



PROGRAM PLANNING COMMITTEE

Stephen M. Ayres, M.D.
William T. Butler, M.D.
D. Kay Clawson, M.D.
William B. Deal, M.D.
John W. Kendall, M.D.
Louis J. Kettel, M.D.
Robert H. Waldman, M.D.

**ASSOCIATION OF
AMERICAN MEDICAL
COLLEGES**

**COUNCIL OF DEANS
SPRING MEETING**

Program

April 5-8, 1987
Stouffer's Wailea Beach Resort
Maui, Hawaii

SPRING MEETING of the COUNCIL OF DEANS

April 5-8, 1987

Stouffer's Wailea Beach Resort
Maui, Hawaii

Sunday, April 5

12:00-4:00 pm, Foyer

ARRIVAL & REGISTRATION

SESSION I

4:00-5:30 pm, Wailea Ballroom

WELCOME & OVERVIEW
PRESIDENT'S REPORT
Robert G. Petersdorf, M.D.

5:30-7:00 pm, Luau Grounds

RECEPTION

Monday, April 6

SESSION II

8:30-9:00 am, Wailea Ballroom

CHALLENGES OF TEACHING PREVENTIVE
MEDICINE

Stephen M. Ayres, M.D.
Dean

VCU Medical College of Virginia

9:00-10:30 am

SMALL GROUP DISCUSSIONS

10:30-11:00 am

BREAK

SESSION III

11:00-11:30 am, Wailea Ballroom

CONFRONTING THE NEED FOR GERIATRIC
EDUCATION

Cecil O. Samuelson, Jr., M.D.
Dean & Professor of Medicine
University of Utah

11:30 am-1:00 pm

SMALL GROUP DISCUSSIONS

1:00 pm

UNSCHEDULED TIME

Tuesday, April 7

SESSION IV

8:30-9:00 am, Wailea Ballroom

PHYSICIAN SURPLUS?
TRUTH AND CONSEQUENCES

James A. Pittman, Jr., M.D.
Dean & Professor of Physiology
& *Professor of Medicine*
University of Alabama

Robert H. Waldman, M.D.

Dean & Professor of Internal Medicine
University of Nebraska

9:00-10:30 am

SMALL GROUP DISCUSSIONS

10:30-11:00 am

BREAK

SESSION V

11:00-11:30 am, Wailea Ballroom

TRANSITIONITIS: ACTION STEPS
Peter O. Kohler, M.D.

Dean

University of Texas, San Antonio

11:30 am-1:00 pm

SMALL GROUP DISCUSSIONS

1:00 pm

UNSCHEDULED TIME

Wednesday, April 8

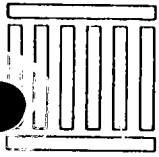
SESSION VI

8:30-12 noon, Wailea Ballroom

COD BUSINESS MEETING

12 Noon

ADJOURNMENT



ALBANY
MEDICAL
CENTER

ALBANY MEDICAL COLLEGE OF UNION UNIVERSITY • ALBANY MEDICAL CENTER HOSPITAL


ACADEMIC HEALTH SCIENCES DIVISION

Robert L. Friedlander, M.D.
Executive Vice President

March 2, 1987

MEMORANDUM

TO: Deans of the Private, Free-Standing Medical Schools

FROM: Robert L. Friedlander, M.D. 
Chairman

SUBJECT: Meeting Dates

As has been our practice, we plan a meeting of the Council of Deans of the Private, Free-Standing Medical Schools in conjunction with the AAMC Council of Deans Spring Meeting.

Our meeting will be held at the Stouffer Wailea Beach in Maui, Hawaii on Sunday, April 5 from 9:00AM to 2:00PM. Shortly, you will receive an agenda for our discussions. As it would be helpful to know how many people to expect at this meeting, my office will call yours in the near future to inquire about your plans.

Of importance for calendar planning are the dates proposed for our "Fall" meeting this year. As you will recall, we decided to accept Hank Mendez gracious invitation to host our meeting in Puerto Rico which is best scheduled slightly later in the academic year than has been our custom. The attached letter from Hank details the dates in 1988 for our meeting; at the Council meeting on April 15, we will need to discuss the schedule Hank and I have proposed.

I look forward to seeing you in Hawaii. Al Sutnick and I are meeting with Paul Jolly next week to discuss further how our membership can maximize the use of the LCME database through our sharing agreement. We have asked Paul to join us on April 5th to detail this project for you. In addition to this agenda item, we have several topics for discussion at our Spring meeting. If you have additional agenda items you wish included, please let me know.

RLF:dgl

Association of American Medical Colleges

Council of Deans

1987 Spring Meeting

**Stouffers Wallea Beach Resort
Maui, Hawaii**

April 5-8, 1987

List of Participants

Deans

Wayne Akeson
June Akeson
UC - San Diego
School of Medicine

Stephen M. Ayres
VCU Medical Coll of Virginia
School of Medicine

Anthony L. Barbato
Mary Gearen Barbato
Loyola University of Chicago
Stritch School of Medicine

G. William Bates
Susanne Bates
Med Univ of South Carolina
College of Medicine

Harry N. Beaty
Georgia L. Beaty
Northwestern University
Medical School

B. Lyn Behrens
Dave Basaraba
Loma Linda University
School of Medicine

Richard E. Behrman
Ann N. Behrman
Case Western Reserve Univ
School of Medicine

Henrik H. Bendixen
Lilo Bendixen
Columbia University
Coll of Physicians & Surgeons

George M. Bernier
Mary Jane Bernier
University of Pittsburgh
School of Medicine

Stuart Bondurant
Peg Bondurant
University of North Carolina
School of Medicine

L. Thompson Bowles
George Washington University
School of Medicine

Arnold L. Brown
Betty S. Brown
University of Wisconsin
Medical School

David M. Brown
University of Minnesota
Medical School - Minneapolis

George T. Bryan
Peggy Bryan
University of Texas
Medical School at Galveston

Lester R. Bryant
Linda H. Bryant
Marshall University
School of Medicine

William T. Butler
Carol Butler
Baylor College of Medicine

Colin Campbell
Catherine Campbell
Northeastern Ohio Universities
College of Medicine

Robert M. Carey
Theodora Carey
University of Virginia
School of Medicine

James J. Castles
Kris Castles
UC - Davis
School of Medicine

John E. Chapman
Judy Chapman
Vanderbilt University
School of Medicine

D. Kay Clawson
University of Kansas
School of Medicine

Richard A. Cooper
Medical College of Wisconsin

Milton Corn
Georgetown University
School of Medicine

Walter J. Daly
Indiana University
School of Medicine

Robert S. Daniels
Vikki Daniels
LSU-New Orleans
School of Medicine

John M. Dennis
Mary Helen Dennis
University of Maryland
School of Medicine

Larry D. Edwards
Ann Edwards
Oral Roberts University
School of Medicine

C. McCollister Evarts
Nancy Evarts
Pennsylvania State University
College of Medicine

Marshall A. Falk
Marilyn Falk
University of Health Sciences
Chicago Medical School

Phillip M. Forman
Shelley Forman
University of Illinois
College of Medicine

Robert L. Friedlander
Mary Lou Friedlander
Albany Medical College
of Union University

Martin Goldberg
Marion Linblad-Goldberg
Temple University
School of Medicine

Joseph S. Gonnella
Linda Gonnella
Jefferson Medical College of
Thomas Jefferson University

David S. Greer
Marion Greer
Brown University
Program in Medicine

Charles G. Halgrimson
Michael Halgrimson
University of Colorado
School of Medicine

James B. Hanshaw
Marian Hanshaw
University of Massachusetts
Medical School

J. O'Neal Humphries
Mary C. Humphries
University of South Carolina
Medical School

Richard Janeway
Katherine Janeway
Bowman Gray School of Medicine
of Wake Forest University

Joseph E. Johnson
Judy Johnson
University of Michigan
Medical School

Tom M. Johnson
University of North Dakota
School of Medicine

Harry S. Jonas
Connie Jonas
Univ of Missouri - Kansas City
School of Medicine

Robert J. Joynt
University of Rochester
Sch of Medicine and Dentistry

Nathan G. Kase
Mount Sinai School of Medicine
of the City Univ of New York

John W. Kendall
Betty Kendall
Oregon Health Sciences Univ
School of Medicine

Louis J. Kettel
Lois B. Kettel
University of Arizona
College of Medicine

Raja N. Khuri
Soumaya K. Khuri
American University Beirut

M. Kenton King
June G. King
Washington University
School of Medicine

Peter O. Kohler
Judy Kohler
University of Texas
Medical School at San Antonio

David Korn
Phoebe Korn
Stanford University
School of Medicine

Marvin Kuschner
Kathryn Kuschner
SUNY at Stony Brook Health
Sciences Ctr Sch of Medicine

William E. Laupus
Evelyn Laupus
East Carolina University
School of Medicine

Richard G. Lester
Louise Lester
Eastern VA Medical School

William H. Luginbuhl
University of Vermont
School of Medicine

Russell L. Miller
Howard University
College of Medicine

Richard H. Moy
Caryl T. Moy
Southern Illinois University
School of Medicine

Henry L. Nadler
Benita Nadler
Wayne State University
School of Medicine

John Naughton
Margaret Naughton
SUNY at Buffalo
School of Medicine

William B. Neaves
Priscilla Neaves
Univ of Texas Southwestern
Medical School at Dallas

Richard L. O'Brien
Joan O'Brien
Creighton University
School of Medicine

Stanley W. Olson
Lorraine Olson
Morehouse School of Medicine

Henry P. Russe
Rush Medical College
of Rush University

Theodore J. Phillips
Donogh Phillips
University of Washington
School of Medicine

Cecil O. Samuelson
Sharon Samuelson
University of Utah
College of Medicine

James A. Pittman
University of Alabama
School of Medicine

William D. Sawyer
Jane Ann Sawyer
Wright State University
School of Medicine

Robin D. Powell
Julie Powell
University of Kentucky
College of Medicine

Rudi Schmid
Sonja Schmid
UC - San Francisco
School of Medicine

Richard C. Reynolds
Mary Jane Reynolds
Univ of Medicine & Dentistry
Rutgers Medical School

Kenneth I. Shine
Carolyn Shine
UC - Los Angeles
UCLA School of Medicine

John C. Ribble
Anne Ribble
University of Texas
Medical School at Houston

Frank G. Standaert
Joan Standaert
Medical College of Ohio

Leon E. Rosenberg
Diane D. Rosenberg
Yale University
School of Medicine

Edward J. Stemmler
Joan Stemmler
University of Pennsylvania
School of Medicine

Richard S. Ross
Elizabeth Ross
Johns Hopkins University
School of Medicine

William Stoneman
Bette Stoneman
Saint Louis University
School of Medicine

Kenneth W. Rowe
University of Cincinnati
College of Medicine

Robert L. Summitt
Joyce S. Summitt
University of Tennessee
College of Medicine

Paul C. Royce
Jacqueline Royce
University of Minnesota-Duluth
School of Medicine

Alton I. Sutnick
Mona Sutnick
Medical Coll of Pennsylvania

Robert E. Tranquada
Janet Tranquada
University of Massachusetts
Medical School

Manuel Tzagournis
Madeline Tzagournis
Ohio State University
College of Medicine

Robert H. Waldman
Jean Waldman
University of Nebraska
College of Medicine

John Wellington
Mary Jane Wellington
University of Hawaii
John A. Burns Sch of Medicine

W. Donald Weston
Michigan State University
College of Human Medicine

Michael E. Whitcomb
Gail Whitcomb
Univ of Missouri - Columbia
School of Medicine

I. Dodd Wilson
Ginger Wilson
University of Arkansas
College of Medicine

Israel Zwerling
Hahnemann Medical College

Distinguished Service Members

David R. Challoner
Jacki Challoner
University of Florida
College of Medicine

Robert L. Van Citters
University of Washington
School of Medicine

William D. Mayer
Donna Dashiell
Eastern VA Medical School

Guests

John W. Colloton
University of Iowa
Hospitals and Clinics

Frank G. Moody
University of Texas
Medical School at Houston

Spencer Foreman
Sandra Foreman
Montefiore Medical Center

Virginia V. Weldon
Washington University
School of Medicine

AAMC Staff

David Baime
Ofc of Governmental Relations

Richard M. Knapp
Senior Vice President

James Bentley
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Div of Inst Planning & Dlvp

Debra B. Day
Edward R. Day
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Section for Accreditation

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August G. Swanson
Ellyn Swanson
Div of Academic Affairs

Kathleen Turner
Office of the President



**association of american
medical colleges**

**AGENDA
FOR
COUNCIL OF DEANS**

SPRING BUSINESS MEETING

SESSION I

SUNDAY, APRIL 5, 1987

4:00 PM - 5:30 PM

Wailea Ballroom

SESSION II

WEDNESDAY, APRIL 8, 1987

8:30 AM - 12:00 PM

Wailea Ballroom

Stouffer Wailea Beach Resort

Maui, Hawaii

one dupont circle, n.w. / washington, d.c. 20036

FUTURE MEETING DATES

1987 Meeting Dates:

Executive Council/COD Admin. Board -

April 15-16
June 17-18
September 9-10

AAMC Annual Meeting -

November 7-12
Washington Hilton Hotel
Washington, DC

COD Spring Meeting -

April 5-8
Stouffer Wailea Beach Resort
Maui, Hawaii

1988 Meeting Dates:

Executive Council/COD Admin. Board -

January 13-14
April 6-7
June 22-23
September 7-8

AAMC Annual Meeting -

November 12-17
Hilton Hotel
Chicago, Illinois

COD Spring Meeting -

March 19-23
Inter-Continental Hotel
Hilton Head Island, So. Carolina

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

SPRING BUSINESS MEETING

AGENDA

* * *SESSION I* * *

Sunday, April 5, 1987

4:00 pm - 5:30 pm

Wailea Ballroom

- I. Welcome & Overview -- Louis J. Kettel, M.D.
- II. President's Report -- Robert G. Petersdorf, M.D.

* * *SESSION II* * *

Wednesday, April 8, 1987

8:30 am - 12:00 pm

Wailea Ballroom

Page

- I. Call to Order
- II. Chairman's Report -- Louis J. Kettel, M.D.
- III. Consideration of Minutes 1
- IV. Discussion Items
 - A. Follow-up on Discussion Group Conclusions -- Louis J. Kettel, M.D.
 - B. Legislative Update -- Richard M. Knapp, Ph.D.
 - C. VA Research Budget -- O'Neal Humphries, M.D.
 - D. LCME Terms of Accreditation -- Richard C. Reynolds, M.D.
- V. Information Items
 - A. Matriculating Student Questionnaire and the Student and Applicant Information Management System 7
- VI. Old Business
- VII. New Business
- VIII. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

BUSINESS MEETING

Ballroom A

New Orleans Hilton Hotel

New Orleans, Louisiana

October 27, 1986

2:00 p.m. - 5:00 p.m.

I. CALL TO ORDER

The meeting was called to order at 2:05 p.m. by D. Kay Clawson, M.D., chairman.

II. QUORUM CALL

Dr. Clawson recognized the presence of a quorum.

III. MOMENT OF SILENCE

Council members observed a moment of silence in memory of Joseph St. Geme, M.D., dean, University of Colorado school of medicine, who died on October 11, 1986.

IV. CHAIRMAN'S REPORT

Dr. Clawson directed the attention of the deans to the AAMC annual report which provided a written summary of Council activities in the past year. He commended the members of the Administrative Board for their work and thanked the Council members who had written to him with their opinions and views on various issues. Dr. Clawson also thanked Drs. Hamlin and Daniels on behalf of the Council for their assistance in arranging the previous evening's dinner/dance and Mr. Keyes and Ms. Day for their staff support.

Dr. Clawson used the occasion of his final report to offer a tribute to deans. As leaders of faculty and students, providers of continuity to the educational program, defenders of high standards in medical education and sources of leadership to achieve those standards, deans are special. Dr. Clawson called on Council members to re-dedicate themselves to their leadership roles in achieving quality in medical education.

V. PRESIDENT'S REPORT

Dr. Petersdorf addressed a number of organizational issues he intended to pursue as the new AAMC president. He intended to have a more specific blueprint for change within one year's time.

Among the issues he highlighted were the representation of housestaff and representation of graduate students and postdoctoral fellows in the AAMC. Housestaff representation appeared to have strong support among the AAMC leadership. Graduate student/fellow representation was viewed as important to the future of academic research. Dr. Petersdorf also wanted to explore with the membership the desirability of revising the AAMC governance structure to achieve parity between deans and hospital directors. He expressed an interest in developing closer ties between the special interests groups of the Association and the governance structure.

The AAMC Executive Committee had been exploring mechanisms for closer relationships with its counterpart in the AAHC, including the possibility of a merger. The leadership of the AAHC had reacted cautiously to these overtures and a longer period of negotiation was foreseen.

Dr. Petersdorf believed that he had inherited an excellent staff but one which he needed to mold better into a team. There were several areas of apparent dyshomeostasis in staff organization, notably the fact that the department of academic affairs related to the Council of Academic Societies rather than to the Council of Deans. Also there appeared to be an overlap in legislative liaison functions among several divisions and departments. The Association was thinly staffed relative to responsibilities. This limited the time available for scholarly activities, taking advantage of the extraordinary AAMC databases, and time available for planning. Dr. Petersdorf was desirous of implementing a strategic planning process.

A questionnaire soliciting views on what the Association should be doing for its membership was mailed to all deans as well as other constituents. Dr. Petersdorf urged Council members to give it their attention. As a further data gathering effort, he announced a program of staff visitation to member institutions in the coming year.

In response to a question regarding the time frame of these decisions, Dr. Petersdorf indicated that organizational issues would be discussed at the officers retreat and that a plan for staff re-organization would be available in January, 1987. The blueprint for future direction of the AAMC would be much clearer by the 1987 annual meeting.

VI. APPROVAL OF MINUTES

The minutes of the April 2-5, 1986 Council of Deans meeting were approved as submitted.

VII. ELECTION OF OFFICERS

Dr. George Bryan, chairman of the nominating committee, submitted that committee's recommendations: for COD chairman-elect, William T. Butler, M.D.; for Executive Council members, Walter F. Leavell, M.D. and

John Naughton, M.D.; for COD Administrative Board members at-large, L. Thompson Bowles, M.D., Henry Russe, M.D., and W. Donald Weston, M.D. The committee also recommended that Hibbard E. Williams, M.D. be nominated to fill Dr. Butler's unexpired term on the Executive Council.

Action: On motion, seconded and passed unanimously, the Council endorsed the nominations of Executive Council members and elected the nominees for COD chairman-elect and Administrative Board members-at-large.

VIII. ELECTION OF INSTITUTIONAL MEMBERS

Action: On motion, seconded and passed unanimously, the Council approved the election of Mercer University School of Medicine to Full Institutional Membership.

IX. REPORTING OF NBME SCORES

The Council discussed a proposal for the AAMC to use its influence to encourage the National Board of Medical Examiners to report its examination scores solely on a pass-fail basis. Several Council members rose to voice support for the proposal arguing that the misuse of scores by residency program directors was a serious concern and that the scores had the effect of driving the undergraduate curriculum in undesirable directions. Other members were equally insistent that the scores provided valuable information that should not be withheld from the faculties and institutions. Ms. Darrow stated that the OSR, in concert with other student organizations, was firmly in support of the proposal. A straw vote taken after the discussion showed Council members divided evenly on the question. Dr. Clawson announced that the Executive Council would be considering the question at its January meeting and would report the results of the discussion to that group.

X. REPORT OF THE AD HOC COMMITTEE ON INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION AND THE TRANSITION BETWEEN MEDICAL SCHOOL AND RESIDENCY

The discussion of this report followed a more elaborate program session devoted to it the previous day. Specific comments included the need for 100 percent adherence to the dates set for transmission of deans letters and a mechanism for monitoring compliance with any newly created traffic rules. The non-specific reference to the "institution" in the report, as that responsible for graduate medical education programs, was noted but explained by Dr. Clawson as unavoidable given the diversity of organizational structures conducting residency training. Dr. Tosteston cautioned that the report was only a first step, and did not deal adequately with larger issues, such as distinguishing medical school responsibilities for general and specialty education, the multiple roles of residents as students, teachers, and providers of service, and the roles of various professional organizations in addressing specific issues. In general however, Council members expressed optimism that there was a consensus on many of the report's recommendations and acknowledged that many of them were under the deans' purview and control. The feeling was expressed that changes only required deans to assume their leadership roles.

Action: On motion, seconded and passed unanimously, the Council expressed its support for the recommendations made by the ad hoc Committee on Institutional Responsibility for Graduate Medical Education and the Transition Between Medical School and Residency. It urged that recommendations under the deans' control be implemented and consensus be developed regarding the implementation of other recommendations among other interested groups.

XI. DESIGNATION OF INTERNS AND RESIDENTS FOR GSL PAYMENT DEFERMENT

Dr. Clawson brought to the Council's attention the practice of some schools of designating interns and residents as students for purposes of extending GSL deferral of payment through residency. The Administrative Board had discussed the issue and drafted the following statement: "This practice is unwise and appears to be contrary to the Congressional intent." Dr. Clawson confirmed that the law is clear in offering only an automatic two year deferment after graduation from medical school to those in residencies and advised Council members to review their policies on this matter.

XII. LEGISLATIVE UPDATE

Dr. Thomas Kennedy, director of the AAMC's department of planning and policy development, reviewed the achievements of the 99th Congress and its impact on AAMC members. That Congressional session had been the most productive in recent memory. A written summary was provided on legislation dealing with tax reform, Gramm-Rudman deficit reduction, FY 1987 budget resolution, HHS and VA appropriations, HEA reauthorization, ADAMHA reauthorization, the use of animals in research, mandatory retirement, drug abuse, vaccine injury compensation, and the small business innovation research program. Dr. Kennedy also reviewed changes in regulations governing reimbursement for indirect costs.

Questions from Council members focused on the effect of legislation dealing with mandatory retirement. The law as written and expected to be signed effectively abolished mandatory retirement at any age. Colleges and universities were to be granted a seven year exemption for tenured faculty. The law was seen as likely to heighten the importance of faculty evaluation systems and spur a major examination of the tenure system.

XIII. REPORT OF STAFF ACTIVITIES

Mr. Keyes reviewed a number of staff activities completed or in progress, many of which proceeded from resolutions introduced by the Council at its spring meeting. These included a survey of high scoring MCAT examinees who subsequently did not apply to medical school, the results of which had previously been sent to deans. Negotiations were underway with the Cooperative Institutional Research Program at UCLA, which annually surveys the career interests of college freshmen, to mount a more expanded study on the attractiveness of medicine. Staff were also beginning to gather information on institutional practices for rewarding excellence in faculty teaching, in response to another interest voiced by the Council.

The AAMC ad hoc Committee on Faculty Practice, formed at the Council's urging and chaired by Dr. Stemmler, had suggested various AAMC programs. One now completed was a series of Management Education Programs (MEP) seminars on academic medical centers' relationships with alternative delivery systems. A small group invitational symposium on adapting clinical education to new forms and sites of health care delivery was planned for December, 1986 and would be chaired by Dr. Butler. A proposal for foundation funding of a study of faculty appointment systems and personnel policies developed by institutions coincident with their strategies for coping in a competitive health services delivery environment had been prepared but had not yet received support.

Mr. Keyes also alerted the deans to a current mailing of the COD Directory and announced that the first loans under the AAMC's MEDLOANS programs had been processed.

Comments by Council members focused on studies of students' interest in medicine. Dr. Lester reiterated a concern that physicians were discouraging young people from entering the profession. Dr. Moy suggested that an increase in the AAMC contribution to the Association for Health Professions Advisors might be appropriate at this time. Mr. Keyes reminded the Council that the joint AMA-AAMC-AHA conference scheduled for early next year would be devoted to the topic of the attractiveness of medicine as a profession.

XIV. INFORMATION ITEMS

Dr. Clawson alerted Council members to various information items contained in their agenda materials dealing with AAMC projects on ambulatory care teaching, model federal policy for the protection of human subjects in research, and recently formed commissions and boards; the Biomedical Ethics Board, the Council on Health Care Technology, the Physician Payment Review Commission, and the Council on Graduate Medical Education.

XV. OSR REPORT

Ms. Vicki Darrow, OSR chairperson, reviewed that organization's activities in the past year. They included publication of a full report on the topics of medical liability and access to medical education, cooperation with the Association of Teachers of Preventive Medicine on a survey of the medical school curriculum, and discussions with other student groups on issues of common interest. The OSR had an active interest in promoting problem-based learning in medical education and was working with AAMC staff on a project proposal. The OSR annual meeting program was on physicians' responsibilities for promoting access to the medical profession. Ms. Darrow concluded her remarks by reiterating the strong support of the OSR for the principles espoused in the GPEP report and expressing its pleasure with the prospect of housestaff representation within the AAMC.

XVI. APPRECIATION FOR DEPARTING MEMBERS OF THE ADMINISTRATIVE BOARD

Dr. Clawson expressed the Council's appreciation to the departing members of the Administrative Board, Dr. Eckstein, Brown, and Moy and presented each of them with a gift.

XVII. INSTALLATION OF NEW CHAIRMAN

Dr. Clawson next introduced to the Council, Louis J. Kettel, M.D., dean, University of Arizona School of Medicine, as its new chairman.

At Dr. Kettel's invitation, Council members stood in a round of applause for Dr. Clawson, for his service to the Council as chairman. Dr. Kettel also presented him with a gift as a token of the Council's appreciation.

Dr. Kettel congratulated the newly elected Administrative Board members. He encouraged the deans to respond to Dr. Petersdorf's questionnaire and to forward any comments they wished to make to him as well. He added his appreciation to Mr. Keyes and Ms. Day for their support of Council activities.

XVIII. ADJOURNMENT

Dr. Kettel adjourned the meeting at 4:17 p.m.

Matriculating Student Questionnaire and the Student and Applicant Information Management System

The AAMC Section on Student and Educational Programs is currently developing a new questionnaire to be administered annually to all first year medical students. The Matriculating Student Questionnaire (MSQ) will collect information on the sociodemographic characteristics, attitudes, and medical practice plans of these students.

At present, the AAMC surveys students at two points in the period encompassed by premedical and medical education. The premedical questionnaire, part of the MCAT registration process, is usually completed during the student's undergraduate junior year, and the Graduation Questionnaire is distributed to all senior medical students. The data from these surveys provide the AAMC with selected information regarding family background, finances, career plans, and specialty preferences.

Significant events occur in the five-and-one-half-year period between the completion of these two instruments that influence students' attitudes and decisions concerning such things as choice of specialty and preference for type of practice. Data gathered by the MSQ will facilitate understanding of such influences. The collection of data at matriculation and graduation will also enable the AAMC to report changes to the schools in student attitudes, opinions, and career plans.

Current plans call for further development and field testing of the MSQ between now and May 1. AAMC Staff will be discussing the draft and soliciting feedback at regional meetings this spring. Field testing will take place in April and May, involving a sample of schools in each region and testing approximately 25 students in each of these schools.

The addition of the MSQ to the AAMC's Student and Applicant Information Management System (SAIMS) will enhance SAIMS value as an institutional research resource. Since 1983, the graduates from each school have been tracked through their residency training. Thus, it is possible to determine the specialties chosen by a school's graduates and the courses of their progress through graduate medical education.

Table 1 shows the course of graduate medical education for 826 1986 graduates. Table 2 shows the medical schools from which they graduated. An analysis can be made of the distribution of the graduates from a school during each post-graduate year. The biographic, demographic, and academic characteristics of any subset of graduates can be analyzed by linking with SAIMS data drawn from the MCAT questionnaire, the AMCAS application, and (in future) the MSQ. For example, it is possible to determine the mean and median ages, the family characteristics, the college majors, and the mean and median GPAs and MCAT scores for the 1983 graduates of a school who completed the certification requirements for internal medicine in 1986 and went on to subspecialty training as compared with those who, upon finishing their general program, went into practice.

SAIMS is a resource that can be used by our medical schools in making plans for changes in their admissions policies, their medical student educational programs, and their residency programs. It also can provide useful correlations to be used in discussions with institutional policy makers and state and local governments.

Deans interested in pursuing studies through SAIMS should contact Paul Jolly, Associate Vice President, Section for Operational Studies at the AAMC.

TABLE 1

RESULTS OF PROJECT EXAMINING
US MED SCHOOL GRADS OF 1983 WHO
SPENT THEIR 1986 YEAR OF RESIDENCY IN OB/GYN

| SPECIALTY | YEAR 1983 | YEAR 1984 | YEAR 1985 |
|---------------------------------|--------------|--------------|--------------|
| INTERNAL MEDICINE | 32 | 5 | 4 |
| ANESTHESIOLOGY | 1 | 0 | 0 |
| DERMATOLOGY | 0 | 0 | 0 |
| FAMILY PRACTICE | 17 | 8 | 5 |
| EMERGENCY MEDICINE | 0 | 0 | 0 |
| NEUROLOGY | 0 | 0 | 0 |
| NUCLEAR MEDICINE | 0 | 0 | 0 |
| OBSTETRICS AND GYNECOLOGY | 732 | 793 | 814 |
| OPHTHAMOLOGY | 0 | 0 | 0 |
| PATHOLOGY | 1 | 0 | 1 |
| PEDIATRICS | 3 | 1 | 0 |
| PHYSICAL MEDICINE AND REHAB | 0 | 0 | 0 |
| PSYCHIATRY | 0 | 0 | 0 |
| RADIOLOGY | 0 | 0 | 0 |
| SURGERY | 11 | 6 | 2 |
| PRACTICE | 0 | 0 | 0 |
| NEUROLOGICAL SURGERY | 0 | 0 | 0 |
| ORTHOPAEDIC SURGERY | 0 | 0 | 0 |
| OTOLARYNGOLOGY | 0 | 0 | 0 |
| PLASTIC SURGERY | 0 | 0 | 0 |
| PREVENTIVE MEDICINE | 0 | 0 | 0 |
| THORACIC SURGERY | 0 | 0 | 0 |
| UROLOGY | 0 | 0 | 0 |
| OTHER SPECIALTIES | 17 | 1 | 0 |
| RESEARCH | 0 | 0 | 0 |
| NOT IN GME OR MISSING | 12 | 12 | 0 |
| TOTAL RESIDENCY RECORDS CHECKED | | | 826 |

This table shows the prior graduate medical education experience of 826 1983 U.S. medical school graduates who are in OB-GYN residency programs in 1986-87. The vast majority (732) began their OB-GYN programs in their PGY-1 year. There were 32 who started their graduate medical education in internal medicine, and nine of these continued in internal medicine for two to three years. Seventeen started in family practice, and 13 continued in family practice for two to three years before entering an OB-GYN program. Eleven 1986 graduates were in general surgery programs before starting their OB-GYN training.

TABLE 2

1983 U.S. MED SCHOOL GRADS IN OBGYN RESIDENCY SPECIALTY IN 1986
BREAKDOWN BY MEDICAL SCHOOL OF GRADUATION

| | | |
|-------|--------------------|----|
| AL101 | ALA-BIRMINGHAM | 6 |
| NY102 | ALBANY | 3 |
| AR103 | ARKANSAS | 4 |
| TX104 | BAYLOR | 11 |
| MA105 | BOSTON UNIVERSITY | 6 |
| NC106 | BOWMAN GRAY | 5 |
| NY107 | SUNY-BUFFALO | 3 |
| CA108 | CALIF-SAN FRAN | 5 |
| CA109 | CALIF-LOS ANGELES | 10 |
| IL110 | CHICAGO MEDICAL | 11 |
| IL111 | U CHICAGO-PRITZKER | 4 |
| OH112 | CINCINNATI | 8 |
| CO113 | COLORADO | 6 |
| NY114 | COLUMBIA | 1 |
| NY115 | CORNELL | 7 |
| NE116 | CREIGHTON | 6 |
| FL117 | FLORIDA | 7 |
| NH118 | DARTMOUTH | 0 |
| NC119 | DUKE | 4 |
| NY120 | ALBERT EINSTEIN | 7 |
| GA121 | EMORY | 9 |
| DC122 | GEORGETOWN | 9 |
| DC123 | GEORGE WASHINGTON | 12 |
| GA124 | MED COL OF GEORGIA | 6 |
| PA125 | HAHNEMANN | 5 |
| MA126 | HARVARD | 3 |
| DC127 | HOWARD | 15 |
| IL128 | U ILLINOIS | 19 |
| IN129 | INDIANA | 15 |
| CA130 | CALIF-IRVINE | 10 |
| IA131 | IOWA | 13 |
| PA132 | JEFFERSON | 10 |
| MD133 | JOHNS HOPKINS | 0 |
| KS134 | KANSAS | 15 |
| KY135 | KENTUCKY | 9 |
| NY136 | SUNY-BROOKLYN | 6 |
| LA137 | LSU-NEW ORLEANS | 15 |
| KY138 | LOUISVILLE | 4 |
| IL139 | LOYOLA-STRICTH | 1 |
| FL140 | MIAMI | 6 |

This table shows the medical schools who have 1983 graduates in obstetrics/gynecology training programs in 1986-87. The largest number came from the University of Texas-Southwestern (22). The medical schools who have no 1983 graduates currently in OB-GYN training are Dartmouth, Johns Hopkins, Brown, South Florida, Oral Roberts, and Northeastern, Ohio.

TABLE 2 Continued

1983 U.S. MED SCHOOL GRADS IN OBGYN RESIDENCY SPECIALTY IN 1988
 BREAKDOWN BY MEDICAL SCHOOL OF GRADUATION

| | | |
|-------|--------------------|----|
| WI141 | MED COL WISCONSIN | 9 |
| MD142 | MARYLAND | 6 |
| CA143 | LOMA LINDA | 7 |
| TN144 | MEHARRY | 7 |
| MI145 | U MICHIGAN | 4 |
| MN146 | MINN-MINNEAPOLIS | 11 |
| MS147 | MISSISSIPPI | 10 |
| MO148 | MISSOURI COLUMBIA | 11 |
| NE149 | NEBRASKA | 6 |
| NM150 | NEW MEXICO | 1 |
| NY151 | NEW YORK MED | 12 |
| NY152 | NEW YORK UNIV | 5 |
| NC153 | NORTH CAROLINA | 6 |
| ND154 | NORTH DAKOTA | 1 |
| IL155 | NORTHWESTERN | 11 |
| OH156 | OHIO STATE | 8 |
| OK157 | OKLAHOMA | 7 |
| OR158 | OREGON | 4 |
| PA159 | U PENNSYLVANIA | 13 |
| TX160 | TEXAS-SAN ANTONIO | 10 |
| PR161 | PUERTO RICO | 7 |
| PA162 | PITTSBURGH | 8 |
| NY163 | ROCHESTER | 1 |
| MO164 | ST LOUIS | 5 |
| SC165 | MED U SO CAROLINA | 6 |
| SD166 | SO DAKOTA | 4 |
| CA167 | SOUTHERN CALIF | 13 |
| TX168 | TEXAS-SOUTHWESTERN | 22 |
| CA169 | STANFORD | 2 |
| NJ170 | UMDNJ-NEW JERSEY | 10 |
| NY171 | SUNY-SYRACUSE | 4 |
| PA172 | TEMPLE | 13 |
| TN173 | TENNESSEE | 15 |
| TX174 | TEXAS-GALVESTON | 12 |
| MA175 | TUFTS | 11 |
| LA176 | TULANE | 12 |
| UT177 | UTAH | 7 |
| TN178 | VANDERBILT | 6 |
| VT179 | VERMONT | 5 |
| NJ180 | UMDNJ-R W JOHNSON | 2 |

TABLE 2 Continued

1983 U.S. MED SCHOOL GRADS IN OBGYN RESIDENCY SPECIALTY IN 1986
 BREAKDOWN BY MEDICAL SCHOOL OF GRADUATION

| | | |
|-------|--------------------|----|
| VA181 | VIRGINIA | 10 |
| VA182 | MED COL VIRGINIA | 7 |
| WA183 | U WASH-SEATTLE | 10 |
| MO184 | WASH U ST LOUIS | 6 |
| MI185 | WAYNE STATE | 17 |
| OH186 | CASE WESTERN RES | 10 |
| WV187 | WEST VIRGINIA | 1 |
| WI188 | U WISCONSIN | 5 |
| PA189 | MEDICAL COL PENN | 10 |
| CT190 | CONNECTICUT | 3 |
| CT191 | YALE | 1 |
| RI192 | BROWN | 0 |
| AZ193 | ARIZONA | 2 |
| CA194 | CALIF-SAN DIEGO | 11 |
| MA195 | MASSACHUSETTS | 8 |
| MI196 | MICHIGAN STATE | 6 |
| HI197 | HAWAII | 2 |
| PA198 | PENN STATE | 3 |
| NY801 | MOUNT SINAI | 10 |
| CA802 | CALIF-DAVIS | 5 |
| OH803 | OHIO AT TOLEDO | 3 |
| LA804 | LSU-SHREVEPORT | 2 |
| NY805 | SUNY-STONY BROOK | 6 |
| FL806 | SOUTH FLORIDA | 0 |
| NV807 | NEVADA | 5 |
| MO808 | MISSOURI-KC | 8 |
| TX809 | TEXAS-HOUSTON | 7 |
| IL810 | SOUTHERN ILLINOIS | 6 |
| FL811 | *FLORIDA STATE | 0 |
| IL812 | RUSH | 5 |
| NC813 | EAST CAROLINA | 3 |
| TX814 | TEXAS TECH | 6 |
| MN815 | *MINNESOTA-DULUTH | 0 |
| AL816 | SOUTH ALABAMA | 2 |
| MN817 | MAYO | 1 |
| VA818 | EASTERN VIRGINIA | 6 |
| OH819 | WRIGHT STATE | 6 |
| SC820 | UNIV SC COLUMBIA | 2 |
| MD821 | UNIFORMED SERVICES | 2 |
| CA822 | *CALIF BERKELEY | 0 |

TABLE 2 Continued

1983 U.S. MED SCHOOL GRADS IN OBGYN RESIDENCY SPECIALTY IN 1986
 BREAKDOWN BY MEDICAL SCHOOL OF GRADUATION

| | | |
|-------|---------------------|----|
| TX823 | TEXAS A M UNIV | 3 |
| OH824 | NORTHEASTERN OHIO | 0 |
| GA825 | + MOREHOUSE | 0 |
| TN826 | EAST TENNESSEE | 1 |
| OK827 | ORAL ROBERTS U | 0 |
| WV828 | MARSHALL UNIV | 4 |
| PR829 | PONCE SCH OF MED | 3 |
| PR830 | U CENTRAL CARIBE | 10 |
| CA831 | *DREW/UCLA MED SCHL | 0 |
| GA832 | + MERCER | 0 |

* Non degree granting

+ Did not graduate a class in 1983



**association of american
medical colleges**

**BACKGROUND PAPERS
FOR
SMALL GROUP DISCUSSIONS**

**AT THE
COUNCIL OF DEANS SPRING MEETING**

APRIL 5-8, 1987

**Stouffer Wailea Beach Resort
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College of Human Medicine
A-118 E. Fee
East Lansing, MI 48824
(517) 353-1730

ITEMS FOR DISCUSSION

- I. PREVENTIVE MEDICINE Blue
- II. GERIATRIC EDUCATION Yellow
- III. PHYSICIAN SUPPLY White
- IV. TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY Pink
- V. Discussion Group Assignments Green

I. PREVENTIVE MEDICINE

The degree to which preventive medicine is emphasized in the course of medical students' and residents' education is a topic of continuing discussion and debate. In the GPEP report, the panel stated,

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

The emphasis on preparing medical students to care for individuals with acute illnesses must be balanced by an equivalent emphasis on promoting health and preventing disease among groups of people. Students' general professional education should provide them with the knowledge and skills required to work with patients and communities to prevent or ameliorate disease. This emphasis is less likely to be achieved by a specific course than by continual attention to teaching the concepts of prevention throughout all phases of medical education."

How much attention is paid by faculties to teaching the concepts of prevention throughout all phases of medical education is not susceptible to analysis from AAMC data. The following data is drawn from the Curriculum Directory and the Graduation Questionnaire.

Courses in Preventive Medicine/Epidemiology

Required

In 1983, there were 83 schools with a required course in preventive medicine. The average number of hours was 51.

Elective

| | <u>Number of Schools</u> | |
|-----------------------|--------------------------|-------------|
| | 1983 | 1986 |
| Community Medicine | 115 (91.3%) | 117 (92.0%) |
| Occupational Medicine | 54 (42.0%) | 71 (56.0%) |

The percentage of respondents to the Graduation Questionnaire who took electives in preventive medicine is small.

| | <u>Percent of Respondents</u> | |
|---------------------|-------------------------------|--------------------|
| | 1983 n = 10,481 | 1986 n = 10,739 |
| Preventive Medicine | 1.5% | 1.6% |
| Public Health | 2.1% | 2.0% |
| Occupational Health | 1.4% | 1.1% |

The percentage of respondents who deemed that the time devoted to preventive care and public health was inadequate was in the 50-60 percent range.

| | <u>Percent of Respondents</u> | |
|-----------------|-------------------------------|-------|
| | 1983 | 1986 |
| Preventive Care | 60.0% | 60.6% |
| Public Health | 47.1% | 49.8% |

Questions for Discussion:

- Is preventive medicine/epidemiology as now taught to medical students preparing them to be concerned with preventive patient care?
- Do clinical faculty members place sufficient stress on prevention and health promotion in teaching medical students?
- Can the emphasis on preventive medicine and health promotion be improved without expanding curricular time?
- Which disciplines should take the lead in enhancing the emphasis on prevention in medical students' education?

II. GERIATRIC EDUCATION

The increasing number of elderly citizens in the United States has stimulated an increasing call for greater emphasis on geriatric education for physicians. In 1982 the Association held four regional institutes on geriatrics and medical education. There was broad specialty and discipline participation, with almost 90 percent of the medical schools represented.

National data on the degree to which geriatrics has permeated medical student and resident education are not easily available. AAMC data, derived from the Curriculum Directory and Graduation Questionnaire (Table 1) show an increasing number of schools offering electives in geriatrics and a constant small percentage of students taking a geriatric elective.

TABLE 1

| | <u>1983</u> | <u>1986</u> |
|---|-------------|-------------|
| Number of Schools Offering a Geriatric Elective | 95 (74.8%) | 110 (86.6%) |
| Percent of Graduates Taking a Geriatric Elective | 3.2% | 3.9% |
| Percent of Graduates who believe inadequate time was devoted to care of the elderly | 38% | 34% |

These data indicate that formal courses in geriatrics are taken only by a few students and only a third believe there was inadequate time spent on the care of the elderly during their education.

The question of whether there should be an academic unit for geriatrics in medical schools has been considered by many institutions. Thirty-two schools have established an administrative unit for geriatrics or gerontology, and twenty of these have been organized since 1980. (Table 2)

The American Board of Internal Medicine and the American Board of Family Practice are planning to provide a certificate of added qualifications in geriatrics to physicians in these specialties. Certification will require two years of training and passing an examination. The examinations are expected to be first given in 1988. At present, there are approximately 40 training programs. Of

5,259 1983 U.S. medical school graduates who entered internal medicine for their first residency year, 24 are in subspecialty geriatric programs in 1987. The Residency Review Committees for both internal medicine and family practice are in the process of preparing Special Requirements for the accreditation of these programs.

Questions for Discussion:

- Are the metabolic and regulatory changes that occur with aging sufficiently emphasized in the education of medical students?
- Are students made aware of the social changes that may occur with aging and debilitation?
- Are the diseases prevalent among our aging population sufficiently stressed?
- Will the movement toward certification of internists and family practitioners with special qualifications in geriatrics enhance the education of both students and residents?

GERIATRICS IN U.S. MEDICAL SCHOOLS

TABLE 2

| School | Med Sch Admin Staff | Dept of Medicine | Dept of Family Medicine | Department of Geriatrics/Gerontology |
|----------------------|---------------------------|------------------------|-------------------------------|---|
| U Alabama * | | Gerontology/Geriatrics | | |
| Arizona | | Geriatrics | | |
| Arkansas | | Geriatrics | | |
| Southern Cal * | | Geriatrics | | |
| Stanford | | Gerontology | | |
| Miami | | Gerontology | | |
| South Florida * | | Geriatric Medicine | | |
| Chicago Medical * | | Geriatric Medicine | | |
| Massachusetts | | Geriatric Medicine | | |
| U Michigan * | | Geriatrics | | |
| Missouri, KC | | Geriatrics | | |
| Saint Louis * | | Geriatrics | | |
| Nebraska | | Geriatrics/Gerontology | | |
| Nevada * | | | | Geriatrics/Gerontology Center |
| New Mexico * | | Gerontology | | |
| Cornell * | | Geriatrics/Gerontology | | |
| Mount Sinai | | | | Geriatrics/Adult Dvlpmnt Dept |
| New York Med * | | Gerontology/Geriatrics | | |
| New York U * | | Geriatrics | | |
| Bowman Gray * | | General Med/Geriatrics | | |
| Duke * | | Geriatrics | | |
| East Carolina * | | | Geriatrics | |
| North Dakota | | Geriatric Medicine | | |
| Case Western | Assoc Dean, Geriatric Med | | | |
| Oregon | | Gerontology | | |
| MC Pennsylvania * | | Geriatric Medicine | | |
| Pennsylvania State * | | | Geriatrics | |
| Meharry * | | Gerontology | | |
| Texas A&M * | | Geriatrics | | |
| Vermont | | Gerontology | | |
| MC Virginia * | | Geriatrics | | |
| MC Wisconsin * | | Geriatrics/Gerontology | | |

*Established since 1980.

Source: AAMC Directory of American Medical Education, 1985-86

III. PHYSICIAN MANPOWER

The question of how many physicians should be graduated from our domestic medical schools is one for which there is no precise answer. Having doubled the number of graduates since 1970 and having had a surfeit of applicants throughout the 1970s, medical schools are now faced with the issue of whether the present size of entering classes should be maintained, even though the number of applicants has declined at an average annual rate of 6.7 percent since 1984.

The following papers present data and projections about physician manpower and raise questions about medical schools' responsibilities in adjusting the future supply of physicians.

There are many issues ranging from the availability of qualified applicants to the specialty and geographic distribution of our graduates. The principal question for discussion is:

- What roles and responsibilities do medical schools have in the adjustment of the supply of physicians to the nation's future needs?

PHYSICIAN MANPOWER

At the outset, let me assure you that this rather atypical format---an opening plenary session of all of the Administrative Boards---is simply for convenience. I was asked to open the discussion of the Physician Manpower item in your agenda book by repeating a presentation made at the Officers Retreat last month. Since I am speechless without slides, it seemed easier to give the talk once to all rather than set up screens and projectors in each room.

The impetus of the original presentation was a request by Dr. Petersdorf to try to sharpen the focus on the problem so as to stimulate movement toward decision. I interpreted his instruction as a dispensation to play, at least to a small extent, the role of a provocateur.

First, a couple of disclaimers. The manpower problem is not an area of AAMC expertise and it's been a long time since staff has looked searchingly at the available data. Thus, this introduction is intended to simply scope out a part of the territory. The next phase of the effort can refine the details and examine how realistic emerging proposals may be. But to focus your attention right now, I want to offer a specific set of recommendations with which to open the discussion.

Clearly, no sound proposal can prescind from facts. (Slide 1.) The state of factual knowledge seems to be about as follows. As far as "supply" is concerned, especially in the aggregate, the data base is extensive and

growing, the projection models are good and improving, and the determinants of supply are reasonably well understood. With respect to "need", data is not as good, projection models are less reliable and the determinants are only partially understood. Thus, when the estimate of balance between "supply" and "need"---surplus or shortage---is based on projection models, ambiguities and uncertainties arise. Most observers and critics place more trust in intuitive and experiential assessments.

At this moment, I do not believe that additional data would be of critical and determinative help. More important would be answers to questions such as: when is enough enough? can the concept of free market regulation be efficiently and effectively operationalized when the time constants of the process are so long? how will the physician behaviors that determine "supply" and "need" respond to the changing social climate? Unfortunately, precise answers to these and similar questions are not likely to be available soon, or perhaps ever.

Therefore, it seemed appropriate to make several egregiously simplifying assumptions, (Slide 2), based on good "supply" data, fair "needs" data and the overwhelming intuitive and experiential consensus that the nation has, or will soon have, too many physicians, too many specialists and a far too high ratio of specialists to generalists.

Accordingly, I suggest that an appropriate set of national goals (Slide 3), would be: to reduce the number of medical school matriculants; to increase the proportion of generalists in the practice pool, with a concomitant reduction in specialists; to expand graduate education in the biomedical and

behaviorial sciences; and to minimize the inflow of FMG's, both domestic and alien.

When or if the time comes for the AAMC to make a public proposal, a justification for it that is powerfully persuasive to all segments of society will have to be articulated. But if the case for overproduction and specialty maldistribution is as strong as most shrewd observers of the contemporary scene seem to believe, that task should be feasible. One line of argument might be (Slide 4) that oversupply diminishes the attractiveness of the profession in terms of intellectual and professional satisfaction, social status, economic return and personal life style aspirations. As a consequence, the calibre of medical school applicants diminishes, the quality of graduates wanes, professional standards deteriorate with an eventual adverse impact on the medical care available to the public. But, however argued, the primary criterion by which a proposal such as this will be viewed by the public, is whether it is justifiable as a public good.

On class size reduction, a look at some numbers may be helpful. Slide 5 outlines one of many approaches available to defining the target of the effort, beginning with the selection of the ideal steady state level of the physician pool that should prevail at some future date. For illustrative purposes, I've chosen the requirement projected by GMENAC for the year 2000 A.D. The steady state replacement level is the product of this and the annual percentage turnover, and is the equivalent, after adjustment for dropouts, to the number of medical students who must matriculate annually to maintain the desired steady state level. If the population changes, further fine-tuning would be necessary.

Turnover rates are principally a function of the length of a practice career, a complex variable influenced by death and disability rates, as well as by the host of professional, social and economic factors that enter into personal decisions about retirement. (Slide 6.) The value assigned to turnover has a significant influence on the annual replacement level and, in turn, the annual matriculant level. Again, for illustrative purposes, I've selected an average 40 year career span for subsequent calculations, so that the target first year class size is 12,087. This target is 75% of current first year enrollments. Translated into annual actions, the average annual national class size reduction required to achieve this would depend on how rapidly the downsizing is accomplished. Slide 7 indicates that it could be as low as 2.8% per annum if accomplished over a decade, 5.6% per annum for a 5 year schedule and 25%, if done in 1 year.

It is informative to calculate the time required to reach the prescribed steady state pool size after class size reductions have been put into effect. The actual attainment of the desired level is a slow process because past momentum persists for up to 40 years. This is illustrated in the next couple of slides, (Slide 8) using data generated by a model built hastily---over the Thanksgiving weekend, to be precise---by Paul Jolly on assumptions outlined. The top curve in (Slide 9) shows the long term effect first of maintaining current output levels, with "supply" rising for 40 years, and leveling out at about 765,000; the lower curves display the results of several approaches to reduction in 1st year enrollments to the desired level at different rates. Note that supply continues to rise for many years, no matter which of these actions is taken. Obviously, it takes a long time to slow this train down, even if the brakes are applied hard and soon. More refined models that allow one to play out the consequences of many other approaches to this problem will

come in handy as the Association explores a wide variety of courses of action. In a few minutes, Paul Jolly will review the relevance of the AAMC data bases and other data sources to some of the predictive models that could be useful.

Slide 10. Reduction in class size raises some touchy process issues. The most neutral action would be an across-the-board, uniform, unselective reduction. Alternatives raise such issues as whether there should be differential impacts on public or private schools, research oriented or practice oriented schools? And if so, for what reasons and how would they be achieved. Reduction in class size could also be accomplished by closure of schools or by merger with contraction. Closure and/or merger would require that Boards of Trustees, legislators and community supportors be persuaded that such an action is in the public interest---an ironic task to ask of faculty members and institutional officials. Perhaps the rate of enrollments could be reduced by simply insisting on maintaining the current quality of matriculants. However, the data on 1985 matriculants examined at the 1986 COD Spring Meeting and preliminary data on 1986 matriculants show that quality continues to hold, even in the bottom decile, despite the sharp fall in applicants.

The nature, significance and perception of the impact of class size reduction will not be uniform. Slide 11. Applicants would find competition stiffer but would be entering training for a more attractive profession. Other things being equal, students should experience an improved environment for learning. The faculty would stand in greatest danger, although the requirement to reduce faculty size could be off-set to a significant degree, if research and research training could be expanded and delivery of health care increased. A special problem would probably emerge in public schools in

which faculty size is determined by the number of enrolled students. Academic institutions would have to cope with the problems precipitated by the loss of tuition revenues, a loss that might or might not be recoverable by raising tuitions; they would also need to worry about the utilization of space previously allocated to student instruction.

Turning to graduate medical education, an approach could be adopted similar to that used in downsizing undergraduate enrollments (Slide 12) to bring "supply" into better balance with "need". Most data necessary to select ideal target levels, turnover rates, replacement needs and entrants into GME pools exist. Since this approach is similar to that previously outlined for downsizing undergraduate class size, it did not seem necessary to display illustrative calculations.

GME does however present many special problems, a few of which are outlined in Slide 13. In general, the number of GME slots has been approaching the number of medical school graduates with disconcerting rapidity. However necessary it may be to reduce the number of entrants into certain graduate training programs, it is also highly desirable to maintain as many training opportunities and choices as possible. But if an excess of specialty training programs are kept alive in the interest of student choices, there will inevitably be problems in channeling matriculants preferentially into primary care programs. Can the cooperation of the majority of program directors, specialty boards and specialty societies be enlisted? If medical school class size shrinks, the aggregate resident pool will follow suit after a 4 year lag. With a 25% reduction in residents, there may be problems meeting the service load formerly borne by residents.

Moving on to research manpower, (Slide 14) it should be noted that---the current contretemps over the NIH budget to the contrary notwithstanding---considerable optimism pervades Washington on long range prospects for expanding research and research training. The Reagan Administration is apparently convinced---as borne out by the FY 1988 budget submissions for science agencies other than the NIH---that research investments will improve America's edge in international economic competition and in expanding domestic technology-based industry. Expansion of research and research training could minimize the faculty lay-offs that might otherwise attend downsizing, especially in the preclinical departments of medical schools.

One should not close this introduction without highlighting some of the as yet unresolved problems of specifying a goal that this country downsize and/or close academic institutions or academic programs. (Slide 15) To lay out the criteria against which the candidate institutions for constriction are to be selected, to imagine a process for applying these criteria to the existing set of institutions and programs and to support the development of an impartial, objective and even-handed machinery for attaining the national goals would constitute a formidable challenge to the AAMC leadership. This is especially true when the Federal Trade Commission must be convinced that AAMC actions are in the public interest, not self interest.

Let me close with a personal estimate of the feasibility of the proposal.

Undergraduate class size reduction is a idea whose time came several years ago. After initial shock, an AAMC statement favoring it should be widely accepted, fairly easily adopted and relatively painless.

Justifications must be carefully prepared, but can probably persuade a substantial majority. However, Government assistance by, for example, decapitation awards, is almost inconceivable to me.

Shifting GME toward generalism and away from specialism is going to be a very tough nut for the AAMC to crack. Why? (Slide 16) The first reason is furnished by that great pair of sages, Karl Marx and Willie Sutton. The second is that the AAMC has no official handle on the problem. Over sixty years ago, graduate medical education escaped from the hegemony of academic institutions. The only device available to the latter to exercise their authority over educational programs is to prescribe the requirements for what academic institutions are legally empowered to do, namely, confer degrees. Despite AAMC preachments about institutional responsibility for GME programs, the fact is that academe, qua academe, has no legitimate or enforceable authority in this area. It is out of academe's control. Authority and responsibility have moved to organizations that resemble another ancient and honorable institutional form, Universities Without Walls, the disciplinary Colleges and Societies---the Royal Societies in The U.K. are prototypic---that emerged in the 17th and 18th centuries to serve the intellectual, social and economic needs of professionals in medicine and the sciences who had completed their formal academic education.

This being the case, AAMC is not in a very powerful position. About the only thing we can do is jawbone our colleagues in leadership roles on the Boards and in the Colleges to take appropriate action before government becomes exasperated with overspecialization and specialty maldistribution and steps in.

But if Marx and Sutton are correct, it seems to me that, in the final analysis, anyone who claims to be serious about achieving better specialty distribution but is not willing to work toward reform of the physician reimbursement system is simply posturing, pirouetting, and attitudinizing on the stage while whistling Dixie. Even if training opportunities were truncated, many physicians would aspire to perform highly compensated procedures despite their lack of formal credentials.

Let me quickly express a few other heretical views that don't even warrant inclusion in a slide.

My personal belief is that knowledge has expanded so much and the intellectual content, including research opportunities, of most medical disciplines is so extensive, that an advanced degree, conferred by a university, is now a more appropriate recognition of competence than a certificate bestowed by a specialty board or college. While murky, my crystal ball seems to indicate that, if academe were to thus formally extend its hegemony over selected GME programs, its degrees would become the gold standard of the realm and, in the fullness of time, it would recapture authority over GME. With authority would come the ability to control.

I detect little appetite among academicians for such a proactive endeavor, for a variety of reasons, including the fact that, as board certified specialists and members of speciality societies, they have a conflict of interest. However, a less ambitious effort along the same lines to deal with some of the minor anomalies of the present might warrant some consideration.

I have always had difficulty reconciling two policy positions of the Association. One is that without several years of GME, no physician is prepared for the independent practice of medicine. The other is that the AAMC does not view as objectionable the moonlighting by residents, an activity that, more often than not, involves extensive independent practice. If the AAMC is really convinced of the validity of its position on the need for GME as a precondition for independent practice, it should urge its institutions to include the proper amount of GME as a degree prerequisite, despite the licensure, logistical and other problems that would be precipitated. Adoption of that policy could, incidentally, go a long way towards mooting many of the issues related to the transition year and extend academe's hegemony over GME at least a soupcon.

Expansion of graduate education in the sciences holds high promise, (Slide 17), particularly if academe gets actively behind efforts such as that undertaken by the ad hoc Group for Medical Research Funding. The NSF's Erich Bloch has for the last several years publically advocated a doubling of the NSF's budget over a 5 year period and the President, in his FY 1988 budget request, adopted this target as the Administration's official position. The NIH's Jim Wyngaarden has been quietly on record in favor of a similar rate of growth for the NIH.

Finally, a substantial amelioration of the FMG problem should be possible if a coherent comprehensive political effort can be mounted.

The AAMC has never updated its last published policy on manpower: that every qualified student should be able to get a medical education. We are currently drifting. As the graph showed, this drift is heading the U.S. to a

pool of 765,000 physicians, or over 300/100,000 population. Even the drastic action of reducing enrollment by 25% does not reduce the growth of the pool size for almost 20 years. Drift invites outside interference. Can we afford to drift?

Thomas J. Kennedy, Jr., M.D.
Associate Vice President

Data Issues

Physician "supply", in the aggregate and by specialty.

Data: extensive and growing.

Prediction models: sound and improving.

Determinants: well understood.

Physician "need".

Data: less rigorous, available and extensive.

Prediction models: less reliable.

Determinants: partially understood.

Balance estimates.

by modeling: open to question.

by intuition and experience: more trusted.

How will more data help decision making?

Assumptions

From good "supply" data, fair "need" data, and an overwhelming intuitive and experiential consensus.

- Current rate will soon create a "supply" greatly in excess of any conceivable "need".
- In both absolute and relative terms, there are too many specialists and too few generalists in the practice pool.

A Modest Proposal

Reduce aggregate undergraduate class size.

Increase the proportion of physicians entering practice as generalists.

Expand graduate education in the biomedical and behavioral sciences.

Minimize inflow of foreign medical graduates.

Justification

- Oversupply destroys appeal of profession.
 - Calibre of applicants declines.
 - Quality of graduates wanes.
 - Professional standards deteriorate.
 - Calibre of applicants decline further.

.

Mae West to the contrary notwithstanding

There can be too much of a good thing.

- Sound public policy and the national good require downsizing.

Reduction in class size: The Target 5

Select desirable steady state level:

GMENAC predicted for 2000 AD a total requirement of 474,000 physicians

- Estimate the average annual pool turnover rate.
- Calculate the absolute number disappearing from the pool: the annual need for graduates.
- Adjust for dropout rate to derive number of matriculants.
- Note need to evolve with population changes.

Reduction in class size: The Target

Assume an ideal steady state 2000 prevalence of 474,000 physicians.

Assume career length.

| Career length (years) | Turnover rate (percent/year) | Needed grads | Needed matriculants |
|-----------------------|------------------------------|--------------|---------------------|
| 50 | 2.0 | 9,480 | 9,670 |
| 45 | 2.2 | 10,533 | 10,744 |
| 40 | 2.5 | 11,850 | 12,087 |
| 35 | 2.9 | 13,543 | 13,814 |
| 30 | 3.3 | 15,800 | 16,116 |

Reduction in class size: Reaching the Target⁷

Assume whatever individual schools do, the national average will reflect exponential decrease.

Assume: target of 12,087 matriculants
current matriculants number 16,103

| Target Attainment Date (years hence) | Required Annual Reduction (percent per year) |
|---|---|
| 5 | 5.58 |
| 6 | 4.67 |
| 7 | 4.02 |
| 8 | 3.52 |
| 9 | 3.14 |
| 10 | 2.83 |

Assumptions

Current Rates:

16,117 graduates each year.

3,000 FMG's each year.

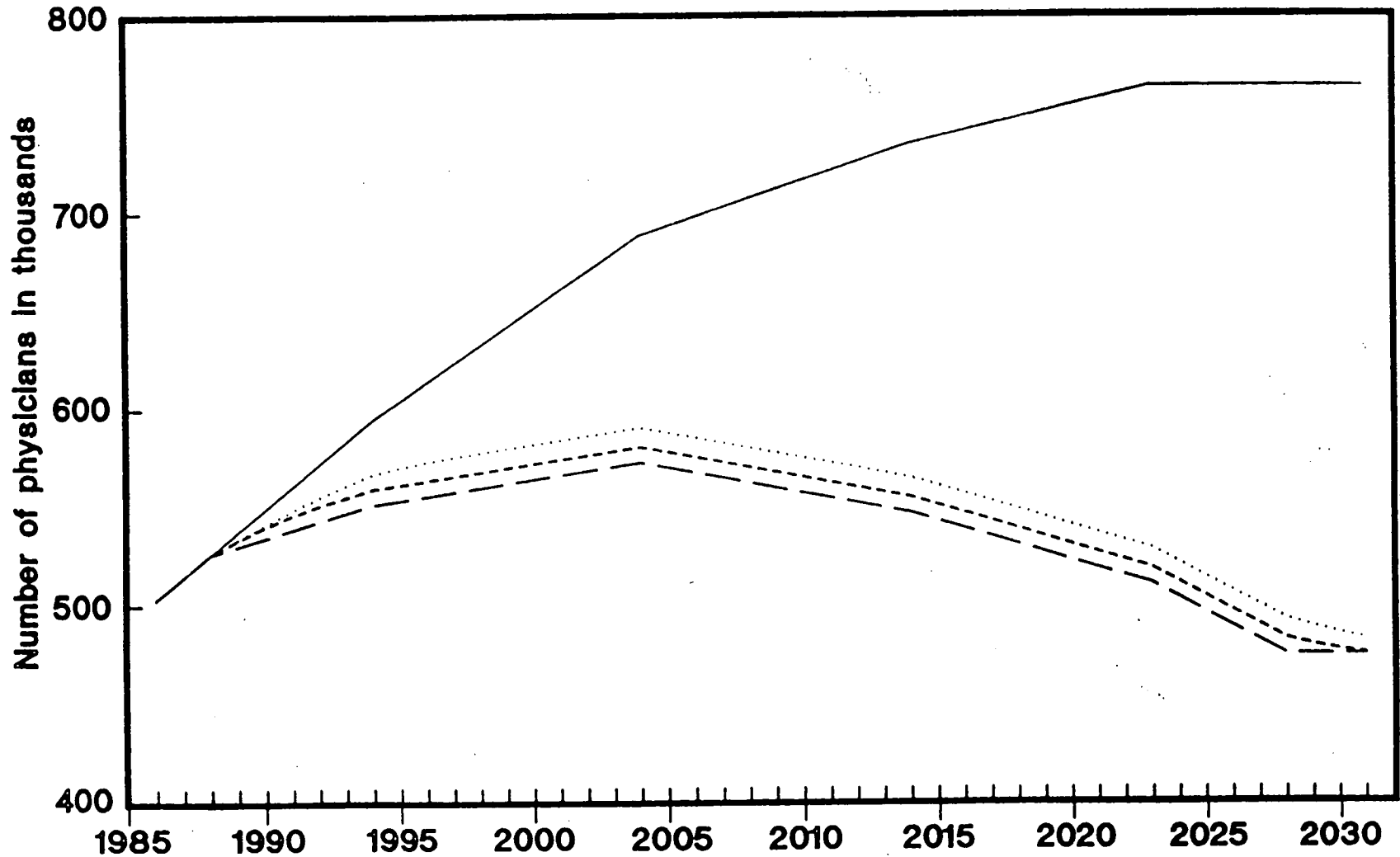
40 year professional life.

Reduction:

1. Cut FMG's to 1,000 in 1988
and 0 in 1989.
2. Cut new entering classes
beginning in 1988.
3. Graphs do not include osteopaths.

Allopathic Physicians

- No change in policy
- - - Cut to 12,087 new entrants by 1993
- - - Cut to 12,087 new entrants in 1989
- Cut to 12,087 new entrants by 1998



Reduction in class size: Methods ¹⁰

Reduce class size uniformly in all schools.

Reduce class size selectively.

privates vs publics.

research oriented vs practice oriented.

. . . .

Reduce number of schools.

by abolition.

by merger.

Reduction in class size: Impact:

On applicants: admission more competitive.
professional attractiveness enhanced.

On students: smaller class size should
improve learning.

On faculty: preclinical vs clinical.
private vs public
(with formula determination).
reduction off-set by research training.
reduction off-set by practice increase.

On institution: revenue loss.
loss off-set by tuition increase.
infrastructure reconversion.

Graduate Medical Education: The Target

- Select the desired steady state level for each specialty. GMENAC predicted a 1990 requirement of 23,500 general surgeons.
- Estimate the average annual pool turnover rate.
- Calculate the absolute annual loss from each pool: the required number of pool entrants.
- Adjust for fraction of candidates not completing training: the training program matriculants.
- Note need to evolve with population change.

Graduate Medical Education: Special Problems

- Available slots: total, generalist, specialist.
- Influencing student choice.
- Influencing specialty governance mechanisms.
- Impact of reduced number of residents on service delivery in teaching programs.

Biomedical and Behavioral Research Manpower

- Sanguinity re probability of increasing Federal and industry investments.
- Expanding opportunities for improving health and business.
- Emphasis on maintaining U.S. competitive position in international markets through R&D.
- Expansion of R&D in medical schools could blunt the magnitude of faculty reduction caused by downsizing.

A Few Residual Problems

- Identification of institutions/programs for reduction or abolition:
 - Criteria
 - Process
 - Mechanism
- Defense against monopolistic practice charges.
- Persuasive justification.

Feasibility of Proposal

- Undergraduate class size reduction
Should be easy.

Substantial pain relief from expansion of research/research training; some from tuition increases and expansion of practice; government assistance unlikely.

- Increasing generalists/decreasing specializations
Should be difficult.

Karl Marx: Man is an economic animal

Willie Sutton:'Cause that's where the money is.

Can the government be kept out of the act?

Will the threat of government action facilitate desirable change?

Can a solution be reached without reform of the basis
for physician reimbursement?

Feasibility of Proposal (Cont.)

- Expansion of graduate education in the biosciences

Bloch, Wyngaarden and others have a 5 year doubling target (15 percent per annum) for research. The international economic competition argument gets a sympathetic ear. Strong public support for health research is traditional and has been strongly reinforced lately by Alzheimers and AIDS.

- Terminating FMG entry into practice pool
Should be possible.

The Changing Applicant Pool

For two decades, medical faculties had the privilege of choosing who is to be admitted to their schools from among a surfeit of qualified candidates (Figure 1). During the 20 years between 1964 and 1984, there were consistently twice as many applicants to our nation's medical schools as there were entering positions, and as the number of positions grew with the expansion of our medical education capacity, the rate of increase in the number of applicants even exceeded the rate of expansion. In 1974, '75, and '76, there were 2.8 applicants for each position. This level of competition for admission to medical school was only seen once before--in the four years from 1947 through 1950 when a flood of returning veterans sought a medical career.

Beginning in 1977 and augmented in 1978, the number of applicants dropped from the 40,000 plus range to the 36,000 range. From 1978 through 1984 the applicant pool remained stable. But in 1985 we experienced an 8.5 percent decrease, and in 1986 a 4.8 percent decline to a level of 31,323 with an applicant position ratio of 1.9.

The fall off in applicants is not geographically uniform. Some states, such as California and Texas, have experienced essentially no change from 1981 through 1986 in the number of state residents applying for medical school. Fourteen states have had a fall of 25 percent or more in the number of residents applying to medical school between 1981 and 1986 (Figure 2). The

largest numerical decline was 401 for Michigan. The largest proportional decrease was in Minnesota, where the loss of 319 applicants represented a 37 percent drop.

The total number of new matriculants has not changed in proportion to the change in applicants. Between 1981, when the largest class in history was admitted--16,660 men and women, and 1986 the number of new entrants has dropped by only 647, a decrease of 3.8 percent. During the same period, applicants fell by 15 percent (Figure 1).

The most dramatic change in both medical school applicants and matriculants has been the drop in men and the increase in women (Figure 3). Since 1974, the number of men applying has steadily decreased. In 1974 there were 33,912 male applicants. In 1986 there were 20,056--a 59 percent decrease. Females increased by 30 percent between 1974 and 1984. Since 1984 the number has dropped by 10 percent, from 12,476 to 11,267. In 1986 women comprised 34.6 percent of the entering class.

There is also a shift toward both older applicants and older matriculants (Figure 4). In 1978, 65 percent of the applicants were less than 24 years old, and only 2.5 percent were 32 years or older. In 1986 the less than 24 year old age group dropped to 59 percent of the applicants, and those 32 years and older increased two and one-half times to 6.5 percent.

The entering class of 1978 had only 177 members who were 32 years or older (one percent) (Figure 5). In 1986, their number grew to 709, a four-fold increase. The attractiveness of this age group

to admissions committees has clearly increased. Their acceptance rate has almost doubled, from 18 percent in 1978 to 34 percent in 1986. The acceptance rate for those under 24 only increased by two-thirds, from 37 percent to 59 percent.

During the last decade, the only major change in the distribution of applicants and matriculants among ethnic groups has been a doubling in the number of Asian-American applicants, and a 2.5-fold increase in their number admitted to medical school (Figure 6). In 1978, 5.8 percent of applicants and 4.7 percent of matriculants were Asian-Americans. In 1986, 13 percent of the applicants and 12.2 percent of the matriculants were of this ethnic group (Figure 7). Their rate of acceptance increased by 13 points in this period, from 35 percent to 48 percent.

The proportion of blacks in the applicant pool in 1978 was 6.9 percent, and they made up 5.8 percent of the matriculants (Figure 6). In 1986, blacks were 7.6 percent of the applicants and 6.3 percent of the matriculants. They had a six point increase in acceptance rate, from 36.6 percent to 42.6 percent (Figure 7).

Other underrepresented minorities (Mexican-Americans, Native Americans, and Mainland Puerto Ricans) constituted 2.7 percent of the applicants and 3 percent of the matriculants in 1978 (Figure 6). In 1986, their proportion had dropped so that they composed only 2.6 percent of applicants and 2.7 percent of matriculants (Figure 7). However, their acceptance rate had also increased by 6 percentage points. Both white applicants and matriculants have decreased in parallel with the increase in Asian-Americans and now constitute 74.4 percent of the applicant pool and 76.9 percent of matriculants. Their acceptance rate increased by 7.5 points from 45.6 percent in 1978 to 53.1 percent in 1986.

With the decrease in the number of applicants for medical school, there has been a concomitant increase in concern about whether, in future, there will be a sufficient number of qualified students to fill the more than 16,000 entering positions provided by our 127 medical schools. In the late 1950s and early 1960s, when the applicant-position ratio was in the 1.7 range, an AAMC study of medical student attrition found that half of the year to year variance in attrition rate could be accounted for by the size of the applicant pool. (1)

There are several factors that determine whether students are qualified to enter medical school. Among them are candidates' college grade-point averages and their Medical College Admission Test scores. These are the only criteria of the academic abilities of applicants and matriculants for which there are uniform national data.

Figure 8 shows the percentage distribution of combined biology, chemistry, physics, and mathematics grade-point averages among applicants and matriculants for the entering classes of 1978 and 1986. There has been a downward shift in the proportion of both applicants and matriculants in the higher ranges and an increase in the proportion of matriculants from the middle range. In 1978, 15 percent of applicants and 26 percent of matriculants had science grade-point averages in the "A" range of 3.76 to 4.0. In 1986, these percentages fell to 13 percent and 20 percent, even though the percent accepted from this group rose from 78 percent to 80 percent. Although the distribution of applicants' science GPAs are close and nearly parallel for 1978 and 1986, the downward shift in matriculant science GPAs is illustrated by the leftward shift of the 1986 matriculant curve. The percentage of matriculants with science GPAs in the 3.01 to 3.25 range increased from 10.7 in 1978 to 14.5 percent in 1986. The acceptance rate of candidates in this group rose by 14 points, from 31.2 percent to 45.6 percent. Figure 9 shows that a similar pattern prevails for overall grade-point averages.

While these changes are not dramatic, they do show a distinct downward trend in matriculants' college academic records. This correlates with a diminishing applicant pool of candidates deemed to be qualified by medical school admissions committees.

The Medical College Admission Test scores of both applicants and matriculants have not changed as much as their grade point averages. The MCAT has six subtest scores. To illustrate the relationships between 1978 and 1986 scores, the chemistry and

reading subtest scores are shown (Figures 10 and 11). For chemistry, the 1978 and 1986 curves are essentially the same. For reading, there is a slight shift to the left, but only in the 9 to 10 range.

What does the future hold? Since 1984 we have seen an average decrease in applicants of 6.7 percent per year. With over 90 percent of the applicants for the entering class of 1987 accounted for, it is estimated that there will be 7.3 percent fewer than for the entering class of 1986. That means approximately 29,000. If the 1987 class size proves to be 16,000, there will be 1.8 applicants for every position. Should the schools reduce entering positions sufficiently to maintain a 1.9 ratio, the 1987 class will approximate 15,250. To achieve the historic ratio of two applicants per position will require a 1987 class of 14,500, a reduction of 10 percent below the 1986 class.

In the winter of 1986, it was predicted that the applicant pool would continue to fall at between a 4 to 8 percent rate per year until at least 1990 (2). Table 1 shows the possible results. If the medical schools maintain a class of 16,000 and the rate of decrease is toward the 4 percent per year side, we will reach an applicant-position ratio of 1.7 for the entering class of 1990. If the rate is toward the 8 percent per year side, the ratio could be as low as 1.37 applicants per position. If we maintain the present 7 percent rate, by 1990 there will be 23,300 applicants, which could mean 1.5 applicants per position. However, it is unlikely that the pool of qualified candidates

will be sufficient for faculties to maintain such a class. The ratio will probably go no lower than 1.8, which will cause a drop in the 1990 class to approximately 13,000.

There is little data on why students are turning away from the study of medicine. It is difficult to ask people who have not appeared why they have not appeared. One factor is surely the widespread public discussion of a physician surplus. It is probably not coincidental that the GMENAC report, which predicted a physician surplus, was released in the fall of 1980, and the downward break in the applicant curve began in 1985 when the entering college class of 1981 graduated.

Last spring the AAMC surveyed 1,549 persons who had taken the Medical College Admissions Test, scored 9 or better, and had advanced far enough in college to be eligible to enter the 1985 class but had not applied. Members of this cohort could reasonably expect to be competitive for admission to medical school. Five hundred thirty-four returned usable questionnaires. Of these, 69 percent were planning to apply in a later year. One hundred twenty-eight individuals (21 percent) said they had changed career plans. Of these, 53 percent planned to go on to graduate school, predominantly in the biological and physical sciences. The reasons given for deciding against a career in medicine were:

- o Their scientific interests could be better satisfied by a career in another discipline. (52%)
- o The medical education program is too long. (26%)

- o The cost and debt incurred is too great. (37%)
- o They were discouraged by physicians with whom they counselled. (29%)

Thirty-four percent said that changes in the health care system are impairing doctors' independence. Only 8 percent said that the public's lessened respect for physicians was a reason for not pursuing a career in medicine.

August G. Swanson, M.D.
Vice President for Academic Affairs
Association of American Medical Colleges

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- (1) Johnson, D.G. and Hutchins, E.B., Doctor or Dropout?: A Study of Medical Student Attrition, *J. Medical Education* 41:1097-1269, 1966.
- (2) Swanson, A.G. in, *From Physician Shortage to Patient Shortage: The Uncertain Future of Medical Practice*. Westview Press, Boulder, pp. 11-34, 1986.

FIGURE 1

Number of Medical School Applicants and Matriculants 1960 to 1986

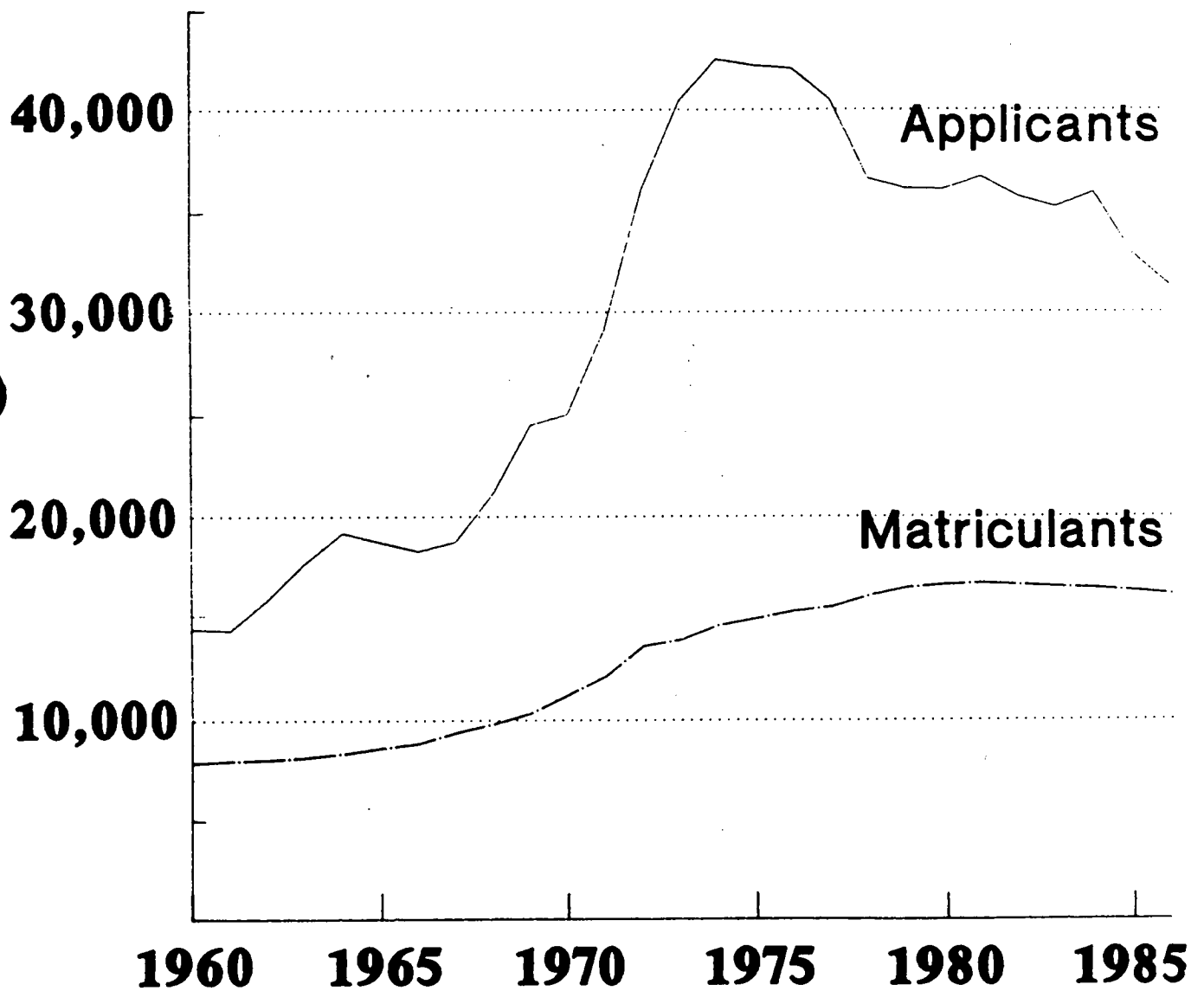


FIGURE 2

States Having a 25 Percent Decline or More in Applicants between 1981 and 1986

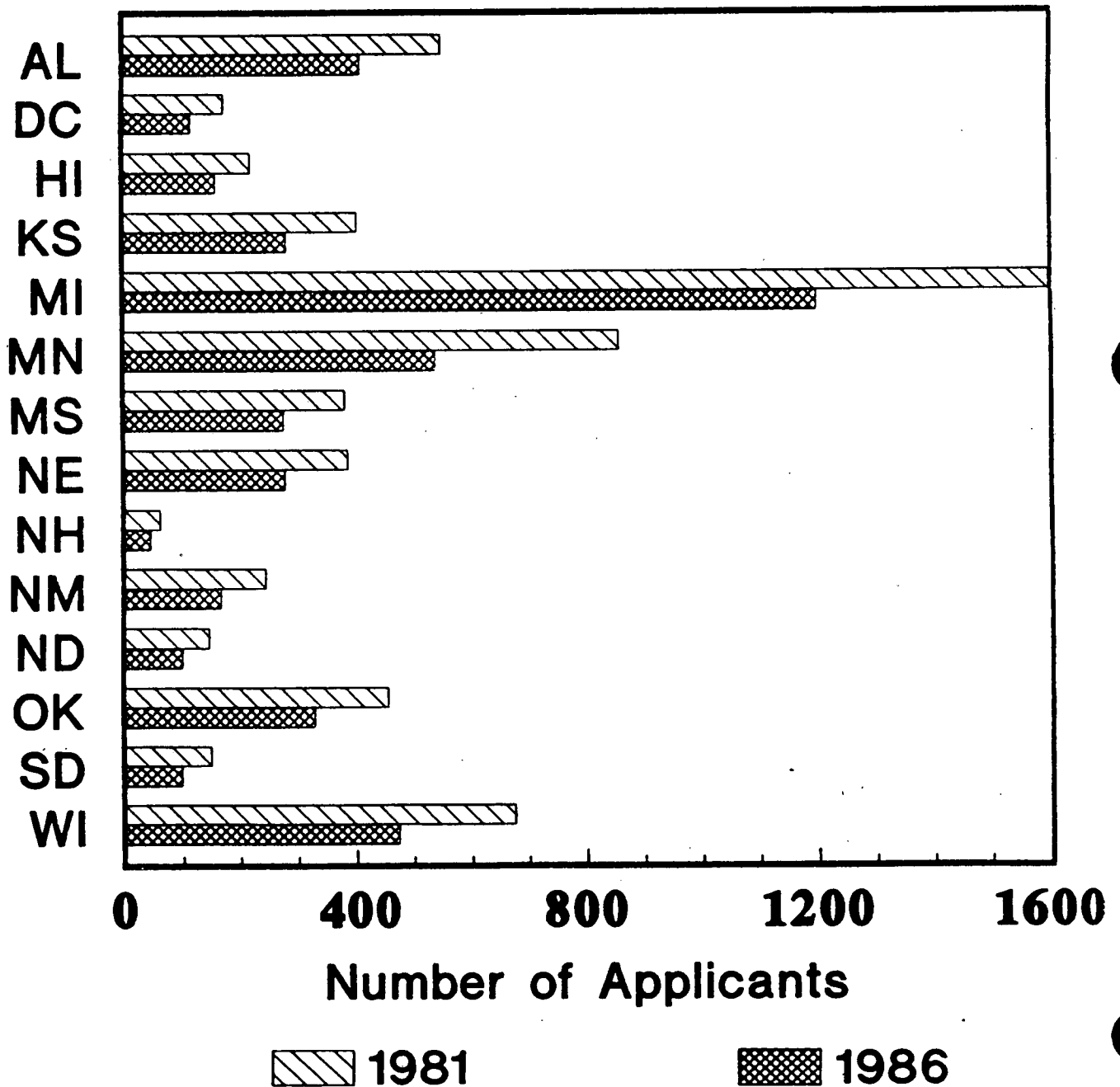
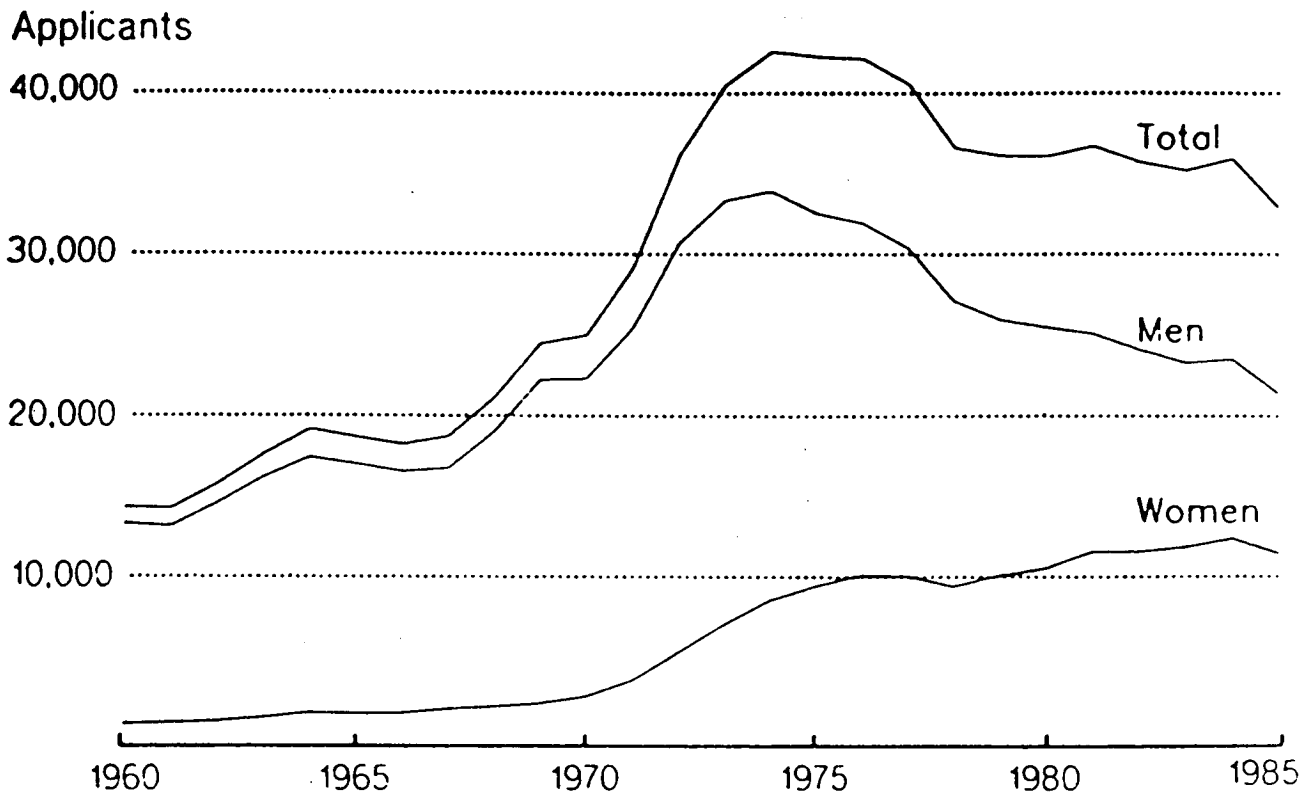


FIGURE 3

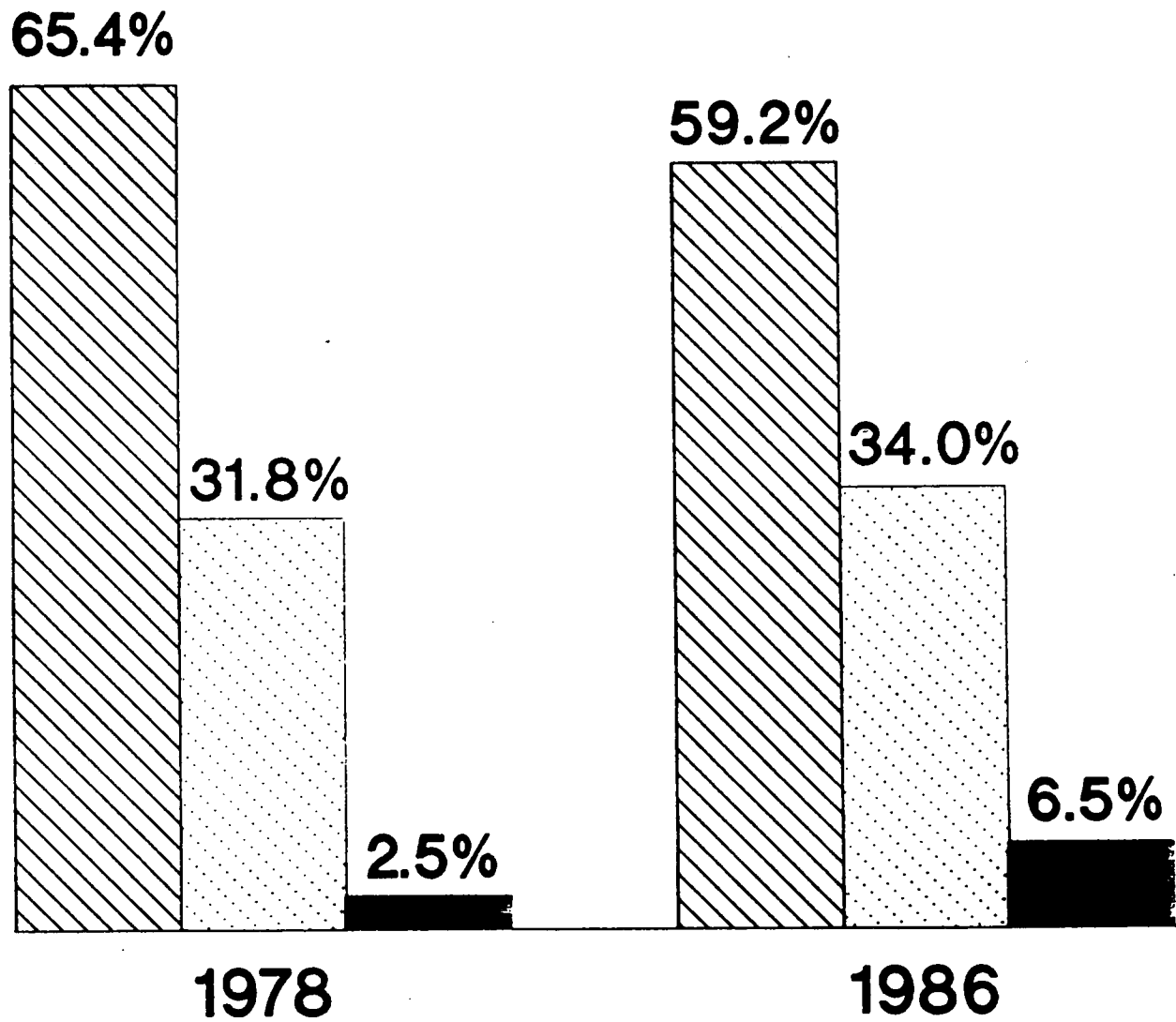
Medical School Applicants 1960-1985 Men, Women and Total



Source: AAMC Division of Student Services

FIGURE 4

Age of Applicants 1978 and 1986






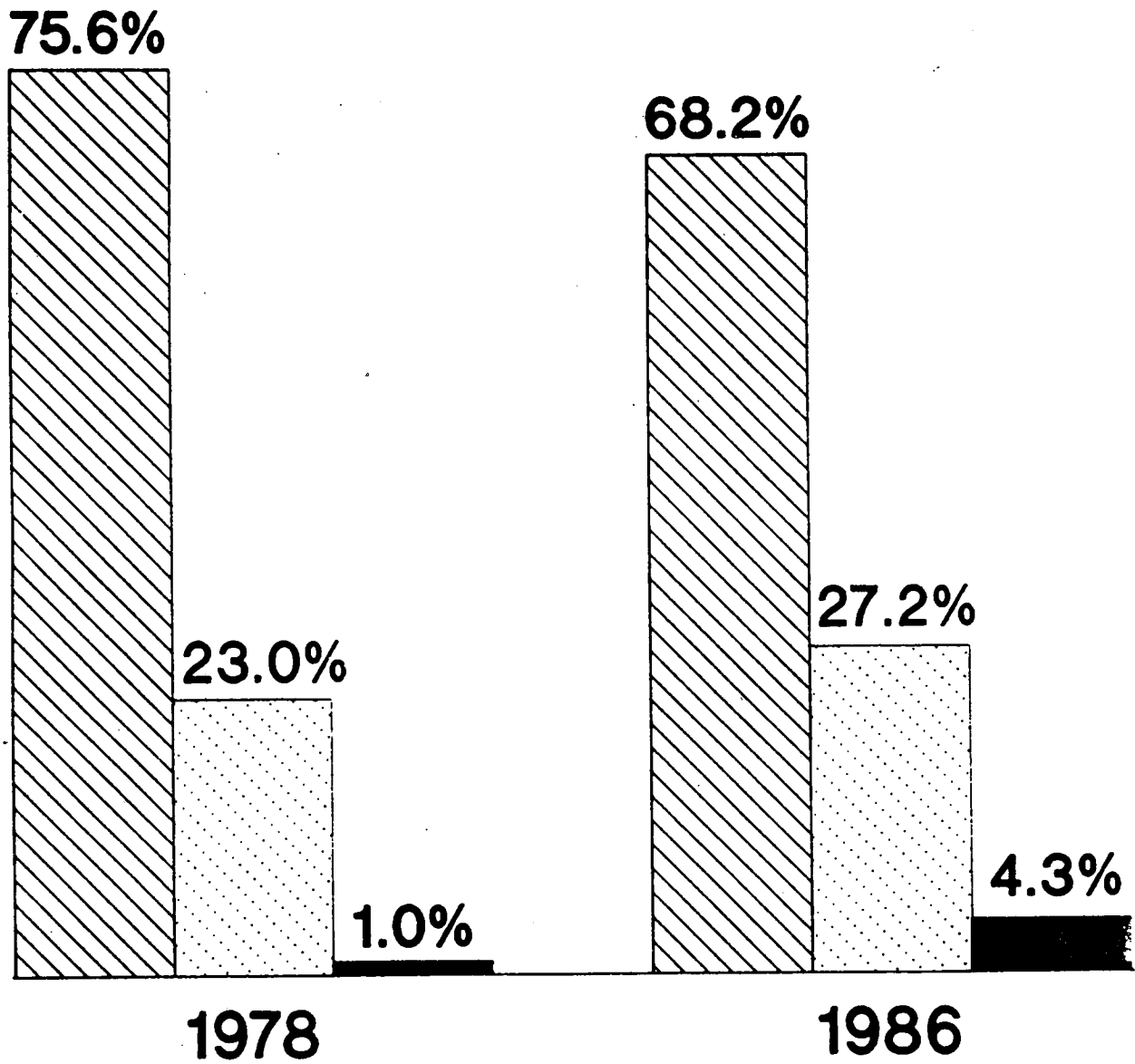
-  Less than 24 years
-  24 - 31 years
-  32 years and older

FIGURE 5

Age of Matriculants 1978 and 1986






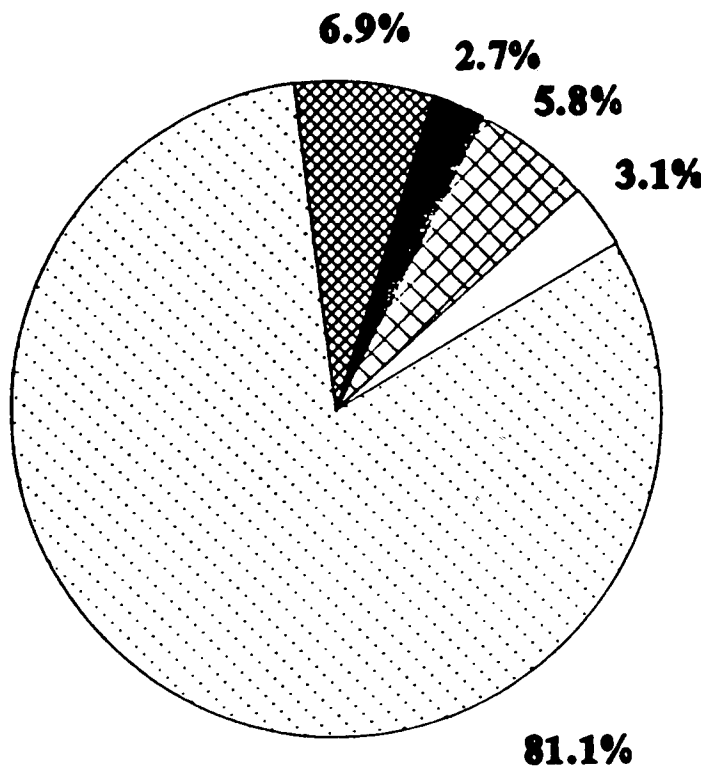
-  Less than 24 years
-  24 - 31 years
-  32 years and older

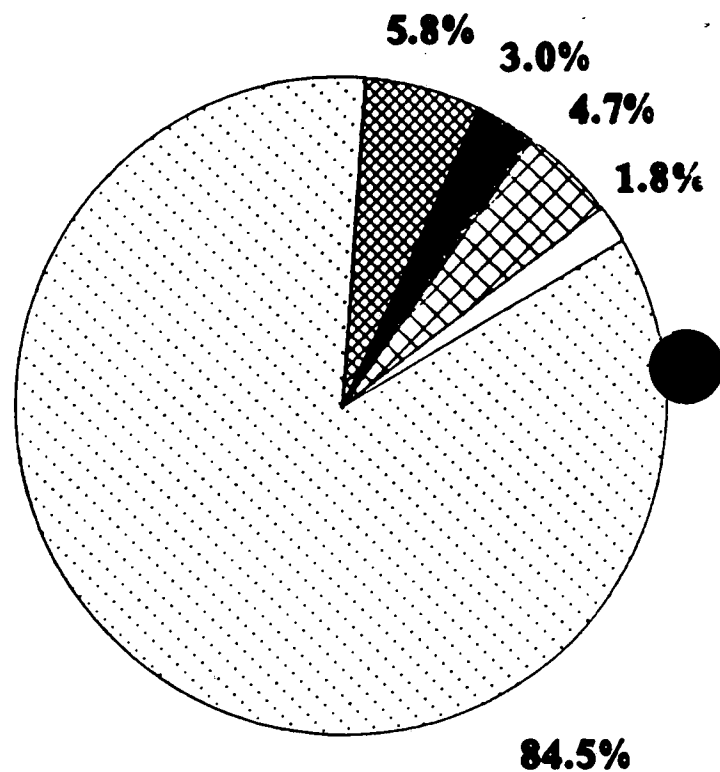
FIGURE 6

Ethnicity of Applicants and Matriculants 1978

Applicants



Matriculants

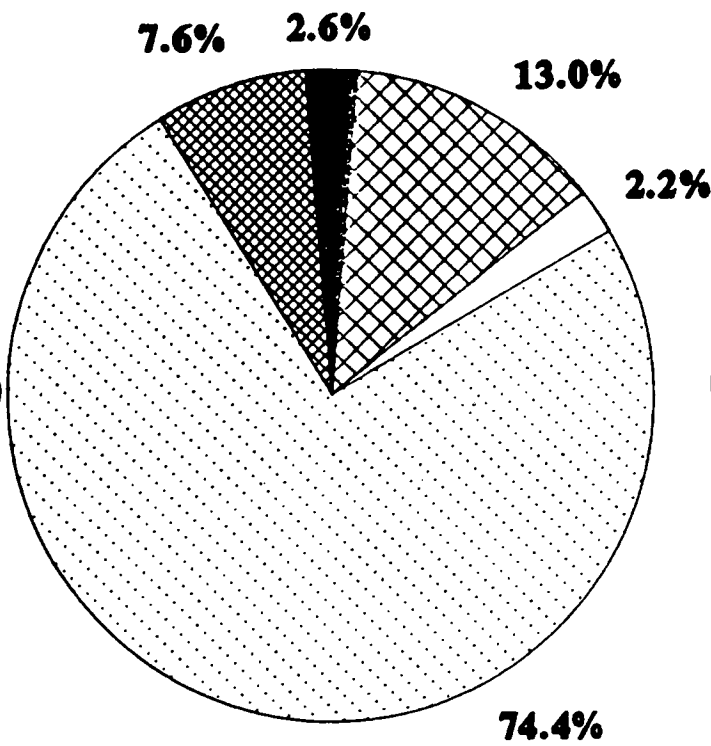


-  White
-  Black
-  Other Underrepresented Minority
-  Other
-  Unknown

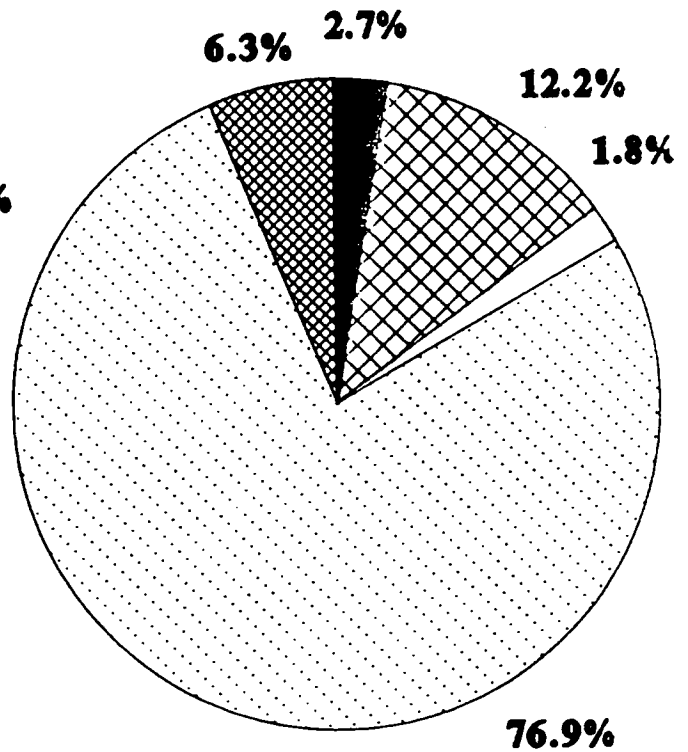
FIGURE 7

Ethnicity of Applicants and Matriculants 1986

Applicants



Matriculants

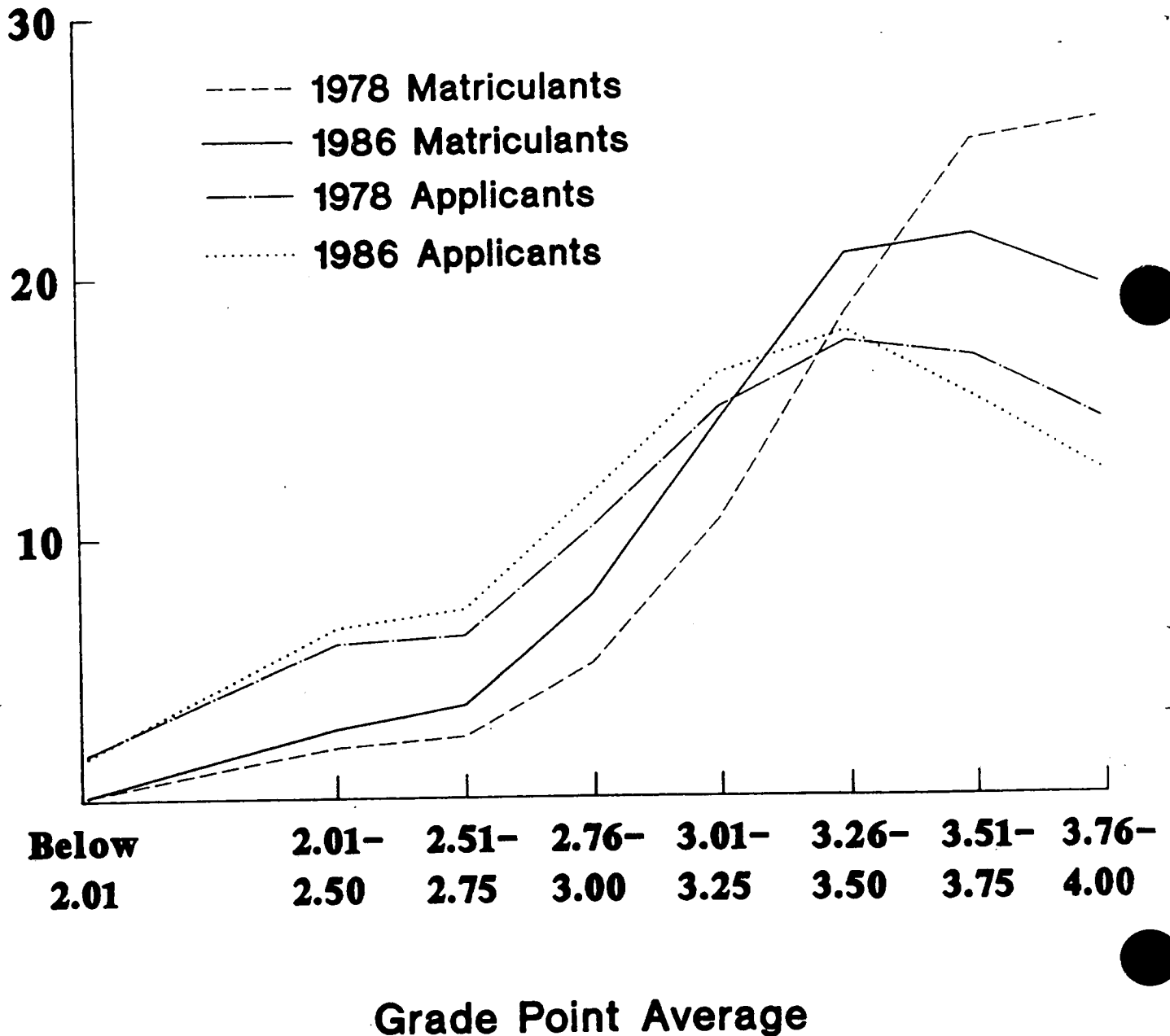


-  White
-  Black
-  Other Underrepresented Minority
-  Other
-  Unknown

FIGURE 8

Science Grade Point Average of Applicants and Matriculants 1978 and 1986

Percentage



Overall Grade Point Average of Applicants and Matriculants 1978 and 1986

Percentage

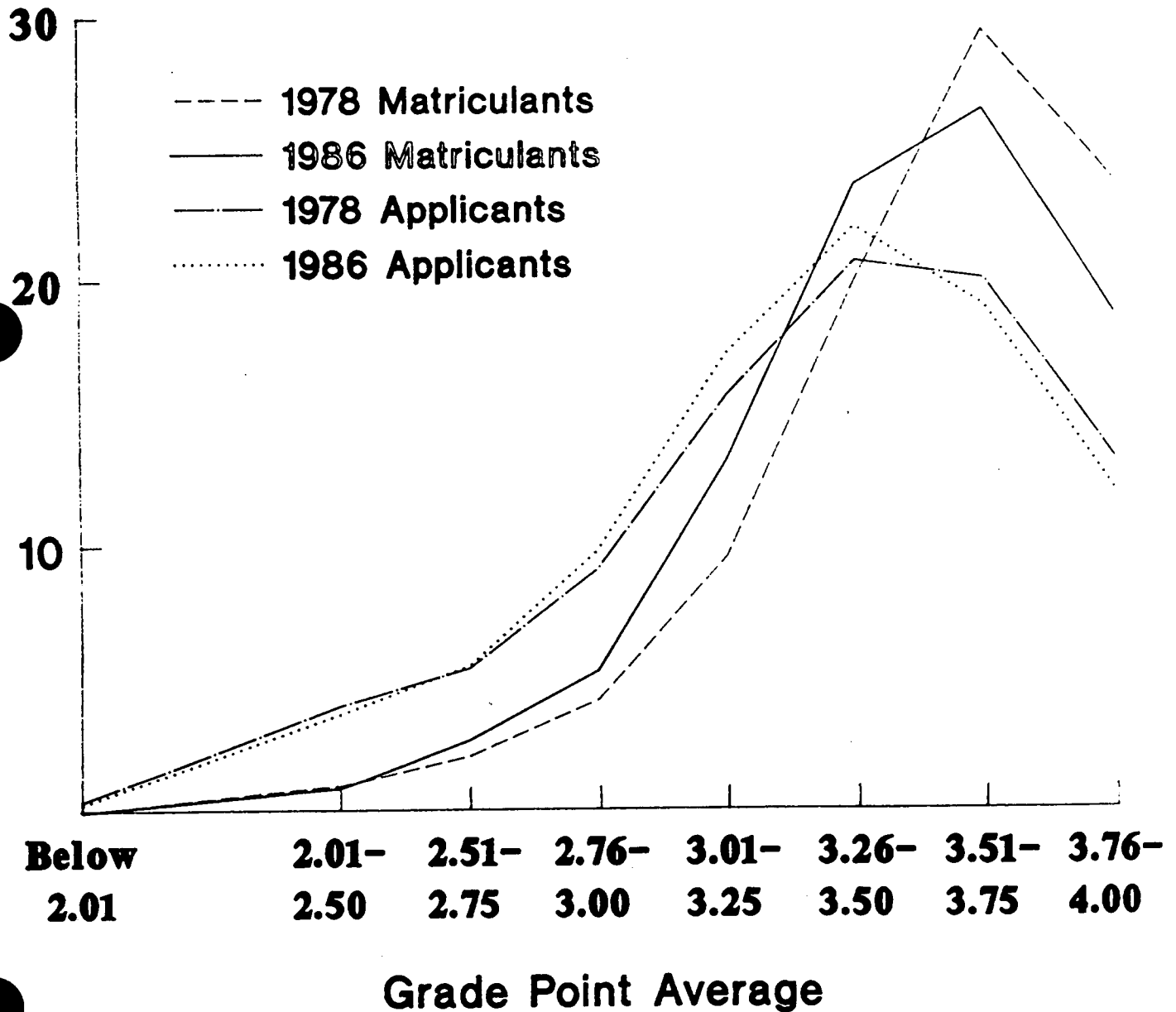


FIGURE 10

MCAT Chemistry Scores for Applicants and Matriculants 1978 and 1986

Percentage

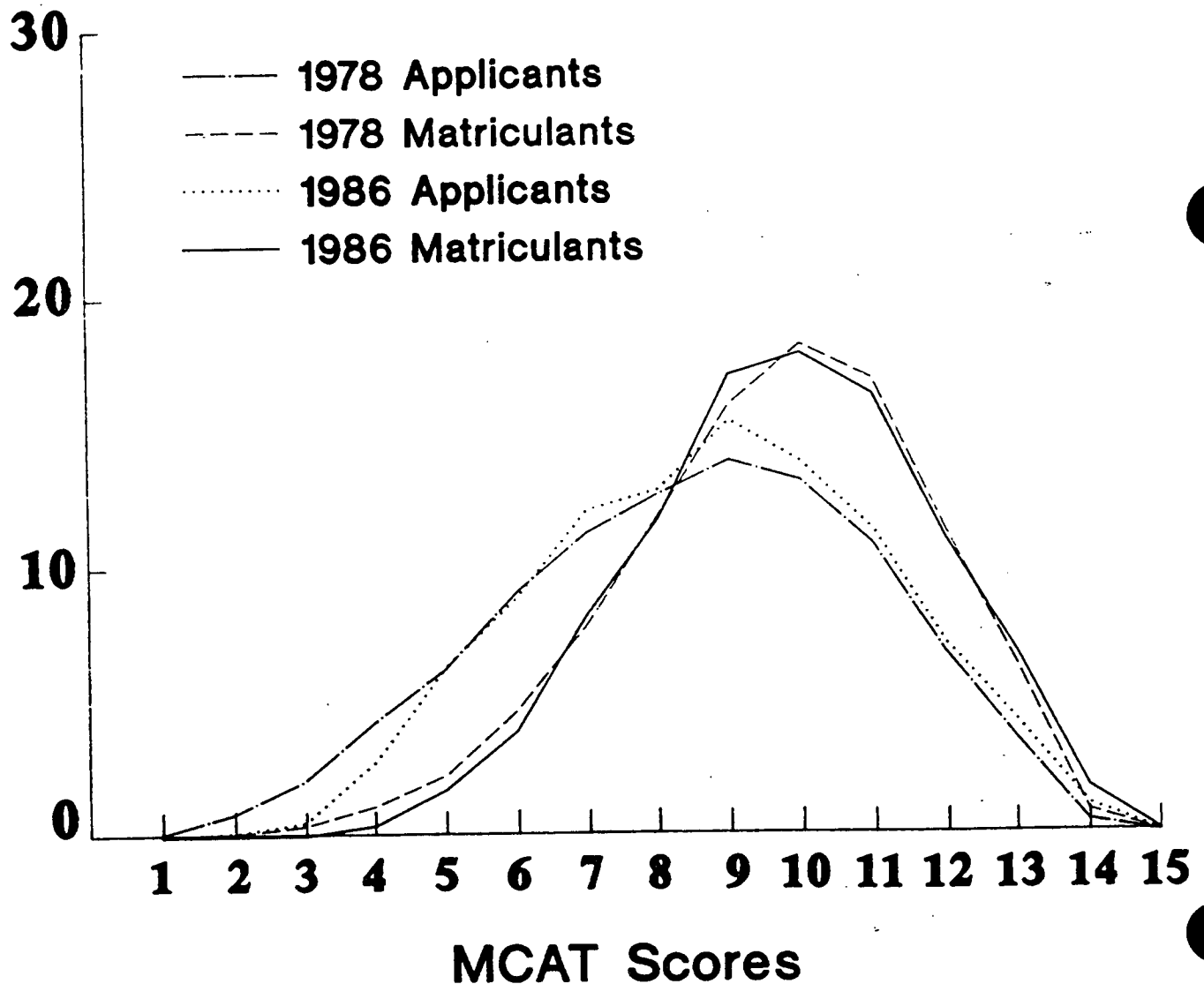


FIGURE 11

MCAT Reading Scores for Applicants and Matriculants 1978 and 1986

Percentage

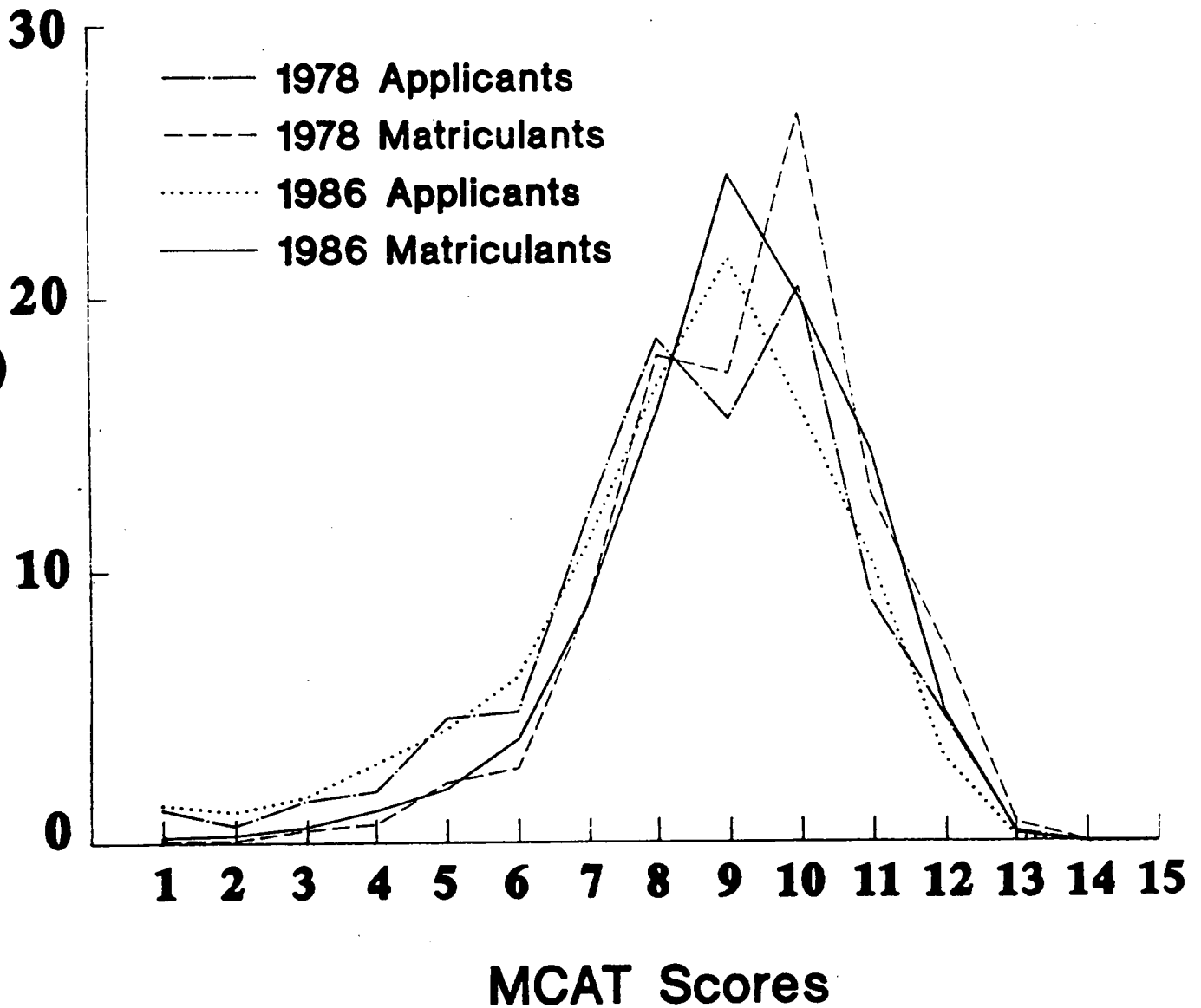


TABLE 1

**PROJECTIONS FOR APPLICANT/MATRICULANT RATIO
WITH MATRICULANTS DECREASING BY 0.6 PERCENT PER YEAR
1986-1990**

| | Applicant Decrease by 4%/Yr | Applicant Decrease by 8%/Yr |
|---------------|--------------------------------|--------------------------------|
| 1985 (Actual) | 1.90 | 1.90 |
| 1986 | 1.95 | 1.89 |
| 1987 | 1.88 | 1.73 |
| 1988 | 1.82 | 1.60 |
| 1989 | 1.76 | 1.48 |
| 1990 | 1.70 | 1.37 |

Source: AAMC Division of Student Services

THE MEDICAL MANPOWER ISSUE: A WORD OF CAUTION

The movement to more aggressively limit the number of entering medical students seems to be growing rapidly--almost as rapidly as the movement 15-20 years ago to enter a crash program to increase the number of medical graduates. Before we enter into another phase of this cycle, with the potential disruption and harm it might cause, I should like to encourage a moment of reflection and propose the following:

- (1) The policy of nearly all of the major medical organizations, including the AMA, AAMC and ACP, either explicit or implicit, has been that every qualified student who desires it should be able to get a medical education. While risking sounding like a traditionalist, I believe this "tried and true" policy is still sound. Why should the young people of this generation be deprived of that opportunity?

- (2) A medical school's continued existence, and its maximum allowed class size, should be based on strict quality criteria. The LCME should probably close (or force mergers) of some medical schools, and reduce class sizes (based on applicant pool and/or clinical teaching material) of many others.

- (3) Medical schools should admit that the selection process is imperfect and that mistakes are made, and should dedicate themselves to not graduating a less than absolutely qualified physician. Medical schools currently graduate 97-98% of matriculants. A maximum realistic figure would be around 90%.
- (4) We should increase our efforts to remove from practice poor quality physicians. This will probably necessitate federal legislative relief from the Federal Trade Commission.
- (5) Additional foreign medical graduates (including USFMG's) should not be licensed to practice in the U.S. However, we should encourage governmental programs to support training of FMG's in the U.S. for return to their native lands. This is important to the U.S. politically (physicians are often leaders in their home countries, and it is far better for us to have U.S., rather than Moscow-trained doctors), is in the best interest for world health, is broadening for our own students and residents, and could provide needed manpower in less desirable (inner-city) hospitals.
- (6) Market forces do work: e.g., more physicians are moving to rural areas, and declining medical school applicant pool.

(7) Financial considerations are not morally or politically wise. Organized medicine has a terrible (and largely deserved) reputation for being self-serving. To the general public, and to the media, most of the current pressure to control medical manpower is based on doctors' desires to maintain their lucrative incomes.

(a) In fact, much of the clamor regarding oversupply comes from doctors who are not as busy as they would like to be. (These are many of the same physicians who, ten years ago, were complaining that they did not have adequate time to spend with patients, for journal reading, or having well-rounded lives.) The public perception is certainly not that there are too many doctors.

(b) Much of the rest of the clamor emanates from the fact that a more adequate supply of physicians has made possible the development of alternative health care delivery systems.

(8) Current projections of physician manpower needs often fail to take into account several factors:

(a) Not all doctors are good doctors: when calculating that we need 5 of specialty A per 10,000 population, and that by 1995 we shall have 10/10,000, it is nearly never taken into account that the projected need is for 5 competent practitioners of specialty A per 10,000 population, and that it is unlikely that all 10/10,000 will be good

docs. This is painful, but true. It is highly unlikely that in the foreseeable future there can be too many good doctors of any specialty.

(b) Changes in physician characteristics:

- (1) A higher percentage of physicians are women, and women, on the average, practice fewer hours per week and see fewer patients (both probably desirable characteristics).
- (2) Medical students, on the average, are older on entrance to medical school, and therefore may have a shorter practice lifetime.
- (3) There appears to be a changing practice lifestyle by recent graduates, e.g., a desire for more leisure time, more time spent with families, decreased work week, possibly earlier retirement--arguably all changes which could lead to happier, more satisfying lives, and therefore better patient care.
- (4) With adequate numbers of good physicians, we could find that doctors will spend more time interacting with patients and more time in CME. This could even result in an easing of the "medical malpractice crisis".

(c) Changes in the patient population:

- (1) The aging of our population, leading to a greater need for medical services.
- (2) The AIDS epidemic.
- (3) Wider recognition of chemical abuse as a medical problem.

(d) Possible (and desirable) changes in the health care delivery system:

- (1) National health insurance, or some related plan(s), may make health care more available for the 30-35,000,000 Americans with no or insufficient health insurance: currently, even in such cities with a physician "glut" such as San Francisco and Boston, there are large populations not getting even minimal health care.
- (2) Most Americans, even upper class ones, are not getting adequate preventive health care, e.g., routine sigmoidoscopy at age 50, diagnosis and management of hypercholesterolemia, etc.

(e) International health care problems, such as preventable and treatable blindness, schistosomiasis, childhood diarrheas, could beneficially utilize some of our medical manpower "excess". I believe that young people, given the opportunity, would sign up in large numbers for a "medical Peace Corps".

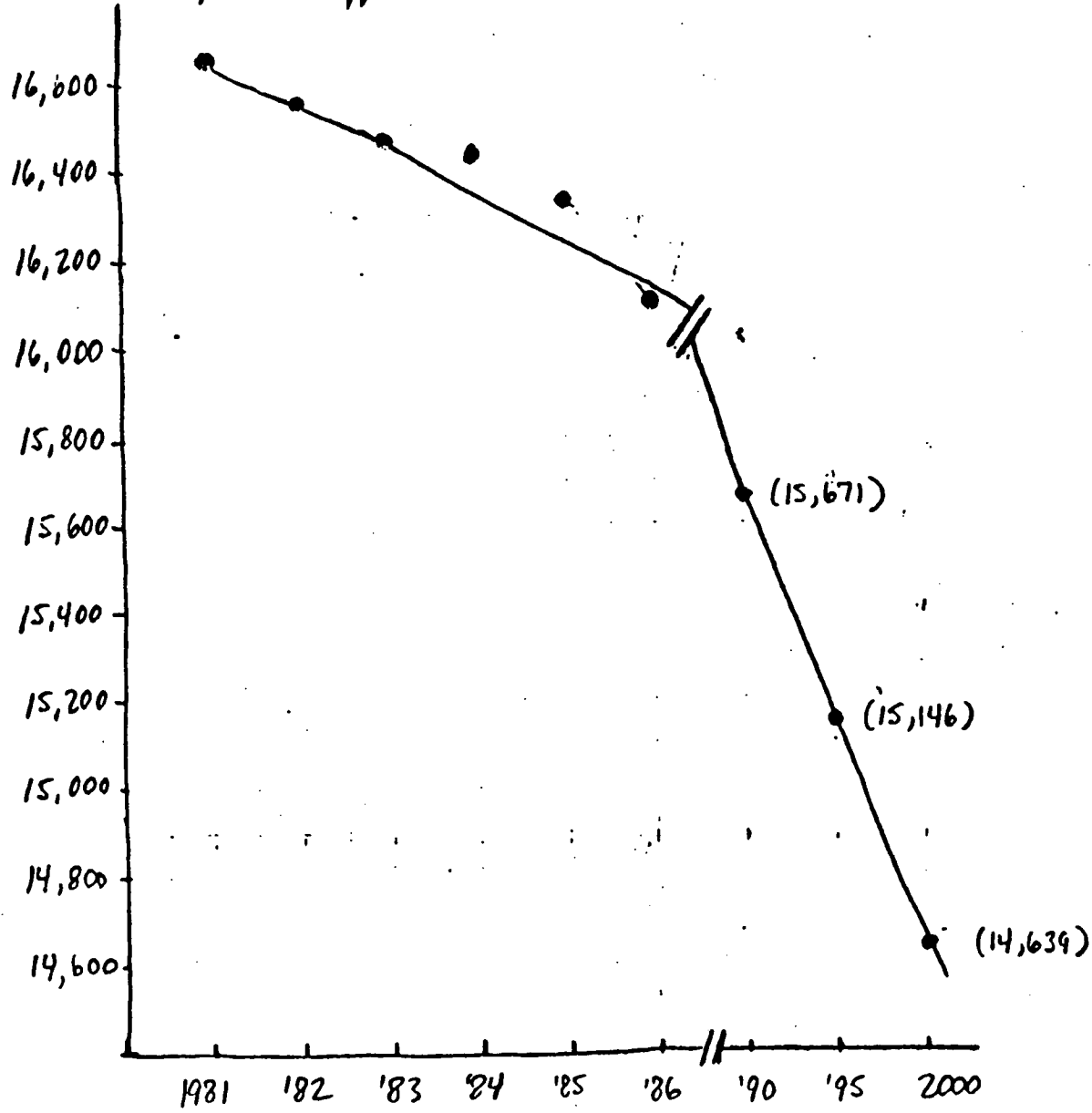
- (9) There is no need to take any radical or precipitous action, since the number of entering medical students is falling quite steadily anyway--a little less than 1% per year since 1981. If the current trend continues at present rate, we shall have fewer than 15,000 entering students by 1996 (Figure), a number which would give us a "steady state" of physicians (Table).
- (10) In my opinion, the greatest danger is to have government management of medical manpower. We should learn our lesson from how our nation's agriculture system has been handled. Thomas Jefferson, in my opinion, will always be thought of as one of, if not the greatest American ever. Lyndon B. Johnson probably will not. As an old West Virginian told me, "If it ain't broke, don't fix it".

Robert H. Waldman, M.D.
Dean, College of Medicine
University of Nebraska

RHW/tb

12/29/86

Entering 1st Year Medical Students, LCME-approved schools



REDUCTION IN CLASS SIZE: THE TARGET

ASSUME AN IDEAL STEADY STATE YEAR 2000 PREVALENCE OF 474,000 PHYSICIANS:

| CAREER LENGTH (YEARS) | AVERAGE AGE AT RETIREMENT* | TURNOVER (%/YEAR) | NEEDED GRADS | NEEDED MATRICULANTS** |
|--------------------------|----------------------------------|----------------------|-----------------|--------------------------|
| 50 | 83 | 2.0 | 9,480 | 10,533 |
| 45 | 78 | 2.2 | 10,533 | 11,703 |
| 40 | 73 | 2.5 | 11,850 | 13,167 |
| 35 | 68 | 2.9 | 13,543 | 15,048*** |
| 30 | 63 | 3.3 | 15,800 | 17,556 |

* AVERAGE AGE AT START OF PRACTICE = 33

** 90% GRADUATION RATE

*** A ~~MORE~~ REASONABLE GOAL (AT CURRENT RATE, WILL BE REACHED BY 1996)

IV. STATUS OF ACTIVITIES RELATED TO
THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

The final report of the ad hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency provides an agenda of actions to improve the residency selection process. The status of activity related to the agenda follows:

- Change the National Residency Matching Program schedule: All medical schools and 28 program director organizations have been asked for their preferences of dates for the submission of rank order lists and the release of match results in 1988. It is expected that the NRMP will announce its 1988 schedule around April 1.
- Improve the Universal Application Form: A revision of the form will be undertaken this spring, working with a subcommittee of the Group on Student Affairs.
- Improve Deans' Letters: A working group will be convened this year to develop guidelines on the evaluative information that should be included in letters to program directors.
- Ensure Appropriate Use of NBME Test Scores: A subcommittee of the Group on Medical Education is working with the National Board to develop an informational brochure for program directors.
- Restrain Excessive Audition Electives: Letters have been sent to the presidents of program director organizations asking them to work with their constituents to stop requiring or suggesting to students that they must come to their institutions for electives in order to be considered for selection.
- Improve the Coordination of PGY-1 and PGY-2 Selections: A working group will be convened in the fall of 1987 to explore how the selection of students who will start their speciality training in their second or later graduate years can be improved.

- Ensure Institutional Responsibility: A letter has been sent to the chief executive officers of the sponsoring organizations of the Accreditation Council for Graduate Medical Education to urge their involvement in implementing the General Requirements section of the Essentials of Accredited Residencies.
- Establish a date for the Release of Deans' Letters: All medical schools and the presidents of 23 program director organizations were surveyed to determine their preferences for the time interval between the receipt of deans' letters and transcripts and the submission of rank order lists to the NRMP by the programs. The results of the survey are shown in Table 1.

Looking at the schools' preferences, 14 weeks (3½ months) would appear to be an acceptable interval. Although 11 program director organizations preferred 16 weeks, 6 preferred 12 weeks and 1 preferred 14 weeks. Thus, 14 weeks should also be acceptable to the program directors who will receive the letters.

If the deadline for rank order list submission is set by the NRMP for Friday, February 26, 1988 (one of the options), and a 14 week interval is applied, deans' letters would be sent on November 20, 1987. For the early matching specialties (ophthalmology, otolaryngology, neurology, neurosurgery, and urology) the same interval would be applied. Thus, if the ophthalmology match deadline is moved to January 15, 1988, ophthalmology program directors would be provided deans' letters for their candidates on October 9, 1988.

The Council should discuss the data on the preferred intervals and reach a consensus for recommendation to the Executive Council.

TABLE 1

Preferred Interval for the Time Between Receipt of Deans'
Letters and Submission of NRMP Rank Order Lists

| <u>Number of Weeks</u> | <u>Number of Schools</u> | <u>Number of Program Director Organizations</u> | <u>Totals</u> |
|------------------------|--------------------------|---|---------------|
| 10 | 1 | --- | 1 |
| 12 | 37 | 6 | 43 |
| 14 | 29 | 1 | 30 |
| 16 | 31 | 11 | 42 |
| 18 - 20 | 2 | --- | 2 |

TABLE 2

Preferred Interval for the Time Between Receipt of
Deans' Letters and Submission of NRMP Rank Order
Lists by Program Director Organizations

| <u>Specialty Organization</u> | <u>12 weeks</u> | <u>14 weeks</u> | <u>16 weeks</u> |
|--|-----------------|-----------------|-----------------|
| American Academy of Allergy & Immunology | X | | |
| Society of Academic Anesthesia Chairmen | | | X |
| Society of Teachers of Emergency Medicine | | | X |
| Association of Departments of Family Medicine | X | | |
| Association of Program Directors in Internal Medicine | | | X |
| Association of Professors of Medicine | | | X |
| Association of University Professors of Neurology | X | | |
| Association of University Professors of Ophthalmology | | X | |
| Association of Orthopaedic Chairmen | | | X |
| Association of Academic Departments of Otolaryngology | | | X |
| Association of Pathology Chairmen | X | | |
| Association of Medical School Pediatric Department Chairmen | | | X |
| Association of Academic Physiatriests | | | X |
| Association of Teachers of Preventive Medicine | | | X |
| American Association of Chairmen of Departments of Psychiatry | | | X |
| American Association of Directors of Psychiatric Residency Training | | | X |
| American Association of Plastic Surgeons | X | | |
| Society of Surgical Chairmen | X | | |
| | <hr/> | <hr/> | <hr/> |
| TOTALS | 6 | 1 | 11 |

DISCUSSION GROUP # 01

Monday, April 6

(Lost Horizon)

GROUP LEADER: William T. Butler
Baylor College of Medicine

John W. Colloton
University of Iowa Hospitals and Clinics

Milton Corn
Georgetown University School of Medicine

Martin Goldberg
Temple University School of Medicine

Charles G. Halgrimson
University of Colorado School of Medicine

Harry S. Jonas
Univ of Missouri - Kansas City School of Medicine

Robert J. Joynt
University of Rochester Sch of Medicine and Dentistry

Peter O. Kohler
University of Texas Medical School at San Antonio

Richard G. Lester
Eastern VA Medical School

Richard H. Moy
Southern Illinois University School of Medicine

John F. Sherman
AAMC

Virginia V. Weldon
Washington University School of Medicine

DISCUSSION GROUP # 02

Monday, April 6

(McKenna Lawn - A)

GROUP LEADER: L. Thompson Bowles
George Washington University School of Medicine

George T. Bryan
University of Texas Medical School at Galveston

Walter J. Daly
Indiana University School of Medicine

Joseph S. Gonnella
Jefferson Medical College of Thomas Jefferson University

Nathan G. Kase
Mount Sinai School of Medicine of the City Univ of New York

Thomas J. Kennedy
AAMC

M. Kenton King
Washington University School of Medicine

William D. Mayer
Eastern VA Medical School

James A. Pittman
University of Alabama School of Medicine

Leon E. Rosenberg
Yale University School of Medicine

William D. Sawyer
Wright State University School of Medicine

I. Dodd Wilson
University of Arkansas College of Medicine

DISCUSSION GROUP # 03

Monday April 6

(McKenna Lawn - B)

GROUP LEADER: Robert S. Daniels
Louisiana State University Sch of Medicine in New Orleans

Wayne Akeson
UC - San Diego School of Medicine

James Bentley
AAMC

Bernard J. Fogel
University of Miami School of Medicine

Spencer Foreman
Montefiore Medical Center

Marvin Kuschner
SUNY at Stony Brook Health Sciences Ctr Sch of Medicine

Russell L. Miller
Howard University College of Medicine

Robin D. Powell
University of Kentucky College of Medicine

Frank G. Standaert
Medical College of Ohio

Edward J. Stemmler
University of Pennsylvania School of Medicine

William Stoneman
Saint Louis University School of Medicine

Robert L. Summitt
University of Tennessee College of Medicine

DISCUSSION GROUP # 04

Monday, April 6

(Wailea Terrace - A)

GROUP LEADER: D. Kay Clawson
University of Kansas School of Medicine

B. Lyn Behrens
Loma Linda University School of Medicine

Stuart Bondurant
University of North Carolina School of Medicine

John M. Dennis
University of Maryland School of Medicine

Richard M. Knapp
AAMC

William B. Neaves
Univ of Texas Southwestern Medical School at Dallas

Stanley W. Olson
Morehouse School of Medicine

Theodore J. Phillips
University of Washington School of Medicine

Alton I. Sutnick
Medical Coll of Pennsylvania

Manuel Tzagournis
Ohio State University College of Medicine

Michael E. Whitcomb
Univ of Missouri - Columbia School of Medicine

DISCUSSION GROUP # 05

Monday April 6

(Wailea Terrace - B)

GROUP LEADER: Louis J. Kettel
University of Arizona College of Medicine

Lester R. Bryant
Marshall University School of Medicine

Larry D. Edwards
Oral Roberts University School of Medicine

James B. Hanshaw
University of Massachusetts Medical School

Richard Janeway
Bowman Gray School of Medicine of Wake Forest University

David Korn
Stanford University School of Medicine

Richard L. O'Brien
Creighton University School of Medicine

John C. Ribble
University of Texas Medical School at Houston

August G. Swanson
AAMC

John Wellington
University of Hawaii John A. Burns Sch of Medicine

Israel Zwerling
Hahnemann Medical College

DISCUSSION GROUP # 06

Monday, April 6

(Wailea Ballroom - A)

GROUP LEADER: John Naughton
SUNY at Buffalo School of Medicine

Anthony L. Barbato
Loyola University of Chicago Stritch School of Medicine

Arnold L. Brown
University of Wisconsin Medical School

David R. Challoner
University of Miami School of Medicine

David S. Greer
Brown University Program in Medicine

Joseph E. Johnson
University of Michigan Medical School

William E. Laupus
East Carolina University School of Medicine

Kenneth W. Rowe
University of Cincinnati College of Medicine

Cecil O. Samuelson
University of Utah College of Medicine

Rudi Schmid
UC - San Francisco School of Medicine

Elizabeth M. Short
AAMC

Robert H. Waldman
University of Nebraska College of Medicine

DISCUSSION GROUP # 07

Monday, April 6

(Wailea Ballroom - B)

GROUP LEADER: Richard S. Ross
Johns Hopkins University School of Medicine

G. William Bates
Med Univ of South Carolina College of Medicine

Harry N. Beaty
Northwestern University Medical School

Richard A. Cooper
Medical College of Wisconsin

Tom M. Johnson
University of North Dakota School of Medicine

John W. Kendall
Oregon Health Sciences Univ School of Medicine

Joseph A. Keyes
AAMC

William H. Luginbuhl
University of Vermont School of Medicine

Frank G. Moody
University of Texas Medical School at Houston

Henry L. Nadler
Wayne State University School of Medicine

Richard C. Reynolds
Univ of Medicine & Dentistry Rutgers Medical School

Kenneth I. Shine
UC - Los Angeles UCLA School of Medicine

DISCUSSION GROUP # 08

Monday April 6

(Wailea Ballroom - C)

GROUP LEADER: Henry P. Russe
Rush Medical College of Rush University

Stephen M. Ayres
VCU Medical Coll of Virginia School of Medicine

Richard E. Behrman
Case Western Reserve Univ School of Medicine

Henrik H. Bendixen
Columbia University Coll of Physicians & Surgeons

George M. Bernier
University of Pittsburgh School of Medicine

David M. Brown
University of Minnesota Medical School - Minneapolis

Marshall A. Falk
University of Health Sciences Chicago Medical School

J. O'Neal Humphries
University of South Carolina Medical School

Paul Jolly
AAMC

Raja N. Khuri
American University Beirut

Robert E. Tranquada
Univ of Southern California School of Medicine

DISCUSSION GROUP # 09

Monday, April 6

(Wailea Ballroom - D)

GROUP LEADER: W. Donald Weston
Michigan State University College of Human Medicine

David Baime
AAMC

Colin Campbell
Northeastern Ohio Universities College of Medicine

Robert M. Carey
University of Virginia School of Medicine

James J. Castles
UC - Davis School of Medicine

John E. Chapman
Vanderbilt University School of Medicine

C. McCollister Evarts
Pennsylvania State University College of Medicine

Phillip M. Forman
University of Illinois College of Medicine

Robert L. Friedlander
Albany Medical College of Union University

Paul C. Royce
University of Minnesota-Duluth School of Medicine

Robert L. Van Citters
University of Washington School of Medicine

DISCUSSION GROUP # 01

Tuesday, April 7

(McKenna Lawn - A)

GROUP LEADER: William T. Butler
Baylor College of Medicine

Wayne Akeson
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Tuesday, April 6

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AAMC

Israel Zwerling
Hahnemann Medical College

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Tuesday, April 7

(McKenna Lawn - B)

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Johns Hopkins University School of Medicine

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Creighton University School of Medicine

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Ohio State University College of Medicine

Robert L. Van Citters
University of Washington School of Medicine

SUMMARY OF MANPOWER DISCUSSIONS
COD MEETING - MAUI
APRIL 8, 1987

Discussion in all groups reflect the fact that this topic is a complicated one in which we, as a group of deans, hold diverse views on the many issues central to the topic; namely, are there too many doctors, and - are we admitting, educating, and graduating too many medical students?

In the short period allotted to this summary, all issues will not be identified; however, a few commonly raised concerns will be reported, leaving the others to the discussion.

We are not all persuaded that there are too many doctors or medical students. We are nearly all convinced that many specialities are overpopulated and many geographic locations are medically underserved. Although we have ideas about influencing, the specialty choices of our students, we are not confident about our ability to do so nor are we confident in our authority to implement our ideas. We acknowledge that reimbursement for medical providers is very influential and is changing. None of us confidently, foresees how the changing world of medical practice will sustain or diminish current incentives to seek what are now the high paying specialties.

We fear that attempts to reduce the number of physicians will be seen as self serving by politicians and the public. We distrust all economic analyses including that which purports to relate the high cost of medical care generally to the number of practicing physicians, unless that economic argument happens to support our bias toward a specific action on the issue.

Among us, there is a strong consensus on the need to continue selecting highly capable people for our medical schools. The decreasing applicant pool is perceived as a significant threat to this quality issue and there is near unanimity that this issue should be addressed by each of us and our spokesman, the AAMC. Specifically, many believe that the AAMC should continue its current efforts to improve the image of medical

careers and to offset the discouragement communicated by many practicing physicians about the profession. Further, all deans may wish to consider student recruitment a relatively new but now important function of a dean. Some of us believe that the dwindling applicant pool will result in the reduction of entering class size in many schools and that no other action is currently indicated because of this high probability. A segment of the issue of quality students and quality education relates to foreign medical graduates and other health professionals who are working diligently to increase their share of patient care. There is consensus among us that the AAMC should continue its proactive stance discouraging the admission of FMG's to post graduate education in America (with rare and highly specific exceptions) and that all deans, cooperating with the AAMC, should work with medical societies, licensing boards and state and federal legislators to tighten the screen in this arena.

We individually and collectively feel a sense of frustration about our limited authority to deal with osteopaths, podiatrists, psychologists, optometrists, pharmacists and other competitors who we believe are less well prepared to provide our level of medical care.

With respect to class size, there is much concern about reduction or possible closure of medical schools. As institutions, academic medical centers have become more complicated in recent decades and their research roles, their roles in indigent care, their multiple educational missions, their centrality in many Universities all combine to make closure, or even significant reduction in medical student education, a many sided social issue. Reducing class size would be a serious, and in some instances, devastating financial action for many private and public schools for both common and differing reasons. AAMC policy devised to attack this issue on a national basis would underscore the heterogeneity of our constituency and no doubt result in some serious divisions among us. Further, many are reluctant to reduce the number of their graduates until the proliferation of less educated professionals into medical care subsides.

The important social issues contained within this topic make it

clear that we cannot reconcile all social agendas within any one course of action. For example, if we respond to the decreasing applicant pool by maintaining our current admissions standards, as all of us believe we must, and deal in part with projections of excess manpower by raising graduation standards and increasing our failure rates, we will damage minority programs many in this room have worked more than a decade to develop and promote.

In closing, a number of other issues, major and minor were discussed and are unidentified in this summary. Many views and opinions were expressed, often intensely and eloquently; however, I am able to report only three recommendations based on what I perceive as wide consensus. They are 1. Above all, maintain quality of students and education and deal with the consequences; 2. Do all in our power individually and collectively to terminate the influx of foreign medical graduates for medical practice and most education, regardless of their citizenship and 3. Deans and the AAMC should increase efforts to communicate the greater than ever before excitement and challenge in a medical career.

Thank you.

L. Thompson Bowles, M.D., Ph.D.
Dean for Academic Affairs
George Washington University
School of Medicine and Health Sciences
April, 1987



**association of american
medical colleges**

April 14, 1987

To: Executive Staff
Fm: August Swanson
Re: COD Meeting - Maui

Attached please find Summary of Manpower Discussions, COD Meeting,
Maui, April 8, 1987.

attachment