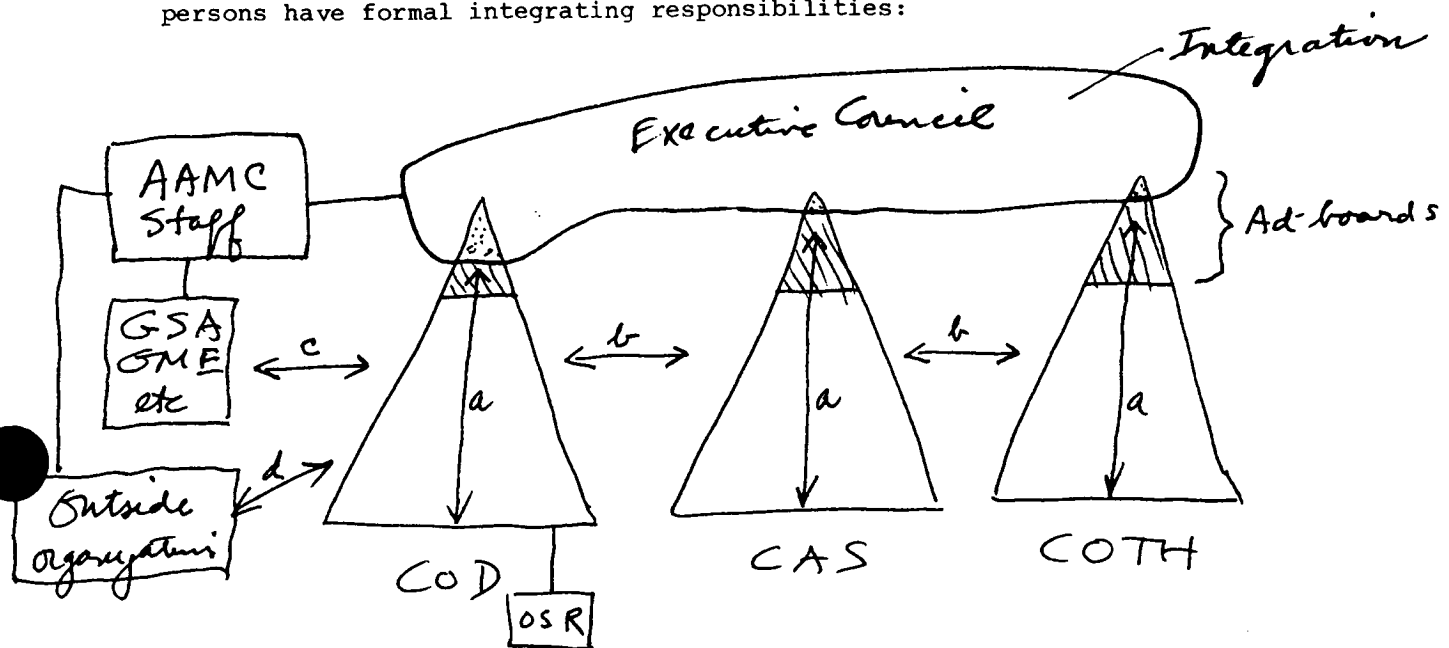
Mr. Joseph A. Keyes, Jr.
November 19, 1984
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sufficiently flexible and adaptable to allow quick mobilization of the deans, faculty, students, house staff, hospitals, and other relevant components, to address substantive issues. More times than not, we are forced to decision making by factors outside our control, but to which we must respond with vigor and in unison if at all possible. Political realities continually force the organization into reactive stances. It is difficult to be creative and visionary when the energies of the staff are diverted to crisis issues. Fortunately, John Cooper has realized this and obviously has protected some of his staff for academic functions. It is essential that this protection be continued in order to assist in the continued development of our schools.

It is important to recognize that many deans have felt disenfranchised and isolated from the process of deliberation on the issues and from other components of the organization. Admittedly, this is an extremely difficult problem, because the creation of a more deliberative process which involves many people may slow the machine down to the point that consensus can not be attained before a critical vote in Congress or a final decision is required.

After reading the three issue papers, reviewing the discussions of recent Administrative Board meetings, and learning that the Executive Council is sometimes poorly attended by the deans, the COD may not have the input I thought it had. Furthermore, we should be more concerned about the extent to which the Executive Council is really integrating the activities and developing policies of the various constituencies and functions of the AAMC. Currently, formal integration takes place only at the "top" when most issues are nearing the "rubber stamp" level, and apparently sometimes after many deans have gone home.

The following conceptual diagram summarizes my concept of the organization and indicates, as stated above, that only a small number of persons have formal integrating responsibilities:



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Assuming that we want to retain the current overall organizational structure of three or more councils, which I believe has strong merits, I believe we need to examine possible ways to improve the system's overall efficiency. I offer the following questions for discussion:

1. Do we need more vertical communication and interaction within each council ("a" on the diagram)? Procedures could be developed to assist the Administrative Boards' members in having a better feel of the "pulse" of the membership's thoughts on policy matters. This input may have to be actively sought because I believe that most non-Ad Board members tend to be somewhat passive participants. I congratulate Ed Stemmler in beginning to develop models of vertical communication within the COD. We need to discuss additional ways to enhance this functional representation, through involvement, participation, and communication.

2. Do we need more horizontal interaction among the Councils ("b" on the diagram)? Currently, formal interaction appears to be limited in scope and, as indicated above, takes place primarily at the Executive Council level. Do we need a mechanism to promote grass roots involvement in discussion of critical issues? For example, we may be losing a golden opportunity to discuss the critical issues of clinical education in larger groups that should include faculty, deans, hospital administrators, and students. Through active discussion of deans with hospital administrators, we could evolve a better understanding of each other's needs and concerns and develop mutual support for policies that benefit both schools and hospitals. It occurs to me that not once in my experience at the AAMC have I met with hospital administrators in a formally structured session. Such joint discussion could result in more meaningful input to the respective Administrative Boards so that by the time decisions reach the Executive Council, there is not only broader understanding of the issues, but, hopefully, a broader base of support and consensus for a final AAMC position. I realize the complexity of establishing such a mechanism and that many ad hoc committees have been formed over the years to serve this function. But, what I am proposing is the formation of standing committees comprised of a number of deans, faculty, COTH members, and students to meet on a regular basis. The majority of committee members would not be members of the Ad Boards although all Ad Boards would be represented, and one Ad Board member would serve as chairman. The committees would be advisory to each of the respective councils, and each council would benefit from the diversity of opinions expressed in their deliberations. How many such standing committees would be needed or useful needs careful study. For example, if we really wish to be innovative in

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addressing the GPEP recommendations on the baccalaureate/medical school interface, changes would require the active participation of members of all existing councils as well as representatives from undergraduate universities. This is but one example; there are many others as well.

3. Do we need more interaction among certain categorical components or groups within the AAMC which now exist without any direct relationship to the COD or other councils ("c" on the diagram)? Specifically, I suggest that the Group on Student Affairs, and the Group on Medical Education, as examples, are freestanding entities, essentially reporting to staff. There is no mechanism for regular dialogue or direct communication with these groups. Often, these persons really understand better than we as deans the operational problems in our schools, and I believe we could benefit from their input and counsel. At the Administrative Board meeting, each of us has some understanding of the issues in our respective schools, but we may not understand collectively the problems and concerns of the GSA, for example, in the other 128 schools. Thus, a formal mechanism to integrate these functions would provide a more meaningful base of information for decision making by the respective councils. I have been struck on occasion that the student representative on the COD Ad Board is the one member who seems to know more about what the other councils are discussing than the rest of us do. Such input is too narrow in scope.
4. Do we need more interaction with outside organizations ("d" on the diagram)? I do not really have sufficient understanding of the working relationships which now exist to comment constructively. On the other hand, the development of appropriate coalitions may be essential if we are to be effective in bringing about change.

I am pleased that Bud Brown has engaged us in thoughtful discussion of the structure and functions of the AAMC. It is a potent organization and has developed great strength under John Cooper's leadership. Perhaps it can be made even stronger in meeting the needs of our constituent institutions in the future.

With personal regards,



William T. Butler, M.D.

WTB:hd

xc: Arnold L. Brown, M.D.

University of Cincinnati
Medical Center



Office of the
Senior Vice President
for the Medical Center
and Dean, College of Medicine

231 Bethesda Avenue (ML 555)
Cincinnati, Ohio 45267-0555
Phone (513) 872-7391

November 5, 1984

Joseph A. Keyes, Jr., Director
Department of Institutional Development
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, DC 20036

Dear Joe:

I attach my comments about "Issues for Consideration," from the
Administrative Board of the Council of Deans. I hope that it
is useful. Good luck on the "synthesis."

Sincerely,

A handwritten signature in cursive script, appearing to read 'Bob Daniels'.

Robert S. Daniels, M.D.
Senior Vice President for the Medical Center
and Dean, College of Medicine

4717E

"Issues for Consideration"

The "Background" statement is a good one. I would expand it by including a statement on the multiple functions--education, research, and clinical care. Comments on trends in each of these in terms of activity and financial support would be appropriate. The Association has such data in its recent testimonies to Congress. This information could be woven into "The Issues" paragraph.

In the introduction it would be useful to make clear that this statement has as its purpose the posing of questions to which the Association and its member institutions should turn their attention. This statement attempts to address a three to five-year agenda for the rest of this decade (the 1980's).

At the end of "Recruitment and Admissions" I would add other questions. Should the Association and its members undertake to inform the public better about the extraordinary career opportunities which exist in medicine and to encourage young people to take more seriously the possibility of choosing this career? Further attention to the finance of tuition and living expenses is indicated and the need to promote low-interest loan funds in the service of improving the financial feasibility of medical education is important. Mention might also be made of the real experiences with women and minorities since the 1960's and the potential that the profession may be undergoing a restructuring in that more physicians will practice in large organizations, more will be employed and salaried, more will work fewer hours, and the life of a physician will be more regularized.

The "Foreign Medical Graduates" section should be moved to close proximity to the paragraph on size. It would be worthwhile to emphasize the importance of a comprehensive approach to manpower issues which assure adequate numbers; there should not be large over-population; there must be assurances about quality; the decision should be made on quality bases and a good evaluation system.

In the "Financing" paragraph there might be some further comment about the possible commercialization of the academic medical center, the need to evaluate new corporate forms, both for-profit and not-for-profit, and the possibilities of new and diverse functions.

It is in the "Role of the AAMC" that I would make the most substantive changes. The goals are acceptable but I believe that it would be helpful to interrelate these goals with three functions--education, research, and clinical care. About that, I comment that the Association until the last two years has not emphasized sufficiently in recent years its interest in medical education. This relative neglect is now being corrected with GPEP and other such developments. Organizationally, too, I believe that it would be wise to articulate the groups interested in education in the AAMC with the policy making and governance structures. There should be clarity between the goals of most associations and the specific functions of education, research, and clinical care.

A related issue is the function and activity of the Council of Academic Societies. My impression is that they have not represented education well nor have they represented their faculties well. However, their statement is balanced and comprehensive so perhaps they are modifying their historic position. I hope so because I believe greater breadth of interest and activity is indicated. This interest should include not only medical student education but also graduate medical education as well (house staff and fellows).

It is extremely important that we maintain this organization as representing multiple constituencies and multiple institutions. The medical college, medical education, and the deans must be the first among equals. This primacy should not be exploited, however, and in no way should we de-emphasize or depreciate the other functions, agencies, or people. The strength and creativity of the AAMC has been its capacity to adapt to the socioeconomic circumstances of particular times and represent many viewpoints and many narrower interests. We cannot afford to fragment this organization. I believe that it would be very bad for everyone.

The environmental impact in relationships might be expanded and developed. Are we still respected and are we listened to by legislative and public administrative bodies? The collaborations with other bodies representing constituencies (the other associations) are also very important.

I continue to believe that our statement is a useful one. Along with the other two papers, there could be generated a synthesized statement about which there could be a consensus. Such a statement would be very valuable. It should not, however, be focused on the answering of questions. It should concentrate, rather, on raising questions which then might direct the search by suggesting important functions and activities and necessary skills and strengths. More important, though, is to find the best and strongest person. I would be suspicious of a search focused too much on a person who would be a specialist in one or another aspect of our fields. We need a strong generalist with broad interests and experience who can oversee and develop the many different aspects of the Association.

11/2/84
Draft #2

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THE
GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER

Dean for Academic Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 676-3501

November 12, 1984

Mr. Joseph A. Keyes, Jr.
Director
Department of Institutional Development
Association of American Medical Colleges
Staff
One Dupont Circle, N.W. - Suite 200
Washington, D. C. 20036

Dear Joe:

In reflecting on the past two decades of the Association's activities, it is hard for me to see why its function should be significantly changed. In my opinion, the organization should continue to represent the major constituencies involved in medical education. To this end the Association already provides numerous valuable services to medical schools, teaching hospitals and many academic societies and I would hope that these services from AMCAS to newsletters would continue.

Further, the Association is the one major spokesman for medical education. Continuing to monitor and influence federal legislation effecting medical education should continue as a major activity.

With respect to changing the mission or function I have no enlightening suggestions. I like the idea of keeping some kind of regular dialogue with the AAHC. I am skeptical and, for now, opposed to creating a new Council for Faculty. I am also opposed to the AAMC taking on health science programs beyond those relating to the education of medical doctors. The one function I would elevate is that of promoting biomedical research and defending it from the animal research movement. I know that the Association is already moving in this direction, and I applaud the expanded commitment to protect this vital and threatened enterprise.

I'm afraid that this letter does not offer much in the way of new initiatives but it is an endorsement of the powerful and helpful support provided by the AAMC to its members. I hope we don't change directions very much.

Sincerely,

L. Thompson Bowles, M.D., Ph.D.
Professor of Surgery
Dean for Academic Affairs

LTB/apr

1885



The University of Arizona

Health Sciences Center
College of Medicine
Office of the Dean
Tucson, Arizona 85724
(602) 626-7383

1985

A Proud Beginning

November 2, 1984

Joseph A. Keyes
Staff Counsel
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Joe:

Enclosed is a rapid draft of the essay you requested. "Cut and paste" as you see fit.

Thanks for your special effort in this regard.

Sincerely,

Louis J. Kettel, M.D.
Dean

LJK:jt

cc: Arnold L. Brown, M.D.
D. Kay Clawson, M.D.
Richard Janeway, M.D.
Edward J. Stemmler, M.D.

enc.

ISSUES FOR THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

It is assumed that the Association of American Medical Colleges, the AAMC, will remain the "organization for schools of medicine and its professional educators" just as the American Hospital Association serves for the institutions of hospitals, the Association of Academic Health Centers similarly for academic medical centers, the American Medical Association (AMA) for individual practicing physicians, the Federation of basic scientists, the American Board of Medical Specialties for specialty disciplines, and so on. There is no other "home" for medical school deans, professional medical educators nor medical student advocates. Hence, the AAMC will remain, as in the past, both an organization of colleges (institutions) and of medical education professionals. Its activities, thus, must center about the omission of advancing medical education in its broadest sense.

Organizationally, the new directions should recognize that there is no other "home" for the faculty medical educators separate from their scientific society, nor equivalent in the clinical arena to the Hospital Staff Section of the AMA nor the specialty societies of the various sponsors of the medical specialty boards. Further, there is not a group for housestaff in the AAMC equivalent to the Organization of Student Representatives (OSR). Neither is there a precise "home" for directors of continuing medical education,

directors of licensing boards, housestaff program directors, and the like within the AAMC. While simplistic, straightforward solutions lie in the formation of a faculty group equivalent to the Group on Student Affairs called the Group on Faculty Affairs (GFA), and an organization of housestaff representatives (OHR) equivalent to OSR. Within the Group on Medical Education a subset for program directors, CME directors, licensing directors, and the like, could be created. Representation on the Council of Deans Administrative Board could occur from the several Groups and Organizations within AAMC parallel to the successful OSR membership on the Board.

A new view of interfaces with AAMC should be taken. Restudy of the interfaces with "parent" universities, affiliated hospitals, organized medicine, industry, government and those who represent other health professionals is timely and needed. While the agenda may vary, each of these six constituencies represent potential adversaries and potential allies. There are many common problems and some common solutions. For the university interfaces, goals are changing for vice presidents, provosts, and hospital directors. Priorities among the various campuses have changed. Universitywide basic science departments have become more common and sundry academic stresses prevade all colleges within universities. For the affiliated hospital interfaces, preprospective pricing and changes in financing of health care are causing pressure on established college and hospital relationships. Identifying winners and losers, altering educational missions, and indeed changes in teaching arena

from inpatient to outpatient settings are occurring. Organized medicine at its interfaces is "fighting" with hospitals, raising manpower questions and suffering under the new environment of competition. Industry interfaces are represented by proprietary pressures and "for profit" has become a dynamic force. Federal government is shifting responsibility more to states and the interfaces have become much more local. At the same time, the boundaries of health professions in their delivery of care have become blurred. Even the definition of a physician is being widely attacked. The solutions to interfaces do not follow from more isolation of the schools of medicine from the other organizations. Rather, AAMC must advocate a sharing of resources and cooperative interdigitation.

If the assumptions and organizational matters are accepted, then action areas can be defined. In my view, these appear under the following set of priorities.

1. Financing of graduate education and determination of a national program size. The critical sub-issue is the impact of U.S. born foreign medical graduates.
2. Financing of undergraduate medical education and determination of a national program size. The critical sub-issue is the regeneration of momentum to correct persisting underrepresentation of many of society's groups.

3. Curricular change should occur only as deemed necessary after sizing of programs. Alteration of the selection/admission process follows after curricular changes. The issues of the quality of education too follows sizing of classes. For example, it should be anticipated that smaller class sizes in themselves will improve the quality of education simply by providing a better teacher/student ratio.
4. The content of the curriculum must not be changed in isolation from considerations of licensing, certification and recertification.
5. The establishment of a proper role for faculty in the Group on Medical Education should lead to attention to tenure, promotion and reward systems.
6. Testing format for licensing, certification and recertification will follow once curricular directions are established.

The advocacy role for the Association follows from the sense of priorities determined after reorganization and prioritizing of action areas. The advocacy role includes "lobbying efforts" at the federal and state level and the interface considerations with other organizations. The focus remains persuasion to our position and/or moving our position in a compromise way to theirs.

It would seem to me that the qualities of the successor President of the AAMC must include skills and commitment to direct the changes I have described. This includes first and foremost a sympathy to the needs of medical schools via their deans in the new roles being identified. Such an individual must have the experience to understand the national scene in health care but not to allow such changes to alter the higher priority of the basic educational needs in medicine. Innovative skills in a new management/organizational structure will be required with a flexible nature to tolerate the ambiguity of change and yet strong enough to carry forth the leadership against resistance to change. A knowledge of the federal scene may or may not be highly critical if the forces at work are more organizational and if the state and local level forces dominate. Finally, if medical education is truly to be the driving force, then a person of stature in the educational arena must be sought. Suffice it to say, the President should be a seasoned leader and manager.

Louis J. Kettel, M.D.
Dean, College of Medicine
University of Arizona
Tucson, Arizona

November 2, 1984



Southern Illinois University
School of Medicine
P.O. Box 3926
Springfield, Illinois 62708

Office of the Dean and Provost
801 North Rutledge Street

November 15, 1984

Arnold L. Brown, M.D., Chairman
Council of Deans
c/o Joseph A. Keyes, Jr., J.D.
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Bud:

In considering future directions for the AAMC, there are a couple of thoughts that I would like for you and Kay to have in mind at the Executive Committee Retreat. One of the great strengths of the Association has been the quality and continuity of the senior staff that John has brought together. It would be my hope that the process of the search, as well as its result, would maximize the likelihood of these people continuing with the organization and that when they must be replaced, it is by people of the same general caliber. As you know from our meeting in Chicago, I strongly support the concept that medical schools are the prime focus of our organization and that it should be all medical schools. In this regard, I would like to have thought given to the substructures of the Association or, at least, the Council of Deans. Our only official substructures are the four geographic regions which, as we have observed, are not terribly functional with the current exception of the Southern Deans. On the other hand, there are groups that appear to be functional and to be meeting needs. These are state groups. (For example, the New York Deans and the Illinois Deans, which have active state organizations, met together in Chicago for the first time and found common interests which will prompt them to meet again.) There also is a group of free-standing schools and the community-based schools.

This latter group, which was formerly known as The New and Developing Community-based Medical Schools, is choosing to drop the "New and Developing" and essentially commit itself to representing those medical schools, old or new, and those components which are community based and, thus, share unique concerns or unique variations of general concerns as compared to more traditional schools. At their meeting in Chicago, this group asked their new president, Bill Sawyer, to explore having official status within the Council of Deans or the AAMC. I expect he will be bringing this to your attention. It may be that these new groupings, since they are responding to real needs, might be more effective than the geographic groupings and potentially strengthen the Association on one hand, as well as dispersing the chronic allegations that the Association tends toward more support for the elitist institutions.

I suspect, for example, that there is relatively little active participation in the Council of Teaching Hospitals by the administrators of the hospitals affiliated with community-based medical schools for a variety of reasons, but in part because the COTH has been traditionally accommodated by and concerned with the problems of more traditional university owned and operated institutions. An example being the first draft of the COTH "New Challenges." At any rate, the four traditional regions appear to be rather arbitrary and not clearly meeting needs and I would suggest that at this nexus it would be appropriate to apply some creative thought to alternatives.

Sincerely,

A handwritten signature in cursive script, appearing to read "R. H. Moy".

Richard H. Moy, M.D.
Dean and Provost



UNIVERSITY AT BUFFALO
STATE UNIVERSITY OF NEW YORK

Office of the Dean
School of Medicine
Faculty of Health Sciences
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Buffalo, New York 14214

February 26, 1985

Mr. Joseph Keyes
AAMC
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Joe,

I have finally formulated my thoughts about the AAMC in writing. The report is attached. I hope it is not too late to include in your summation. At any rate, it may assist you in your deliberations.

Best regards.

Sincerely,

John Naughton, M.D.
Vice President for Clinical Affairs
Dean, School of Medicine

JN:tje
Enclosure

FUTURE DIRECTIONS FOR THE AAMC

1. Mission

The proposed mission statement seems adequate. Any mission statement should be simple, short, general and capable of providing a long range view. I agree with those who have made the core mission of medical education a major emphasis. There is a national preception that medical education has become subservient to other missions rather than the other way around. I think the other responses reflect that preception and concern. My own bias is that somehow the AAMC became the principle spokesperson for the CAS and the NIH rather than for the school's as educational entities. While the views of these constituencies are important and relevant, their dominance may have led to some of the voids in activity that are now receiving a larger amount of attention from the COD and COTH.

2. Structure

Clearly, under John Cooper's leadership, the AAMC has become an organization capable of complimenting and rivaling the AMA as a public spokesperson for many elements of organized medicine. It is appropriate that the AAMC be composed of multiple constituencies. However, the relationship of these constituencies to the mission is important to define and establish. For example, if indeed it is the principle national spokesperson for medical education and the nation's 127 medical schools, then the primary emphasis must be directed to the concerns and needs of the schools and their deans. If, on the other hand, it wishes simply to be a general spokesperson for medical education, then the deans and other constituencies need to clarify that role and to redefine the way in which we all relate.

The current structure of the AAMC neglects the vast differences that exist among the nation's medical schools. In my view, the AAMC behaves as if a single, national consensus exists for all issues. I think this accounts for some of the lack of commitment to the AAMC on the part of many deans: It seems as though the AAMC is made up of 127 medical schools which have as their common mission the education of physicians. From that point onward, a great deal of diversity exists. For example, some schools are primarily research oriented, others primarily clinically oriented. The AAMC has been a good spokesperson for the former and a lousy spokesperson for the latter. There are also vast regional differences which effect a school's mission and behavior. In general, the northeast is probably overpopulated with medical schools, and differs from the nation as a whole in that the vast majority of private medical schools are located there. On the other hand, most midwestern, northern and western states have a single medical school which is wholly or at least partially publicly supported; California has a balance of publicly and privately supported schools. As currently structured and administered, the AAMC is unable to deal with the issues of institutional diversity. I think the organizational structure should reflect this situation and be administered to deal with it in a constructive manner. If it did, then the gaps which have been identified by others would be minimized.

3. Governance

I think this area requires a great deal of review. While one can reasonably admire the way in which the AAMC functions, it is important to remember that it functions well because of John Cooper's dedication and personality. When an organization has become dependent on the leadership of a singular, strong personality, it oftentimes has problems when a transition comes. The AAMC must be united when John's successor takes over. Thus, the concept of governance cannot and must not be treated lightly. As I read through the materials and organizational charts, I was disturbed by the lack of continuity between the governance of the constituent members and the AAMC staff. Accordingly, I submit the suggested enclosed table for governance. In contrast to the other materials provided it (1) simplifies the organizational structure; (2) depicts a definitive relationship of the President to the Executive Council; and (3) specifies a dotted line relationship between AAMC staff and AAMC Councils. While the chart probably depicts and reflects the actual operation of the AAMC, it is more explicit than the substance of the other two charts circulated by the AAMC.

I have had considerable difficulty attempting to reformulate the figure depicting organizations with which the AAMC relates. There does seem to be a fundamental flaw in the diagram, however. In my opinion the AAMC is a self-sufficient organization designed to influence and speak on behalf of medical education. In that context it is autonomous and not bound by the views of the other organizations. The chart does not reflect that aspect of AAMC behavior. It does reflect its semi-autonomous role, namely that it members a number of important national and international bodies in which its views are manifested, but muted, by their consensus deliberations.

4. Program Priorities

I sense that this is an area that is coming under greater scrutiny. The program priorities must reflect the mission related to medical education. As we go through a resorting of goals over the next few years, there will be a need to examine how the energies of the AAMC staff are used and to determine if the President and the Executive Council can enunciate the priority areas that require emphasis and work.

It is my view that as we move into the new federalism the role of states and of individual institutions will assume greater importance in medical education. The time has come for the AAMC to adapt to a entire set of behaviors designed to maintain its credibility as the chief spokesperson for the nation's medical schools. To do so it must concern itself with the fabric of all medical schools, not just a few. Thus, it must be ready to deal with all aspects of medical education including graduate medical education; alternate strategies for the teaching of medical education, i.e., more community and ambulatory settings; new forms of research, i.e., technological and service delivery; the importance of practice plans; and new forms of inter-institutional governance.

5. External Relationships

These are and will continue to be important. However, it will be more important for the leadership to pay attention to its internal constituents, particularly the medical schools and teaching hospitals.

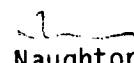
6. Commentary on Issue Paper

I already submitted these to Ed Stemmler.

7. Selection of a New President

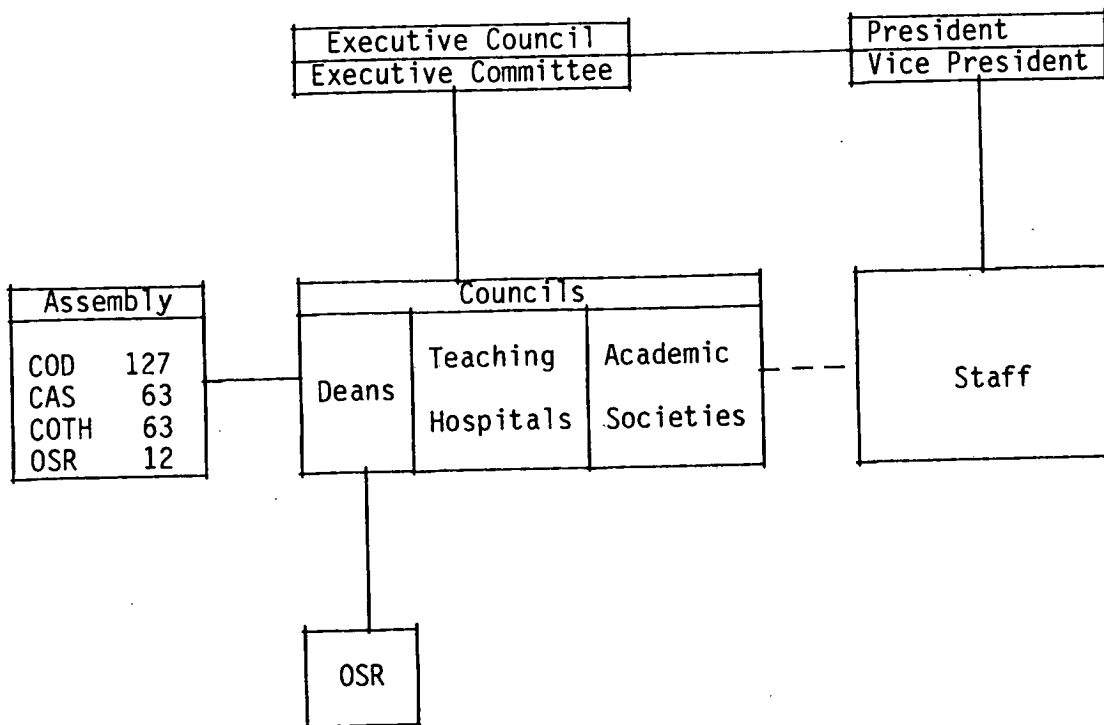
I think the Search Committee is well underway. The next President must have the strength of John Cooper and be able to develop his authority while at the same time encouraging a greater participating role for the Executive Council. The Council will have to be more responsive to its constituent councils. From my vantage point, the spirit of the AAMC seems good, and many well meaning deans, hospital administrators and specialty representatives are prepared to contribute to the organization's work. The new President will be able to capture this spirit if he is willing to encourage participatory management in an effective manner yet able to enunciate the organization's primary mission succinctly and consistently.

Respectfully submitted,


John Naughton, M.D.
Vice President for Clinical Affairs
Dean, School of Medicine

JN:tje
Enclosure

SUGGESTED REVISION FOR DEMONSTRATING AAMC GOVERNANCE STRUCTURE





MEHARRY MEDICAL COLLEGE

WALTER F. LEAVELL, M.D.

DEAN
SCHOOL OF MEDICINE

November 9, 1984

Joseph Keyes, Esq.
Department of Institutional
Development
Association of American
Medical Colleges
One Dupont Circle, N.W.
Washington, DC 20036

Dear Joe:

This will probably reach you a day late, since being out of the office for approximately a week during the annual meeting of the AAMC has placed me somewhat behind schedule. Nonetheless, I wish to follow through with my responsibilities as a member of the Administrative Board of the Council of Deans in providing the requested input on the various position papers.

By way of general comment upon re-reading the three (3) position papers, the similarity between the Council of Academic Society's (CAS) and the Council of Dean's (COD) papers was remarkable. The Council of Teaching Hospital (COH) was also focused on the mission of the Association. However, the majority of the paper related to the unique perspective of the teaching hospital in a changing environment of the health care delivery system.

If I can be of additional assistance, please do not hesitate to call upon me.

Sincerely,

Walter F. Leavell, M.D.
Dean, School of Medicine and
Director, Medical Affairs,
Hubbard Hospital

WFL:gjt

18a/19

CRITIQUE OF COD, COTH, AND CAS POSITION PAPERS

Organizational Structure and Mission

The AAMC, as a complex representative federation of academic medical constitutencies, requires a mission statement which is concise, consistently contemporary and reflective of the organization's basic orientation. In my judgment, the current mission statement, without modification, meets these criteria. More specificity would ultimately lead to a loss of contemporariness.

The three (3) position papers (COD, COTH, CAS) are concurrent on the mission. The COTH paper relates to the complexities of being a teaching hospital in support of the mission, while simultaneously maintaining competitiveness in a rapidly changing environment.

Organizational Structure

The current organizational structure appears to have the necessary flexibility to accommodate new constituent groups or constituent interests as the need identifies itself. However, each of the constituent groups recognizing the focus, prioritization and unique requirements of its own subset, tend to seek structured and focused identities within the AAMC. Within the Council of Dean's itself there is regionalization and specialization (free-standing medical schools, and clinical based medical schools).

The COTH increasingly must examine its interfacing relationship with the medical school. This examination is not being done on a philosophical basis, since by definition COTH would not exist unless it is structured as an academic health care delivery system. However, it must also maintain its existence and competitiveness in the marketplace. Several constituent groups (GSA, GME, and GMA) view themselves as organizationally insulated within the AAMC, since their structure does not show up on the organizational chart as do Councils.

In my judgment, if the Association is to have credibility as it would relate to the implementation of the G-PEP Report, focusing on our primary mission of medical education the structure of the AAMC must be organizationally representative in a demonstrable manner.

Name of Association

It is my impression that the discussion concerning a potential name change derives, not from the fact that constituencies have indicated the name itself (AAMC) is not representative of their focus and participation, but rather whether the organization is responsive in a comprehensive manner to the constituent needs. For example, if the COTH becomes an autonomous unit, its first action to remain viable would be to form a linking affiliation with the "AAMC."

Changing the name of any organization is a serious undertaking and the current name recognition in Washington on the legislative level and elsewhere has gained a status and symbolism which would be difficult to duplicate during a reasonable period of time. Any consideration of name change, therefore, should have response and reaction from the external environment as well as internally. This would also present a similar problem for any group seeking its own autonomy and, therefore, adds additional rationale for their remaining within the AAMC. However, the Association, through whatever mechanisms necessary, must be viewed as being totally responsive of each of its diverse constituent groups. This may require greater focus at the various meetings, particularly the Annual Meeting and comprehensively interactive dialogue at the Executive Level of the organizational structure.

Focus of the Association

The focus of the Association should continue to be on medical student education with graduate education being an important variable in the continuum of this educational process. Reflecting this statement, it must also concern itself with the quantity and quality of the applicant pool and, therefore, concern itself with some aspects of the undergraduate educational process. This is recognized in the CAS position paper, as well as in the COD position paper. COD approaches the issue through strong support of the recommendations of the G-PEP, while CAS added the dimension of accreditation, licensing and certifying authority.

Funding Medical Education

There appears to be a uniformity of concern regarding the most appropriate means of funding medical education. The COD expresses an aggregate and comprehensive concern in terms of

institutional support, as well as availability of loans and scholarships for students. The CAS similarly is concerned while the COTH expresses a need for identifying support for academic programs within its constituent environment. The COD, COTH and CAS are each equally concerned about the necessity and dependency on clinically derived income for supporting medical education and the consequences of this dependency, as it would relate to changes in policy by third party payers and legislative bodies.

Research

Both the COD and CAS express strong sentiments in their position papers concerning adequacy of research funding and the support that this traditionally has provided the academic institutions. The Council of Teaching Hospital, likewise, are cognizant of the important role of research. However, they must also concern themselves with cost containment and have the need to be assured that research is paving its own way.

Finally, it would appear that the membership is not seeking a specific organizational change in structure, but wishes to be assured that the Association is truly representative of all participants, is dynamic, adaptable, maintains flexibility and is responsive to the input and concerns of its membership.

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

November 8, 1984

Joseph A. Keyes, J.D.
AAMC
One Dupont Circle
Suite 200
Washington, D.C., 20036

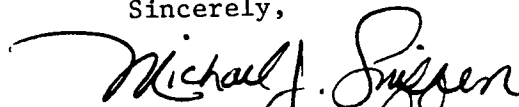
Dear Dr. Keyes:

At Tom Meikle's request, I am forwarding to you a synopsis of his thoughts regarding the AAMC's planning process. The enclosures illustrate a classic approach to planning in the following sequence:

1. Reexamination and possible redefinition of the Mission of the organization and formulation of supportive goals.
2. Identification of the external forces confronting the organization's constituencies.
3. Assessment of the AAMC's current activities, organization and leadership.
4. Development of operational strategies to best serve the constituencies interests in the immediate future.

I trust the attached outline and notes of my conversations with Tom are self-explanatory. If not, do not hesitate to call. Because I am sending you this letter while Tom is away, he has not had the opportunity to review and, he may have further thoughts when he returns.

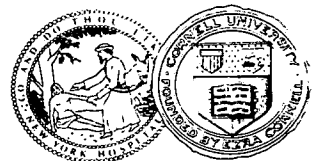
Sincerely,



Michael J. Sniffen
Director of Planning

MJS:tj
enclosures

c.c. Thomas H. Meikle, Jr., M.D.



OUTLINE

Critical Issues: AAMC

- I. Mission, including identification of constituencies and options
 - A. Society for the advancement of medical schools and teaching hospitals
 - B. Society for the advancement of medical schools
 - C. Society for the advancement of medical education
- II. Program Areas: problems confronting constituents
 - A. Medical Schools
 1. Undergraduate medical education
 2. Graduate medical education
 3. Continuing medical education
 4. Medical School Financial support
 - B. Teaching Hospitals
 1. Patient Care activities
 2. Educational activities
 3. Research activities
 - C. Faculty
 1. Educational activities
 2. Research activities
- III. Organization of AAMC
 - A. Job description of president
 - B. Governance
 - C. Staff organization
 - D. Funding support
 - E. Major activities or functions in support of programs
- IV. Operational Strategy (see attached)

IV. OPERATIONAL STRATEGY

ILLUSTRATION

Action Issue	Advocacy of AAMC Positions	Information for Constituents	Education of Constituents & Others	Liason with Other Organizations	Research on Appropriate Topics	Participative - Commun. among Constituents	→
<u>Graduate Medical Education</u>							
° How to control quality & by whom	+ + +	+ +	+	LCME	+ +	Committee	
° How to finance	+ +	+	+ +	HCFA, AAHC	+ + +	Paper	
° Should FMGs continue to be accommodated	+ +	+	+	LCME	+ + +	Conference	
° Should the supply of specialty positions be regulated	+	+ +	+	LCME	+ +	Paper	
° How to attract graduate to underserved areas	+	+	+	HHS	+	Committee	
↓	+ = level of support						

Critical Issues: AAMC

I. Mission, including identification of constituencies: options

A. Society for advancement of medical schools and teaching hospitals

1. more restrictive than AAHC, excluding other health professional schools, etc.
2. broader than present mission, as reflected in By-Laws.
3. reflects increased importance of teaching hospitals: co-equal.
4. president might be primarily experienced in hospital affairs.

B. Society for advancement of medical schools

1. broader mission than only medical education, as at present.
2. includes research, service in addition to education.
3. missions of teaching hospitals not comprehensively considered.
4. president would be from medical school environment.

C. Society for advancement of medical education

1. represents current mission, statement which fails to reflect current activities and governance of AAMC.
2. might suggest person should be a known medical educator.

II. Program Areas = problems confronting constituents

A. Medical Schools

1. undergraduate medical education

- student selection; role of MCAT
- should enrollments be reduced; how to regulate supply/demand
- how to discourage study in inferior foreign medical schools
- will adequate numbers of qualified applicants be available
- how to broaden racial and socio-economic diversity
- how to encourage and finance needed changes in medical curriculum
- how to obtain increased financial aid for needy students
- how to avoid continuing large increases in tuition
- what is appropriate role of LCME; NBME

2. graduate medical education

- how to control quality and by whom
- how to finance
- should FMGs continue to be accommodated
- should supply of specialty positions be regulated
- how to attract graduates to underserved areas

3. continuing medical education

- is CME successful in improving the quality of health care

4. medical school financial support

- how to maintain fiscal stability in environment of change
- how to preserve appropriate balance of research/education with increased commercialization of medical service
- how to control faculty practice plans
- how to determine educational costs

B. Teaching Hospitals

1. Patient care activities

- how to maintain physicians control of patient management
- how to evaluate quality of care in era of cost containment
- how to adapt to a competitive environment
- how to respond to investor-owned initiatives
- how to identify appropriate marketing strategies
- how to develop management/financial data
- how to fund the care of charity patients
- how to determine costs per case
- how to handle ethical problems

2. Educational activities

- what are alternate methods of financing educational costs
- how to maintain reimbursement policies which support medical education and research

3. Research activities

- how to maintain indirect support for clinical research

C. Faculty

1. Educational activities

- how to improve quality of teaching
- how to increase teacher-student interaction
- how to increase importance of teaching and education in medical school environment
- how to support faculty for educational activities directly

2. Research activities

- how to attract bright, creative young faculty in era of reduced or at least stabilized funding for research
- how to maintain graduate programs in research with decreased federal support
- how to make research careers attractive especially to MDs
- how to insure stable, adequate funding for biomedical/behavioral research and research training
- how to achieve balance between support for program projects and individual investigator-initiated projects
- how to improve funding for new equipment and the construction or renovation of research facilities

- how to achieve appropriate balance between direct and indirect support of research costs
- how to develop appropriate regulations for control of research wastes, animal and human subjects in research, and genetically-engineered research products
- how to encourage and appropriately utilize research support from industry

III. Organization of AAMC

A. Job description of president

- qualifications, experience
- authorities, responsibilities
- term of office; reviews

B. Governance

- are COD, COTH, CAS co-equals; should they be equally represented on Executive Council
- COTH: should hospital CEO be representative of TH
 - is membership too broadly defined
 - is widespread constituent participation fostered
 - is regional representation balanced
- CAS: is CAS co-equal with COD and COTH
 - is CAS effective within AAMC
 - does CAS communicate adequately with constituent societies
- COD: does the current structure foster and support interactions among medical schools with common interests
 - should the relationship of GSA, GME, OSR, etc. to the COD be defined better
 - should regional groups be actively encouraged and supported

C. Staff organization

- do the departments and divisions of AAMC and their levels of staffing reflect the associations priorities

D. Funding - support

- is the AAMC too dependent on MCAT revenues
- are the dues appropriate for each constituency
- should more support be sought from foundations and governments

E. Major activities or functions in support of programs

- advocacy of AAMC positions
- information for constituents
- education of constituents and others interested
- liaison with other organizations
- research on appropriate topics
- participation-communication among constituents



HENRY P. RUSSE, M.D.
VICE PRESIDENT FOR MEDICAL AFFAIRS
DEAN, RUSH MEDICAL COLLEGE

February 12, 1985

Mr. Joseph Keyes, Jr.
Director, Department of
Institutional Development
Association of American
Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Joe:

Here is my belated response to your request for my comments on future directions for the AAMC. It is organized along the lines of the redbook for the last agenda for the Council of Deans Administrative Board Meeting.

I believe the mission of the AAMC is well described by the current mission statement. It seemed the consensus of those ideas expressed at my first administrative board meeting following the annual meeting in Washington bore out this impression. I believe the focus of the Association should continue to be undergraduate and graduate medical education with the component societies of the Council of Teaching Hospitals and the Council of Academic Societies lending their support to these activities.

The structure of the AAMC is one which has allowed great flexibility representing all of its participants in a responsive and dynamic interactive whole. This was clearly evident to me during the year that I spent as a Scholar in Residence at the Association and the only suggested change that I make is that there be efforts to increase effective communication between the major councils. In particular, I refer to the fact that I am unfamiliar with any interactions between the Council of Academic Societies and the Council of Deans, either regionally or nationally, whereas interaction between the Council of Teaching Hospitals and the Council of Deans, I believe, occurs much more regularly. I do not believe there is any need for the creation of a new council for faculty affairs, although I might be persuaded in this direction.

Page Two
February 12, 1985
Mr. Joseph Keyes, Jr.

Regarding the governance of the Association, I would second comments made by many of my colleagues that the importance of the Council of Deans be maintained in any considerations of governance or the reordering of the current governance structures. I would concur with comments by Ed Stemmler that John Cooper has managed to balance the governance of the Association extremely well during his tenure. I am pleased that Ed Stemmler and Bud Brown have sought to broaden the participation of the deans within the governance and feel that even as a new administrative board member, I am truly involved in matters of governance. At the most recent meeting of the Executive Council, I feel that the administrative board members and their comments were indeed welcome and were informative in the deliberations of the Executive Council.

Each of us has our own program priorities but for me the critical ones are curricular reform and to this point I refer to our own alternative curriculum experimentation, the funding of graduate medical education so critical to all of us, and the continued emphasis on the identification and preservation of funding for research activities in the medical colleges. Additional high priority items are those which deal with the generation of flexible dollars, i.e., through medical practice plan activity for support of medical college budgets. Finally, I would agree with Don King and his comments at our last spring meeting that we might do well at some of our gatherings to focus somewhat more on the scientific aspects of medical education and the research that supports these activities. I believe it is critical that we maintain our external relationships with other associations and particularly with the Congress of the United States as we seek to continue to be a voice for all of the component memberships of the Association.

As you will recall, I did focus my verbal comments to you largely upon the issues paper in a relationship of the Council of Deans to the Council of Academic Societies and their joint and separate goals.

I would agree with Sherm Mellinkoff that the Association, in order to be effective nationally, needs a leader who is not a replacement for John A.D. Cooper but certainly one who has all of the same excellent characteristics which he has demonstrated for so long.

My apologies for the delay in getting my thoughts to you. I shall look forward to seeing you at the spring meeting.

Sincerely,



Henry P. Russe, M.D.

HPR/ds



OFFICE OF THE DEAN
UCLA SCHOOL OF MEDICINE
CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

November 14, 1984

Arnold L. Brown, M.D.
Dean
University of Wisconsin Medical School
1300 University Avenue
Madison, Wisconsin 53706

Dear Bud:

Yesterday I received a thoughtful letter from you reporting on recent activities of the Council of Deans and asking us to send to Joe Keyes (as I am by copy of this letter) any suggestions we might have regarding the mission or goals of the COD.

First, let me send to you heartiest congratulations upon your election as Chairman of the Council of Deans, and also upon your appointment to the Search Committee with the century's most difficult and important task in American medical education, i.e. the selection of a successor to John Cooper.

Second, I am truly sorry that the start of a conflicting meeting of Alpha Omega Alpha (the last one for me as retiring president) required me to leave the COD meeting before Charlie Sprague's discussion of the recent history of the AAMC and directions for the future. Others reported to me that Charlie's comments were right on target, and it would be my strong guess that his thoughts on these subjects would be very close to or identical with my own. We served for a long time together on the Council and have over the years developed, rightly or wrongly, the same general view of medical education and biomedical research. Thus anything I might say now is probably redundant, but since I missed that part of the COD discussion and in order not to seem, in contrast to my intent, unresponsive to your call for expressions of interest, I will try to answer your questions as best I can.

It seems to me that the central purpose of the Council of Deans is to defend excellence in medical education and biomedical research. Since each dean has his or her own history, local problems and faculty to serve, we can

Arnold L. Brown, M.D.
November 14, 1984
Page 2

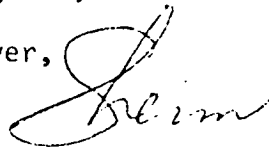
only be effective on a national scope by supporting and working with an intelligent, honorable, well-educated, altruistic, conscientious and talented President like John Cooper. I can remember when we did not have a leader with all those qualities, and the contrast has been very instructive. Problems and issues--both strategic, like defense of the N.I.H. from political harassment and opposition to the "animal rights" zealots, and tactical, like mobilizing a "red alert" or contacting a few key people in the Administration or Congress on a sudden burst of "confused lucidity," as when there was a proposal to augment class size by 5 percent by taking transfer students from foreign medical schools without regard to academic performance--arise almost constantly. The massive job of keeping abreast of those problems and issues cannot be done by large groups such as the COD, the COTH or the Council of Academic Societies, although all of those groups need to be alerted to the problems by the AAMC's central office and need to support the AAMC's constant vigilance on behalf of us all--each contributing to the common weal whenever the opportunity to help arises.

Therefore, the most important single thing in our combined efforts is to have a President like John Cooper. Naturally, that person needs a great staff, and John has consistently picked winners. This uncanny ability is part of the character of a great President.

Best of luck in your two exceedingly important roles at the national level, chairing of the COD and serving on the Search Committee.

With much appreciation and warmest regards,

As ever,



SHERMAN M. MELLINKOFF, M.D.

SMM/ar

cc: Mr. Joseph Keyes ✓
Dr. Charles C. Sprague

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DEAN

SCHOOL OF MEDICINE
DAVIS, CALIFORNIA 95616

November 16, 1984

Joseph A. Keyes, Jr., J.D.
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Joe:

As you know, Bud Brown has written to us suggesting that we give you our views on what the AAMC should be doing and what its future direction should be. I have two simple recommendations. First of all, press on with the emphasis on medical education. This should remain one of our primary goals, and the strong effort made this year with the GPEP Report should be continued in the future.

Secondly, another major mission of medical schools is research. There are many issues surrounding research, such as, funding, industry-university relationships, and research fraud which deserve the attention of the AAMC. I realize that some of these topics have been dealt with in the past, but I believe more work needs to be done on a continuing basis.

Personally, I am becoming more and more discontented with the amount of time and effort that goes into the discussion of financial matters in the medical school. Somehow, we have to balance this with discussions and efforts in more scholarly things. The AAMC should lead the way in these kinds of activities.

I hope these brief thoughts are of some use to the Association.

Sincerely,

Hibbard E. Williams, M.D.
Dean

HEW/jrp

cc: Arnold L. Brown, M.D.
Dean, University of Wisconsin

UNIVERSITY OF WASHINGTON

SEATTLE, WASHINGTON 98195

*School of Medicine
Office of the Dean*

January 8, 1985

Mr. Joseph A. Keyes, Jr.
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Joe:

Shortly after the AAMC meeting in Chicago, I received a letter from Dean Arnold Brown at the University of Wisconsin, concerning future directions for the AAMC. Clearly, a most important immediate task is the selection of John Cooper's successor. In my opinion, it is very important for the AAMC to remain a strong and encompassing organization bringing together the specialties of medicine, the teaching hospitals which support the activities of medical schools and the schools and colleges of medicine. We are in a period of close surveillance and stern criticism of all aspects of medicine. We need an articulate spokesman to lead the AAMC, as well as a careful plan for broad based participation in planning the future of American medical education.

There are many important issues the AAMC will need to address soon. Among these are:

1. Schools and students. The number of medical schools and medical students in the U.S. I frankly feel this is a time for thoughtful introspection and tough external reviews of the activities of the member schools. I hope the AAMC and the Council of Deans in particular will be farsighted in their consideration of this important matter.
2. The curriculum. At the present time, a very practical problem facing medical schools is the three-way struggle over the medical student curriculum. Schools have maintained that this is rightly their domain as academic institutions. On the other hand, the National Board of Medical Examiners and other test writing organizations are often more powerful than the curriculum committee to standardize and rigidify the medical curriculum. State boards are increasingly asserting their influence on the schools curricula by prescribing specific weeks and years of training to qualify for medical licensure. The AAMC

Mr. Joseph A. Keyes, Jr.
January 8, 1985
Page Two

and the Council of Deans needs to consider the implications of this struggle over the curriculum again.

3. Professional standards. I am very concerned about maintaining and improving what might be called the "valued qualities of our profession." By this I mean the role of the physician as a servant of others, who has the highest of ethical values, a lasting concern for the care of the patient and a continuing interest in the scientific basis of medical practice. We are facing a time when economic incentives, competition, "defensive medicine" and selfish interests are becoming a major burden to our profession and society at large. I would like to see us reassert the professional values which have given medicine its valued position in our society. We should work to define ways to bring a fresh emphasis on this aspect of the selection and training of medical students and residents.
4. International Medical Education. I personally would like to see the AAMC take an active interest in international medical education. We have many significant scientific or technical accomplishments; we should find ways to share these with our colleagues who teach medicine abroad. I do not believe that the gap between medicine in our country and that in many underdeveloped countries is simply a problem of resources. I am sure we could learn much, as well as contribute much, by stronger relationships with medical schools abroad.
5. Relationships. I believe the AAMC will be most effective as it works with other organizations and bodies interested in the future of our profession. Through the establishment of joint committees and liaison relationships, the AAMC should actively participate in the development of long-term health policies.

I hope these few comments are useful. I look forward to seeing you again at the Spring meeting of the Council of Deans.

Sincerely,



David C. Dale, M.D.
Dean

DCD:jah

cc: Dr. Arnold Brown
Dr. John Cooper

DRAFT REVISED BY OSR BOARD (BUT NOT SUBSEQUENTLY REVIEWED BY IT)

CHALLENGES IDENTIFIED BY THE ORGANIZATION OF STUDENT REPRESENTATIVES

Background

Along the lines of the self-examinations recently conducted by the three AAMC Councils, the OSR also has been conducting an inventory and looking ahead to the coming transition in AAMC leadership. The OSR Administrative Board has developed the following summary of its deliberations and submits it with the hope that the AAMC officers will find it useful as part of the on-going examination of AAMC's mission. The project is conceptualized as including the following five sections, but only the first three have been completed by the Board:

- A) Role of OSR in AAMC
- B) Role of OSR Members at the Schools
- C) Recurring Issues Raised by OSR
- D) OSR Perspectives on Issues Raised by the Councils
- E) Ideas for AAMC Future Directions

A) ROLE OF OSR IN AAMC

At the 1971 AAMC Annual Meeting, the student representatives adopted and the COD approved "OSR Rules and Regulations". In brief, OSR was created with the following purposes in mind: 1) to facilitate the expression of students' ideas and views; 2) to incorporate students into the governance of AAMC; 3) to foster the exchange of ideas among students and other concerned groups; and 4) to facilitate students'

action on health care issues. Evidence of these four goals is woven throughout this paper.

The built-in mechanisms for OSR participation in AAMC programs and policy development are the OSR chairperson's attending and reporting OSR actions at COD Administrative Board meetings and provision of two voting seats on the Executive Council and 12 on the Assembly. The OSR also has input into the affairs of the AAMC through membership on some AAMC committees. More informal opportunities for information exchange with AAMC officers occur during the quarterly meetings when the OSR Administrative Board joins the other Boards for luncheons, receptions and programs. In addition to these mechanisms, at regional spring meetings important ties are established between OSR and GSA and sometimes GME members. Also the OSR chairperson is a member of the GSA Steering Committee.

Limitations to OSR's effectiveness are inherent in the differences between students and those with line responsibilities for the functioning of an educational institution. Lacking practical administrative experience and the historical perspective which naturally accrues, students cannot bring to the deliberation of many issues in academic medicine as high a level of expertise as officers of the other Councils. Also the environment in which AAMC and its associated institutions operate is very complex. But the students elected to the OSR Board have sought exposure to and recognize their stake in the issues under consideration; and these students, with the guidance of materials and reports from AAMC staff, do achieve a broad level of understanding of them. At times, because they are not

protective of any particular domain or argument, students can contribute in particularly creative and socially responsible ways.

A related hindrance in the OSR Board's participation is that each year usually seven of its eleven members are new to the Board, in contrast to the three-year terms of members of the other Boards. Only the person elected to the office of chairperson-elect serves a three-year term. Occasionally a student will run for one of the other positions and be elected two years in a row. While achieving greater continuity of service on the Board would be desirable, no feasible method is available if the flexibility of the current election procedures are to be retained. One positive byproduct of the present arrangement is that more students benefit from the opportunity to be active at a high level within the AAMC, thus extending AAMC's role as nurturer of future leaders in academic medicine.

Two other kinds of OSR contributions can be mentioned. The programs it sponsors at the annual meeting and GSA regional meetings frequently add breadth to the meetings and are attended by other constituents. Good examples are recent annual meeting sessions on "interacting with nurses" and on "physicians' social responsibilities vis-a-vis preventing nuclear war". The OSR Administrative Board continually monitors the design of its annual meeting program to make maximum use of students' limited time together. OSR Report also contributes in important ways to the Association's on-going activities by directly assisting medical students across the country to give serious consideration to areas not usually covered in their curricula, e.g., the physician manpower scenario, ethical responsibilities of medical students, cost containment, influencing the health legislation

process, computers and medical education. In addition, issues of this publication have been incorporated into student handbooks and into course materials at some schools. The OSR Administrative Board is committed to assuring the continued quality of OSR Report, at the same time as it would like to see it produced three or four rather than the present two times per year and expanded to include more student-written material.

B. ROLE OF OSR MEMBERS AT THEIR SCHOOLS

The "OSR Rules and Regulations" state that "members of the OSR shall be . . . selected from the student body . . . by a process appropriate to the governance of that institution." The OSR Certification Form which deans are annually requested to sign and return to AAMC asks for a brief description of the selection process. The activity levels and structure of student governments vary a lot from school to school, thus so does the selection process for the OSR member. Quite a combination of methods are used, from screening of candidates by the student council with appointment by the dean, to selection by a student executive committee, to election by one class or by total student body. In order to establish continuity of OSR representation from year to year and to stabilize the role of OSR at the schools, very desirable goals in terms of OSR effectiveness at all levels, schools are periodically encouraged to examine what can be done to achieve these goals. Particularly helpful are procedures allowing: 1) recruitment of freshmen for the position; 2) extended terms, i.e., more than one-year; and 3) selection of an alternate or "junior" as well as official OSR member who attends meetings for a year before becoming the school's official representative. Because these ideas can

only be suggested to schools and because OSR is only one of a number of student organizations, many schools still limit the tenure of an OSR member to one year and do not assure prior OSR-exposure. Sharing of materials and advice between the departing and arriving representative does facilitate continuity and appears to be occurring more frequently than in the past.

The OSR Administrative Board is concerned about some schools' poor records of OSR representation at annual and regional meetings. Twenty schools with certified OSR members did not send a student to the 1984 annual meeting; fifteen is a more usual number. When students do not attend, it is not known whether a problem in locating travel funds was primarily the reason or if examination schedules or inability to procure time-off from a rotation were larger factors. The OSR Administrative Board is initiating activities designed to increase meeting participation, including a memo to student affairs deans requesting their support and more phone communication within regions.

The role of the OSR member at the medical school begins as an information channel. OSR members are urged to share with their student council or government, if not with the whole student body, reports of AAMC/OSR activities which they receive via OSR Board meeting minutes, Weekly Activities Report, etc. The most frequently used methods of transmitting information are placing items in the student newspaper and giving reports at student government or class meetings. Other methods include in-person announcements to classes; bulletin board postings in the student lounge area; and establishment of an OSR file in the student affairs office or library. Some OSR members also staff an OSR table at Freshmen Orientation, informing incoming students about a

number of issues, including OSR activities. There are two other important roles to be mentioned. The OSR representative is urged to take the lead in generating student input to the LCME accreditation and school self-study process. Shortly after student representation was achieved on the LCME, a student guide to the accreditation process was prepared; an updated version of this handbook is distributed to OSR members at schools with upcoming site visits. OSR members also are responsible for the distribution to each student of OSR Report.

In order to assist potential and new OSR members to better appreciate these responsibilities, the OSR Administrative Board is preparing a description of OSR member duties and functions. This will serve as a supplement to the OSR Orientation Handbook and will be distributed to student affairs deans in the fall along with the OSR Certification Form. OSR can also serve as a vehicle for action, and are periodically asked by the AAMC to generate letters, usually in support of financial assistance programs. In the recent past, many have worked hard and in laudable cooperation with deans, financial aid officers, and other medical student groups to produce mail to Congress. For the 1983 annual meeting students were also prepared with background materials and guidelines to visit their elected officials while in Washington. The OSR Administrative Board believes that OSR can improve its effectiveness as an action vehicle by providing members with a more comprehensive education on lobbying techniques than they have previously received. Presentations on this subject are planned for the spring meetings, and a Board member has been appointed as a liaison with AAMC legislative analysts. The other Board members also will

become more active in visiting their Congressmen while in Washington for meetings.

C. RECURRING ISSUES RAISED BY OSR

During its first 10 years of existence, the primary method employed by OSR to generate, discuss and present issues was via resolution. Individual members or regions would prepare these before or during the Annual Meeting and distribute copies at the business meeting. Frustrations with this process included OSR members' inflated expectations about actions that would follow from resolutions and repeated focus on language rather than issues. In 1982 OSR began using the "group process" method to select the issues on which to focus and then divided into small groups for discussion. The output from this process is in the form of reports, prioritizing students' concerns and usually including assessment of positive and negative forces relative to progress in that particular area. While this method too is sometimes limited by vagueness regarding who is expected to act and how to address disincentives and barriers to action, it appears preferable to the "resolution" method because it allows greater information exchange among students and encourages refinement rather than repetition of issues; moreover, the Administrative Board finds the group reports more useful than "resolved" clauses as a guide to its activities over the year.

An examination of the minutes of the Annual Business Meeting allows a listing of those issues of continuing concern to the OSR. While there is overlap among categories, it is possible to divide the issues into those addressed: A) to medical schools, B) to AAMC, and C) in general.

A. Medical Schools

1. Establish, with student input, policies on delayed matriculation and leaves of absence
2. Foster social awareness in medical students and seek evidence of this in applicants
3. Eliminate the use of National Boards for promotion
4. Greater use of student evaluations of courses
5. Greater emphasis on primary care and preventive medicine
6. Greater emphasis in the curriculum on communication skills and human values
7. More teaching about cost awareness and professional ethics
8. Improve Introduction to Clinical Medicine/Physical Diagnosis courses
9. Improve the integration of basic and clinical sciences
10. Improve medical student access to computers and information sciences
11. More emphasis on learning skills and use of alternative evaluation methods
12. Create environment to promote excellence in teaching
13. Encourage faculty research in improving teaching and evaluation methods
14. Build-in mechanisms to help medical students improve their teaching abilities
15. Create stress management programs
16. Better financial aid and financial management counselling
17. Better counselling on selecting residencies, using NRMP, and selecting extramural electives

B. Association of American Medical Colleges

1. Increased regular housestaff participation in the AAMC with greater attention paid to: 1) the role of housestaff as educators and evaluators of medical students, 2) frequently poor quality of resident supervision and education, 3) problem of increasing competition for graduate positions, and 4) resident stress and their need for support and counselling mechanisms.
2. Greater detail in school information published in Medical School Admission Requirements so that applicants can better differentiate among schools, e.g., percent of out-of-state applicants interviewed.
3. Create workshops for faculty to improve teaching skills
4. Continued fostering of government sources of financial aid and assisting schools in sharing information about innovative financing methods
5. Endorsement of service-contingent loans

C. General

1. Medical students' need for ethical guidelines in the clinical years
2. Encourage greater use of the University Application Form for residencies
3. Opposition to Federal budget cuts affecting health care delivery to the indigent and request institutions to document the effects of budget cuts on the indigent

4. Support for data collection and improved guidance available to medical schools in the areas of specialty choice and career planning
5. Better sharing of information on medical student-sponsored community projects
6. Better sharing of information on successful medical school programs which encourage personal development, e.g., health awareness workshops, and support groups
7. More research opportunities for medical students

The values of OSR members' raising and considering these issues are many. Other AAMC bodies and AAMC staff learn about the present priorities of the most immediate consumers of medical education. Medical students take home information about programs, courses, trends on-going at other schools; many OSR members effectively share such information via the student newspaper, class announcements, student council meetings, etc. In addition to gaining facts and ideas, students also incorporate enthusiasm about the ability to make a difference at their schools and become better able to motivate other students along these lines. In this way, new programs at schools are begun, e.g., a student-planned and run day-long introduction to clinical responsibilities, including a manual; and a student-initiated alumni telethon for loan funds.

The most tangible results of OSR's raising of issues are the products given national distribution. Good examples are OSR Reports devoted to: 1) taking part in the health legislation process, 2) a guide to financial planning, 3) strategies for dealing with the residency selection process, 4) facing the challenges of the physician

manpower scenario, 5) understanding stresses of medical education and practice, 6) responsibilities of medical students vis-a-vis the rising costs of health care, 7) uses of computers in medical education, 8) the role of National Boards in medical education, 9) ethical responsibilities of medical students, and 10) economic changes affecting medical practice. Other products which have emerged in recent years which have been and are of continuing value at the medical schools are: 1) model due process guidelines, 2) model residency evaluation form (to create a file of alumni overviews to assist senior students in selecting residencies), 3) descriptions of innovative counselling program on specialty selection, 4) listing of medical Spanish resources, and 5) listing of contact persons and basic information on extramural electives.

At present, OSR priorities include keeping GPEP alive at the medical schools (the spring OSR Report recommends to students how to work toward this goal) and distributing a compendium of courses at U.S. medical schools utilizing computers for educational purposes.