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**SESSION V**

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*11:00 am - 1:00 pm*

REPEAT OF DISCUSSION GROUPS

*1:00 pm*

UNSCHEDULED TIME

**Wednesday, March 23**

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**SESSION VI**

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*8:30 am - 12:00 noon, Archer*

COD BUSINESS MEETING

*12:00 Noon*

ADJOURNMENT

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**PROGRAM PLANNING COMMITTEE**

---

William T. Butler, M.D.

William B. Deal, M.D.

David S. Greer, M.D.

Donald G. Kassebaum, M.D.

Jay P. Sanford, M.D.

Kenneth I. Shine, M.D.

Daniel C. Tosteson, M.D.



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ASSOCIATION OF  
AMERICAN MEDICAL  
COLLEGES

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## **COUNCIL OF DEANS SPRING MEETING**

*Program*

March 20-23, 1988

*The Hotel Inter-Continental*  
Hilton Head, South Carolina

# **SPRING MEETING of the COUNCIL OF DEANS**

March 20-23, 1988

*The Hotel Inter-Continental*  
Hilton Head, South Carolina

## **Sunday, March 20**

10:00 - 2:00 pm, *Advantage Area*

ARRIVAL & REGISTRATION

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### **SESSION I**

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3:30 - 4:30 pm, *Barnwell*

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

4:30 - 5:00 pm, *Barnwell*

PHYSICIAN SUPPLY TASK FORCE  
Daniel C. Tosteson, M.D.  
*Chairman*

5:00 - 6:00 pm, *Pool Deck*

RECEPTION

## **Monday, March 21**

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### **SESSION II**

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8:30 - 9:00 am, *Barnwell*

A DECLINING APPLICANT POOL—  
HOW CAN WE PRESERVE  
AFFIRMATIVE ACTION?  
Russell L. Miller, M.D.  
*Dean*  
Howard University College of Medicine

9:00 - 10:30 am,

SMALL GROUP DISCUSSIONS

10:30 - 11:00 am, *Barnwell*

COFFEE BREAK

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### **SESSION III**

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11:00 - 11:30 am, *Barnwell*

DEVELOPMENT OF WOMEN & MINORITY  
FACULTY MEMBERS—  
HOW ARE WE DOING?  
Kenneth I. Shine, M.D.  
*Dean*  
UCLA School of Medicine

11:30 am - 1:00 pm

SMALL GROUP DISCUSSIONS

1:00 pm

UNSCHEDULED TIME

## **Tuesday, March 21**

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### **SESSION IV**

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8:30 - 10:30 am

GRADUATE MEDICAL EDUCATION:  
HOW SHOULD IT BE SUPPORTED  
IN THE FUTURE?  
Jay P. Sanford, M.D.  
*President & Dean*  
Uniformed Services University of the  
Health Sciences

INTERNATIONAL MEDICAL EDUCATION:  
WHAT ARE THE U.S. ROLES  
AND RESPONSIBILITIES?  
David S. Greer, M.D.  
*Dean*

Brown University Program in Medicine

CONTINUING MEDICAL EDUCATION:  
WHO IS RESPONSIBLE FOR ITS QUALITY  
& EFFECTIVENESS?  
Donald G. Kassebaum, M.D.  
*Executive Dean*  
University of Oklahoma College of Medicine

STRENGTHENING THE VA—  
MEDICAL SCHOOL RELATIONSHIP  
John A. Gronvall, M.D.  
*Chief Medical Director*  
Veterans Administration

10:30 - 11:00 am, *Savannah Foyer*

COFFEE BREAK

*Ask your medical school financial aid officer for the 1988-89 MEDLOANS application materials or complete and mail this card.*

☐ YES, I'd like a set of MEDLOANS application material.

Name \_\_\_\_\_

Address \_\_\_\_\_

Medical School (if known) \_\_\_\_\_

◆  
**COMPREHENSIVE  
MEDICAL STUDENT  
LOAN PROGRAM**  
◆

**1988-89**

**SPECIAL FEATURES OF MEDLOANS**

**A** single form allows students to apply for one, two, three or all four loan programs at one time and, within eligibility guidelines, assures access to all four loan programs from one source.

**N**o co-signer(s) are required for any programs.

**N**o application fee is required for any of the four loan programs.

**G**raduated repayment plans will be available which will be sensitive to a modest income during the early years of medical practice.

**L**oan consolidation, including currently outstanding loans, will be offered for Guaranteed Student Loans (GSL), Auxiliary Loans to Assist Students (ALAS), Supplemental Loans for Students (SLS), Perkins Loans (formerly NDSL), and the Health Professions Student Loans (HPSL). Combined repayment options will also be available for HEAL and ALP.

**N**o prior or current banking relationship is required with the lender.

**SPECIAL FEATURES OF MEDLOANS**

**T**he loan origination system is rapid and responsive. Checks are generally issued within 10-15 working days of receipt of application.

**A**ll loans will be held by a single lender, and all communications and repayments will be to a single organization.

**T**he program is tailored for and available only to allopathic medical students attending U.S. medical schools.

**S**tudents attending any AAMC member school may participate, regardless of their state of residence.

**A** multi-year lending commitment has been made, assuring students access to a stable and consistent source of funds.

**P**rivate capital is utilized which is not dependent on tax exempt financing or schools' institutional funds.

**B**elow market interest rates on many loans and no guarantee fees on GSL and SLS significantly reduces the cost of borrowing.

# MEDLOANS<sup>SM</sup>

## Component Loan Program Summary

NOTE: The descriptive information provided in this brochure represents a summary of applicable terms. Laws, regulations and rules pertaining to this information and the four component loan programs are subject to change. Complete information is provided in the MEDLOANS loan application materials.

### GSL

**Interest Rate**—Your annual rate will be 7%, 8% or 9%, the same as any previous GSL you might have, or 8% for the first five years and 10% for the last five years during repayment if you have no prior loans.

**Guarantee and Origination Fee**—Currently, you will not be charged a guarantee fee; however, an origination fee of 5.0% of the loan amount will be charged.

**Annual Borrowing Limit**—You may borrow up to \$7,500 annually.\*\*

**Aggregate Borrowing Limit**—You may borrow up to a total of \$54,750, which includes both undergraduate and graduate borrowing.

**Repayment**—Generally, your repayment will begin after your second year of residency. You will have up to 10 years to repay the loan.

**Eligibility**—You must be enrolled as at least a half time student and pass a needs analysis test demonstrating a financial need for the loan.

### SLS

**Interest Rate**—Your annual rate will be the rate of the 52-week Treasury Bill, plus 3.25%, with a maximum of 12%.

**Guarantee and Origination Fees**—Currently, there is no guarantee or origination fee for SLS loans.

**Annual Borrowing Limit**—You may borrow up to \$4,000 annually.\*\*

**Aggregate Borrowing Limit**—You may borrow up to a total of \$20,000, which includes both graduate and undergraduate SLS borrowing.

**Repayment**—Your repayment will begin after your third year of residency. You will have up to 10 years to repay the loan.

**Eligibility**—Generally, you must be enrolled as a fulltime student, but there is no requirement to demonstrate financial need for the loan.

### HEAL

**Interest Rate**—Your quarterly rate will be variable and indexed to the 91-Day Treasury Bill.

**Guarantee and Origination Fees**—A guarantee fee of 8% of the loan principal will be charged.

**Annual Borrowing Limit**—You may borrow up to \$20,000 annually.\*\*

**Aggregate Borrowing Limit**—You may borrow up to a total of \$80,000.

### HEAL (continued)

**Repayment**—Your repayment will begin 9 months after your fourth year of residency. You will have up to 25 years to repay the loan.

**Eligibility**—You must pass a needs analysis test demonstrating a financial need for the loan.

### ALP

**Interest Rate**—During the in-school period, your interest rate will be variable and indexed to the 91-Day Treasury Bill rate. At repayment, you may switch to a fixed rate, which will be indexed to the 30-Year Treasury Bond.

**Insurance and Origination Fees**—You will be charged an insurance premium which varies depending on certain options which you select. There is no origination fee.

**Annual Borrowing Limit**—You may borrow up to \$30,000, less other loans you have received.\*\*

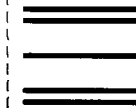
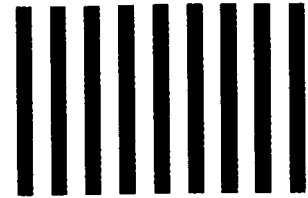
**Aggregate Borrowing Limit**—You may borrow up to \$120,000, less other loans you have received.

**Repayment**—Your repayment will begin after your third year of residency and you will have up to 20 years to repay the loan.

**Eligibility**—There is no requirement that you demonstrate financial need for the loan.

\*\*Your total annual borrowing under all of these programs will always be limited to your cost of education less other aid you receive.

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*An Invitation*

*to*

*the 1988 Council of Deans*

*Spring Meeting Dinner*

*March 22, 1988*

*Wexford Plantation Country Club*

*Hilton Head, SC*

### 1988 Council of Deans Spring Meeting Dinner

This year's Council of Deans Spring Meeting dinner will be held at the elegant and distinctive Wexford Plantation Country Club. Located on a quiet harbourfront and styled in the classic British Colonial style, the Clubhouse is generally not open to the public, but we are fortunate to be able to offer this evening to the Council of Deans.

The reception and dinner will be held on Tuesday, March 22nd, from 6:30 - 11:30 p.m. Entertainment will be provided by the Ken James Band, an 8-piece orchestra specializing in the "Big Band" sound. The evening will begin with cocktails served throughout the Clubhouse and rear veranda of the club. At 7:30, the buffet will be served, with seating overlooking the harbour under a canopy tent. At 9:00, the dancing begins, with music and after dinner drinks in the Clubhouse.

Cost per person for this special evening will be \$75.00. Tickets will not be sold in Hilton Head. Your reservation must be received by March 5, 1988. Please make checks payable to the AAMC, and mail the enclosed response form with your check to:

Amy Eldridge  
AAMC  
One Dupont Circle, NW  
Suite 200  
Washington, DC 20036

### Hors D'oeuvres

Filletts of beef on toast rounds Montepellier  
Shrimp wrapped in bacon  
Baby crepes filled with apple and Boursin cheese  
Pastry puffs filled with chicken, tarragon & red bell peppers  
Roasted loin of lamb on toast points with fennel and tomato

### Appetizers

Scallops St. Jacques  
Shrimp Cocktail

### Salads

Caesar Salad with fresh garlic croutons, plum tomatoes and tangy Caesar dressing  
Boston, Mache and Radicchio Salad, with wild mushrooms and choice of sweet mustard vinaigrette or creamy herb dressing

### Entrees

Blackened Salmon with a fennel and garlic butter  
Roast Tenderloin with light shallot and mushroom demi-glace

### Accompaniments

Roasted New Potatoes  
Fresh Steamed Green Beans  
Carrot Almondine

### Desserts

Strawberry and Raspberry Romanoff  
Triple Chocolate Mousse Torte



# association of american medical colleges

February 11, 1988

## MEMORANDUM

TO: The Council of Deans

FROM: Louis J. Kettel *LJK*, Associate Vice President for Academic Affairs

SUBJECT: 1988 COD Spring Meeting in Hilton Head

The 1988 COD Spring Meeting is quickly approaching, and the number of deans planning to attend is reaching a new record. I am confident that this year's meeting will be one of our best ever.

Enclosed is an invitation to the Council's annual Spring Meeting dinner. This year's dinner is being held at Wexford Plantation Country Club, noted as the most elegant club on Hilton Head. The natives have informed me that Wexford has the best food on the entire island, so I hope that you will plan on taking part in this special evening. To reserve a place for both you and your guest, please return the peach colored reservation form directly to Amy Eldridge at the AAMC. **Reservations must be received by March 5, 1988. Tickets will not be sold at the meeting.**

Also enclosed is a yellow colored reservation request form from Low Country Adventures. Please mail the card with your flight arrival time to them if **you will require limo service to the hotel.** Low Country will then meet your flight and take you immediately to the hotel. We have arranged for a discounted price of \$28.00 **roundtrip** from the Savannah Airport, and \$8.00 roundtrip from Hilton Head Airport.

The final meeting program and background materials will be mailed to you shortly. I look forward to seeing you in Hilton Head.



# association of american medical colleges

April 13, 1988

Robert Beran, Ph.D.,  
Sect for Student and  
Educational Programs  
One Dupont Circle  
Washington, DC 20036

Dear Bob:

The spring meeting of the Council of Deans went very well. Your presence, beyond the special efforts you made in your presentation, was well appreciated. Your presentation, of course, was very important, as well as your presence as a resource. I am impressed with the need for having good staff input at these occasions. I am particularly impressed with the need to have staff present as a "welcoming committee" for the new participants. Working on the inside of this meeting for the first time reinforced what I already knew--the AAMC staff is an incredible group of people who are devoted and committed to medical education in no way that I have seen elsewhere.

Thanks very much for your advice and counsel, the institutional memory and candor you bring to me personally as I try to learn the Association and its workings to better deal with the problems that are so interesting and challenging. Again, thanks very much.

Sincerely,

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

Louis J. Kettel, M.D.  
Associate Vice President  
for Academic Affairs

LJK/db





**association of american  
medical colleges**

**AGENDA**  
**FOR**  
**COUNCIL OF DEANS**

**SPRING BUSINESS MEETING**

**WEDNESDAY, MARCH 23, 1988**

**8:30 AM - 12:00 PM**

**ARCHER EAST & WEST**

**THE HOTEL INTER-CONTINENTAL**

**HILTON HEAD, SOUTH CAROLINA**

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

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Albany, NY 12208

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

SPRING BUSINESS MEETING

The Hotel Inter-Continental  
Hilton Head, South Carolina

AGENDA

Wednesday, March 23, 1988

8:30 a.m. - 12:00 p.m.

Archer East & West

I. Call to Order	<u>Page</u>
II. Quorum Call	
III. Approval of the Minutes .....	1
IV. Chairman's Report --- William T. Butler, M.D.	
V. President's Report --- Robert G. Petersdorf, M.D.	
VI. Legislative Update --- Richard M. Knapp, Ph.D.	
VII. Discussion Items	
A. Small Group Discussion Reports	
B. Medloans Program..... (See insert enclosed)	7
C. Revision of AAMC Recommendations Concerning Medical School Acceptance Procedures.....	9
D. Individual School Applicant/Matriculant Analyses .....	11

COD Spring Meeting Agenda -continued-

**VIII. Information Items**

- A. Robert Wood Johnson Minority Medical  
Faculty Development Program.....29
- B. AAMC Proposal on the Advancement of Women  
in Academic Medicine.....31

**XI. Old Business**

**X. New Business**

**XI. Adjournment**

# ASSOCIATION OF AMERICAN MEDICAL COLLEGES

## COUNCIL OF DEANS ANNUAL BUSINESS MEETING

Monday, November 9, 1987  
2:30 - 5:00 p.m.  
Georgetown East & West  
Washington Hilton Hotel  
Washington, DC

### I. CALL TO ORDER

Louis J. Kettel, M.D., Chairman, called the meeting to order at 2:34 pm. He declared the presence of a quorum.

### II. PRESIDENT'S REPORT

Robert G. Petersdorf, M.D. began his discussion with the AAMC recommendations and guidelines on housestaff supervision. He first explained the reasoning behind the AAMC entering this policy debate. The AAMC plays an integral role in the structure of graduate medical education, and therefore should take a leadership position on this public issue. Additionally, many other medical organizations are beginning to address the problem. Dr. Petersdorf explained that due to major changes in medical technology, shorter hospital stays, etc., the exposure of housestaff to both teaching and service has been radically altered. The AAMC's position needs to stress the importance of enhancing quality care for patients while at the same time preserving the educational ambience. Dr. Petersdorf stressed that the cornerstone of graduate medical education is the increasing amount of responsibility a resident receives. This responsibility must be directly correlated to a resident's gradual acquisition of skills, knowledge and confidence, and this increase in competence needs to be both demonstrated and supervised. Program directors and faculty must work with the administration to set up a system whereby the delegation of responsibility of the housestaff is clearly outlined. This institutional responsibility should then be monitored by the ACGME's residency review committees. Dr. Petersdorf noted that the problem of excessive workloads is mainly found in the medicine, surgery, pediatrics, and OB/GYN specialties. He then highlighted several key points of the AAMC recommendation paper: Residents should be scheduled for no more than 80 hours per week of work time, in concert with the state of New York's recommendations. Each resident should be allowed one 24-hour period per week of unscheduled time, and housestaff should not be allowed to moonlight. Dr. Petersdorf agreed that the financial implications of such guidelines could be staggering, since more residents and faculty would be needed. The state of New York's model, for example, shows a large cost increase. Several deans expressed concern over stating a specific number of hours that a resident can

work. Dr. Petersdorf emphasized that the document would be significantly weakened if the number of hours were not specifically stated. The state of New York's guidelines would then become the leading political document, and other state legislatures might then decide their own "ideal" number of hours a resident would be allowed to work. Dr. Petersdorf reiterated the importance of the AAMC taking a timely position on this issue in an effort to forestall state legislation. Several deans suggested that a clearer distinction needed to be made between assigned and unassigned hours. The number of "hours" recommended in the document are really "working hours", time actually spent taking care of patients. A backup document, not distributed, explains in great detail the issue of sleep hours vs. work hours, etc. Dr. Petersdorf stressed that the 80 stated hours are not a cut-and-dry mandatory rule. The concern is not over whether a resident works 84 hours a week, but rather if he works 120 hours a week. Many deans expressed agreement that the educational experience does suffer when the number of work hours is too demanding. Dr. Petersdorf particularly emphasized that the AAMC appreciates the diversity of each teaching hospital. The document presented is simply meant as a "guideline", not as an absolute "prescription". One suggestion was to amend the document by adding that the AAMC is presenting a "model" to the hospitals, strongly recommending that each institution come up with their own guidelines that follow the general pattern. On motion, seconded and unanimously approved, the Council encouraged Dr. Petersdorf and the AAMC to proceed as needed with the housestaff position paper.

### III. OSR REPORT

Vicki Darrow, M.D. reviewed several of the OSR activities during the past year. She reported that the OSR has been trying to expand the leadership of student representation within the policy making groups of medical education, particularly by increasing the student voice on AAMC committees. The OSR also succeeded in adding a question to the 1988 Graduation Questionnaire on the use of discriminating questions during the interview process. Dr. Darrow noted that the OSR is continuing to work towards PASS/FAIL reporting of the National Boards, for housestaff participation within the AAMC, and for computerization of the OSR for faster networking. One new goal of the OSR is to encourage attending faculty to return to the bedside for clinical instruction. They are also going to assist in improving the Universal Application Form. The OSR still wants the AAMC to make a public statement regarding indigent care, and Dr. Darrow reported that at the 1987 OSR Annual Meeting, students were encouraged to be socially conscious and socially responsible physicians. Dr. Darrow also announced a new look for the former OSR Report. The newsletter has been completely revised and is now distributed as Progress Notes.

### IV. LEGISLATIVE UPDATE

Dr. Richard Knapp reviewed the Association's interest in current legislative matters affecting health care. He reported that there is currently strong support for biomedical and behavior research, exhibited by the appropriations measures adopted by Congress. However, while there is community support, the financial resources needed are not available in the current budgetary environment. Legislative problems to

face in 1988 include the issues of animals and fetuses in research. Dr. Knapp stressed that the strength of the opposition on these issues is remarkable and asked the deans for their support. He also reminded the Council that Title 7, the Health Manpower Act, is up for renewal, with important issues such as student loans, primary care residencies and geriatrics at stake. Finally, Dr. Knapp urged the deans to continue to make Congressional visits whenever they are in Washington.

#### V. REPORT OF THE NOMINATING COMMITTEE

Dr. Richard Moy presented the report of the COD Nominating Committee. For the deans' information, he announced that L. Thompson Bowles, M.D., Ph.D., Dean for Academic Affairs at George Washington University and Robert E. Tranquada, M.D., Dean of the University of Southern California would be nominated the next day to the Assembly to fill two three-year terms on the Executive Council. Henry P. Russe, M.D., Vice President for Medical Affairs and Dean, Rush Medical College, would be nominated to fill a Council vacancy for a two-year term, and W. Donald Weston, M.D., Dean at Michigan State University College of Human Medicine would be nominated to fill a Council vacancy for a one-year term. D. Kay Clawson would be recommended for nomination as Chairman-Elect of the Assembly. Dr. Moy then moved the nominations of William B. Deal, M.D. for Chairman-Elect of the Council of Deans, and of Robert L. Friedlander, M.D., Phillip M. Forman, M.D., and George T. Bryan, M.D. for members-at-large of the COD Administrative Board. The motion was seconded and unanimously approved.

#### VI. DISCUSSION ITEMS

##### A. Transition from Medical School to Residency

##### Status Report & Determination of Uniform Date for Release of Deans' Letters for 1988

Dr. Robert Beran reviewed the 1987 experiences of the first uniform date for the release of deans' letters. With relatively few exceptions, most schools held firm to the AAMC's decision not to release deans' letters prior to November 1. A major problem encountered concerned the "type" of information that could or could not be sent to program directors. Many programs requested transcripts, faculty letters, etc. in an attempt to circumvent the November 1 decision. Most of the problems stemmed from the AAMC's rather late announcement of the uniform date last year. The vast majority of specialties, however, did try to change their application deadline dates, even including most of the surgical subspecialties. Dr. Beran emphasized that an early decision by the deans on the 1988 uniform date would allow the program directors sufficient time to plan their selection schedules accordingly, thus eliminating the majority of the problems encountered this past year. Overall, the first year of implementation went extraordinarily well, and Dr. Beran thanked the Council for their effective networking in enforcing the November 1 decision.

Dr. Joseph Gonella reported on a special transition forum that was held on November 6 involving program directors invited from each of the

matching specialties. The forum was well represented, and the majority of program directors emphasized the importance of retaining November 1 as the 1988 uniform date to prevent even further changes in submission deadlines, interview schedules and application literature. Dr. Gonella asked the Council to return to their institutions with a resolution to encourage their own program directors to comply with the uniform release date.

ACTION:

On motion, seconded and carried, the Council cast a majority vote to establish November 1, 1988 as the uniform date for the release of deans' letters. One "no" vote was recorded.

B. Report of the ad hoc Committee on Housestaff Participation in the AAMC

Dr. Joseph Johnson reported on the establishment of an Organization of Resident Representatives within the AAMC. The ad hoc Committee on Housestaff Participation recommended that a more formal mechanism for representation by housestaff within the AAMC structure should be implemented. The ORR would be analogous to the OSR. One resident representative would be selected from each full member COTH hospital, through a process determined locally. Funding for the representatives would come from the hospitals, with the AAMC funding the expenses of the ORR Administrative Board. Since the hospitals will be providing the funds for their delegates' participation, the ORR would be linked to the Council of Teaching Hospitals. The ORR will also have a formal linkage to the Council of Academic Societies because of the representation of its disciplines. The exact working mechanism of that relationship will have to be evolved. Several deans questioned why the ORR could not be chosen by the medical schools and linked to the Council of Deans. It was decided that this issue would be discussed more in depth at the Council's Spring Meeting in Hilton Head.

C. Where are the resources for extended ambulatory clinical education for medical students?

Ms. Nancy Seline described the recent AAMC study on the transition of medical education from the hospitals into ambulatory settings. The project was a year-long study funded by the Health Resources and Services Administration, dealing with such issues as funding and the availability of resources. During the course of the study, nine institutions were visited that were believed to be innovators in the area of ambulatory education. In the nine centers, there was an idiosyncratic blend of support for medical education; most programs depended upon a variety of government funds, patient care revenues and support from volunteers and faculty practice plans. Ms. Seline commented that most of these funding mechanisms were found to be fragile, dependent on local resources, and any major changes in the federal or local government could threaten their existence. The study concluded that many variables were present that determined the funding of such a program. Costs varied significantly for several reasons, not the least of which was the number of learners that each institution



attempted to integrate into the program. The more learners that were integrated, the greater the cost, and it rose exponentially. The level of learner that was integrated (medical students vs. resident), and how many learners actively participated versus observed also played key roles in determining the cost. Many institutions felt, however, that while costs were minimized when learners merely observed, so was the educational benefit. Learners were integrated into a wide variety of settings, including hospital clinics, private physicians' offices and small group practices. The major cost of integrating the learners into these settings was the change in the efficiency of the operation. This impact differed by specialty; those specialties dependent upon seeing a large volume of patients were more directly affected by the integration of medical students because the efficiency levels were decreased much more significantly. The largest success was seen in primary care situations in which the medical students were spread over a broad base of clinical settings so that each faculty member was responsible for only 1-2 learners. In each setting, there was a definite cost to be faced; however, Ms. Seline stressed that the successful facilities had discovered ways to accept the reduced income generated.

#### D. Trends in the Applicant Pool

Dr. August Swanson reported on the steady decline of the number of students applying to U.S. medical schools. The applicant pool has been steadily decreasing since its peak in 1981, currently reaching a 1.7 ratio of applicants to positions. If the average annual fall in applicants and positions continues, by 1990 a 1.28 ratio will be reached. The question of the quality of these students must then be raised, as a shift to the left for both GPAs and MCAT scores is occurring. A suggestion was made to do an institutional profile for each school showing its applicant/matriculant/position data in comparison to the national ratios. Dr. Paul Jolly agreed that this could be a helpful instrument. The Council expressed a desire to continue the applicant discussion at the Spring Meeting.

### VI. NEW BUSINESS

Dr. Kettel commented on the success and popularity of the AAMC's Management Education Programs and encouraged the deans to participate in the courses. Amy Eldridge confirmed the location and time of the COD dinner at the Old Ebbitt Grill.

### VII. INSTALLATION OF CHAIRMAN

Dr. Kettel thanked the deans for their participation and enthusiasm in making the Council such a vigorous power within the AAMC. He then presented William T. Butler, M.D., President of Baylor College of Medicine, as the new Chairman of the Council of Deans. In his first action as chair, Dr. Butler recognized the Administrative Board members who were retiring from the Board: Hibbard E. Williams, M.D. (UC-Davis School of Medicine), D. Kay Clawson, M.D. (University of Kansas School of Medicine), and Robert S. Daniels, M.D., (LSU-New Orleans School of Medicine) (not present). Dr. Butler then presented Dr. Kettel with a

gavel and thanked him for his successful leadership of the Council of Deans. Dr. Butler also reminded the deans about the 1988 Spring Meeting in Hilton Head, South Carolina and encouraged their input into the program planning.

VIII. ADJOURNMENT

The meeting was adjourned at 5:04 p.m.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

# MEDLOANS<sup>SM</sup>

The Association of American Medical Colleges (AAMC) has instituted MEDLOANS<sup>SM</sup>, a comprehensive student loan program designed to assist qualified medical students in obtaining the funds necessary to finance their medical education. The MEDLOANS program provides access to four different sources of educational loans: the Guaranteed Student Loan (GSL), Supplemental Loans for Students (SLS), the Health Education Assistance Loan (HEAL) and the Alternative Loan Program (ALP).

MEDLOANS streamlines the loan application procedure by enabling students to submit just one application to access GSL, SLS, HEAL, and ALP simultaneously. While the program is designed to allow students to apply for all of these loan types at once, students may choose to initially apply for only one loan type and later apply for other loan types with a new MEDLOANS application if and when the need arises.

## SPECIAL FEATURES OF MEDLOANS

- A single application form allows access to four different sources of assistance
- No co-signer is required for any program
- No application fee is required
- No current or prior banking relationship is required with the lender
- Graduated repayment plans will be available which will be sensitive to a modest income during the early years of medical practice
- Loan consolidation and combined repayment options are available
- All loans will be held by a single lender, and all communications and repayments will be made to a single organization
- The program is tailored for and available only to allopathic medical students attending U.S. medical schools
- Each of the four loan components under MEDLOANS include terms that are as competitive, and in several cases more competitive, than any existing national lending program

MEDLOANS applications and additional information about MEDLOANS, (i.e., specific eligibility requirements, application procedures, interest rates), and other aid administered by the individual medical school may be obtained directly from the medical school's office of financial aid. MEDLOANS applications may also be obtained from the AAMC by calling 202/828-0600 or writing the AAMC at the address listed below.

Suite 301/1776 Massachusetts Avenue, N.W., Washington, DC 20036-1989

## Revision of AAMC Recommendations Concerning Medical School Acceptance Procedures

The decline in the number of individuals applying to medical school is beginning to change the behavior of both our medical schools and applicants. Medical schools in their quest to enroll the best and the brightest from a dwindling source of talent are starting to engage in practices that are creating a state of disorganization for the community of medical schools. Applicants, on the other hand, now realize they are participating in a buyer's market and are starting to emulate our professional athletes by holding out (or negotiating) for the best available contract. While the goals of both the schools and the applicants are not in question, the nature of the pre-selection and pre-decision activities is resulting in a student selection process that extends later in the year, is more expensive for the schools, and produces a chaotic summer for admissions offices.

For example:

- For the 1987 entering class, 1,101 applicants were holding more than one acceptance on July 21, 1987.
- For this same class, 610 applicants were holding more than one acceptance on **August 18**.
- During the last two years, the number of cases reported where a student was offered a position at one school **after they had already matriculated at another school** have increased.
- Schools are now in a situation where an increasing percentage of their entering classes are being filled **after June 1**.

The Recommendations Concerning Medical School Acceptance Procedures (commonly referred to as the "traffic rules") represents a set of guidelines and understandings for offering acceptances to medical schools that were adopted by the AAMC Executive Council in the early 1970's. The "traffic rules" were developed to serve as a code of ethics among the schools regarding policies and procedures for such items as notifying students of acceptance, the size and refundability of acceptance deposits, and the ground rules regarding the processing of students holding multiple acceptances. The intent of the traffic rules is to provide a set of minimum standards and procedures that **all** schools will agree to observe in their process of selecting students.

The reports of "violations to the traffic rules" have increased dramatically during the last several years. The Group on Student Affairs Committee on Admissions has developed a revision to the traffic rules that will be presented to the Executive Council at their Fall 1988 meeting. The committee feels strongly that the medical schools, either individually or collectively, do not have to sacrifice ethical standards to cope with the changes precipitated by the decline in the number of applicants. In order to enhance the sense of cooperativeness among schools and also restore order to our system of student selection, it is necessary for **all** schools to agree on an acceptable set of basic guidelines.

The traffic rules seek uniformity of practice in areas such as:

- amount of acceptance deposit
- deadline date for full refund of deposit
- date when schools should have offered acceptances at least equal to the size of its entering class
- responsibilities of applicants in responding to offers of acceptance
- schools' responsibilities in processing applicants holding more than one acceptance.

The revision will be available for discussion during the business meeting.

## **Trends in Applicants & Matriculants:**

### **A Report from**

### **The Student and Applicant Information Management System**

On the following pages is a report showing the trends in applicants and matriculants at the University of Minnesota Medical School - Minneapolis. This individualized school report is derived from the Association's Student and Applicant Information Management System (SAIMS). It follows the format of the Association's annual publication, Trends in Medical School Applicants and Matriculants 1978-1987, prepared by Cynthia Tudor, Director of Student Studies and distributed last month. Identical reports can be provided for each school on request. The price is \$300.00. Contact Charles D. Killian (202)828-0412.

The Student and Applicant Information Management System (SAIMS) is a collection of interrelated databases containing comprehensive longitudinal information of all MCAT registrants and examinees; all MSKP registrants and examinees; the application materials of all applicants to U.S. medical schools; matriculation and other status change records of enrollment, transferral, withdrawal, leaves of absence, and graduation; Matriculating Student Questionnaire data; Graduation Questionnaire data; Graduate Medical Education records of specialty choice and residency location. Fourth generation computer languages are used to maintain these various databases and to extract research files.

Many other possibilities for research and reporting exist with SAIMS. Among the reports recently prepared from SAIMS is one summarizing the qualifications and characteristics of state residents who applied only to schools outside the state. Counts of these individuals can be made by school of matriculation, undergraduate institution, MCAT scores, and undergraduate GPAs for example. Another report recently prepared from SAIMS summarizes the application and matriculation patterns of under-represented minorities. Examples of some of these reports are available and AAMC staff are prepared to assist you with the identification of data best able to address your particular research needs.

**Trends in Medical School  
Applicants and Matriculants  
1978-1987**

**UNIVERSITY OF MINNESOTA MEDICAL SCHOOL-MINNEAPOLIS**

**Association of American Medical Colleges**

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Sex**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Male</b>	Applicants	75.0	( 1,188)	69.3	( 883)	64.4	( 611)	65.6	( 516)
	Matriculants	74.1	( 177)	65.5	( 156)	62.2	( 120)	67.3	( 132)
<b>Female</b>	Applicants	24.9	( 395)	30.7	( 392)	35.6	( 338)	34.4	( 270)
	Matriculants	25.9	( 62)	34.5	( 82)	37.8	( 73)	32.7	( 64)
<b>Unknown</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Age**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Under 21</b>	Applicants	0.9	( 15)	0.3	( 4)	0.6	( 6)	0.6	( 5)
	Matriculants	0.4	( 1)	0.4	( 1)	0.0	( 0)	0.5	( 1)
<b>21 - 23</b>	Applicants	63.4	( 1,004)	54.8	( 699)	54.4	( 516)	57.9	( 455)
	Matriculants	65.7	( 157)	58.8	( 140)	50.8	( 98)	58.7	( 115)
<b>24 - 27</b>	Applicants	25.9	( 410)	32.0	( 408)	29.9	( 284)	25.6	( 201)
	Matriculants	25.9	( 62)	29.4	( 70)	33.7	( 65)	27.0	( 53)
<b>28 - 31</b>	Applicants	7.6	( 120)	9.5	( 121)	8.0	( 76)	8.4	( 66)
	Matriculants	6.7	( 16)	8.0	( 19)	7.8	( 15)	9.2	( 18)
<b>32 - 37</b>	Applicants	2.0	( 32)	3.0	( 38)	6.0	( 57)	6.0	( 47)
	Matriculants	1.3	( 3)	3.4	( 8)	5.7	( 11)	3.6	( 7)
<b>Over 37</b>	Applicants	0.2	( 3)	0.4	( 5)	1.1	( 10)	1.5	( 12)
	Matriculants	0.0	( 0)	0.0	( 0)	2.1	( 4)	1.0	( 2)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
<b>Mean</b>	Applicants	23.66		24.25		24.48		24.50	
	Matriculants	23.67		24.14		24.69		24.24	
<b>Standard Deviation</b>	Applicants	2.76		3.04		3.67		3.84	
	Matriculants	2.48		2.78		3.67		3.27	



**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Ethnicity/Race**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>White</b>	Applicants	79.9	( 1,266)	80.2	( 1,022)	74.8	( 710)	76.3	( 600)
	Matriculants	90.0	( 215)	94.5	( 225)	91.2	( 176)	89.3	( 175)
<b>Black</b>	Applicants	7.6	( 121)	6.6	( 84)	7.3	( 69)	7.5	( 59)
	Matriculants	2.5	( 6)	0.8	( 2)	0.5	( 1)	1.0	( 2)
<b>Other Under-represented Minority</b>	Applicants	8.0	( 127)	7.1	( 90)	6.7	( 64)	4.7	( 37)
	Matriculants	5.0	( 12)	2.1	( 5)	0.0	( 0)	0.5	( 1)
<b>Other</b>	Applicants	3.5	( 56)	5.0	( 64)	10.4	( 99)	10.6	( 83)
	Matriculants	0.8	( 2)	1.7	( 4)	7.8	( 15)	8.7	( 17)
<b>Unknown</b>	Applicants	0.9	( 14)	1.2	( 15)	0.7	( 7)	0.9	( 7)
	Matriculants	1.7	( 4)	0.8	( 2)	0.5	( 1)	0.5	( 1)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Marital Status**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Never Married</b>	Applicants	70.1	( 1,110)	73.4	( 936)	76.5	( 726)	72.5	( 570)
	Matriculants	65.3	( 156)	73.1	( 174)	80.8	( 156)	76.5	( 150)
<b>Married</b>	Applicants	12.8	( 202)	12.1	( 154)	8.0	( 76)	8.8	( 69)
	Matriculants	8.4	( 20)	12.6	( 30)	8.3	( 16)	9.2	( 18)
<b>Separated</b>	Applicants	0.4	( 7)	0.5	( 6)	0.0	( 0)	0.3	( 2)
	Matriculants	0.0	( 0)	0.8	( 2)	0.0	( 0)	0.0	( 0)
<b>Divorced</b>	Applicants	1.7	( 27)	1.2	( 15)	1.3	( 12)	2.0	( 16)
	Matriculants	2.5	( 6)	1.7	( 4)	0.5	( 1)	1.0	( 2)
<b>Widowed</b>	Applicants	0.1	( 2)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	14.9	( 236)	12.8	( 163)	14.1	( 134)	16.4	( 129)
	Matriculants	23.4	( 56)	11.8	( 28)	10.4	( 20)	13.3	( 26)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Father's Occupation**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Physician</b>	Applicants	10.9	( 173)	10.4	( 133)	14.3	( 136)	11.7	( 92)
	Matriculants	10.0	( 24)	7.6	( 18)	10.9	( 21)	16.8	( 33)
<b>Health Professional/Worker</b>	Applicants	3.4	( 54)	3.5	( 45)	3.7	( 35)	4.2	( 33)
	Matriculants	2.1	( 5)	3.4	( 8)	3.6	( 7)	3.1	( 6)
<b>Professional</b>	Applicants	14.6	( 231)	18.9	( 241)	17.2	( 163)	18.3	( 144)
	Matriculants	17.2	( 41)	22.3	( 53)	21.2	( 41)	15.8	( 31)
<b>Manager</b>	Applicants	12.9	( 205)	11.2	( 143)	11.0	( 104)	11.3	( 89)
	Matriculants	14.2	( 34)	14.3	( 34)	13.5	( 26)	13.3	( 26)
<b>Sales</b>	Applicants	7.1	( 112)	6.7	( 86)	7.1	( 67)	6.5	( 51)
	Matriculants	7.1	( 17)	9.2	( 22)	7.8	( 15)	7.7	( 15)
<b>Small Business</b>	Applicants	6.7	( 106)	7.5	( 95)	6.3	( 60)	5.5	( 43)
	Matriculants	5.0	( 12)	8.0	( 19)	7.8	( 15)	7.7	( 15)
<b>Clerical</b>	Applicants	1.3	( 20)	1.1	( 14)	0.2	( 2)	0.5	( 4)
	Matriculants	1.7	( 4)	0.8	( 2)	0.5	( 1)	0.0	( 0)
<b>Homemaker</b>	Applicants	0.0	( 0)	0.1	( 1)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Student</b>	Applicants	0.0	( 0)	0.1	( 1)	0.2	( 2)	0.1	( 1)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.5	( 1)
<b>Skilled Worker</b>	Applicants	7.5	( 119)	7.0	( 89)	5.7	( 54)	4.6	( 36)
	Matriculants	5.0	( 12)	6.3	( 15)	6.7	( 13)	3.1	( 6)
<b>Unskilled Worker</b>	Applicants	5.2	( 82)	5.9	( 75)	4.6	( 44)	4.7	( 37)
	Matriculants	3.3	( 8)	4.2	( 10)	4.1	( 8)	4.1	( 8)
<b>Unemployed/Retired/Deceased</b>	Applicants	15.6	( 247)	14.4	( 184)	15.6	( 148)	15.6	( 123)
	Matriculants	11.7	( 28)	11.3	( 27)	13.5	( 26)	12.8	( 25)
<b>Unknown</b>	Applicants	14.8	( 235)	13.2	( 168)	14.1	( 134)	16.9	( 133)
	Matriculants	22.6	( 54)	12.2	( 29)	10.4	( 20)	15.3	( 30)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Mother's Occupation**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Physician</b>	Applicants	0.6	( 9)	0.7	( 9)	1.5	( 14)	0.9	( 7)
	Matriculants	0.0	( 0)	0.4	( 1)	1.6	( 3)	2.0	( 4)
<b>Health Professional/Worker</b>	Applicants	8.5	( 135)	11.1	( 141)	10.4	( 99)	11.1	( 87)
	Matriculants	6.7	( 16)	10.9	( 26)	15.0	( 29)	11.7	( 23)
<b>Professional</b>	Applicants	8.3	( 132)	10.6	( 135)	9.6	( 91)	11.3	( 89)
	Matriculants	8.4	( 20)	17.6	( 42)	9.8	( 19)	12.2	( 24)
<b>Manager</b>	Applicants	1.6	( 26)	2.6	( 33)	3.3	( 31)	3.6	( 28)
	Matriculants	1.3	( 3)	0.4	( 1)	2.6	( 5)	4.1	( 8)
<b>Sales</b>	Applicants	5.1	( 80)	5.9	( 75)	7.7	( 73)	5.5	( 43)
	Matriculants	4.2	( 10)	4.6	( 11)	5.2	( 10)	5.1	( 10)
<b>Small Business</b>	Applicants	1.9	( 30)	2.4	( 31)	3.5	( 33)	3.3	( 26)
	Matriculants	0.8	( 2)	4.6	( 11)	4.7	( 9)	4.1	( 8)
<b>Clerical</b>	Applicants	8.5	( 134)	7.8	( 100)	9.1	( 86)	8.8	( 69)
	Matriculants	7.1	( 17)	9.2	( 22)	9.3	( 18)	9.7	( 19)
<b>Homemaker</b>	Applicants	29.9	( 474)	24.9	( 317)	19.9	( 189)	19.1	( 150)
	Matriculants	32.2	( 77)	26.1	( 62)	22.3	( 43)	21.4	( 42)
<b>Student</b>	Applicants	0.1	( 1)	0.4	( 5)	0.7	( 7)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.5	( 1)	0.5	( 1)
<b>Skilled Worker</b>	Applicants	1.8	( 28)	1.9	( 24)	1.5	( 14)	1.9	( 15)
	Matriculants	2.1	( 5)	0.4	( 1)	0.5	( 1)	1.0	( 2)
<b>Unskilled Worker</b>	Applicants	3.6	( 57)	4.4	( 56)	3.3	( 31)	2.5	( 20)
	Matriculants	2.5	( 6)	4.2	( 10)	3.1	( 6)	2.0	( 4)
<b>Unemployed/Retired/Deceased</b>	Applicants	15.9	( 252)	14.7	( 188)	15.6	( 148)	15.3	( 120)
	Matriculants	12.6	( 30)	10.9	( 26)	14.0	( 27)	12.2	( 24)
<b>Unknown</b>	Applicants	14.3	( 226)	12.6	( 161)	14.0	( 133)	16.3	( 128)
	Matriculants	22.2	( 53)	10.5	( 25)	11.4	( 22)	13.8	( 27)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## State of Residence

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Alabama	Applicants	0.2	( 3)	0.1	( 1)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Alaska	Applicants	0.1	( 1)	0.1	( 1)	0.2	( 2)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Arizona	Applicants	0.8	( 12)	0.9	( 11)	0.8	( 8)	0.4	( 3)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.5	( 1)
Arkansas	Applicants	0.1	( 2)	0.1	( 1)	0.2	( 2)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
California	Applicants	12.9	( 204)	14.4	( 184)	12.6	( 120)	12.0	( 94)
	Matriculants	4.2	( 10)	2.1	( 5)	1.0	( 2)	1.5	( 3)
Colorado	Applicants	0.6	( 9)	0.4	( 5)	0.6	( 6)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	1.0	( 2)
Connecticut	Applicants	0.6	( 9)	0.4	( 5)	0.3	( 3)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Delaware	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
District of Columbia	Applicants	0.4	( 7)	0.2	( 3)	0.3	( 3)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Florida	Applicants	1.0	( 16)	0.9	( 11)	1.4	( 13)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Georgia	Applicants	0.8	( 13)	0.3	( 4)	0.2	( 2)	0.3	( 2)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Hawaii	Applicants	0.1	( 2)	0.1	( 1)	0.2	( 2)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Idaho	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Illinois	Applicants	2.5	( 39)	1.9	( 24)	3.0	( 28)	4.6	( 36)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**State of Residence (Cont'd)**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		<b>%</b>	<b>(n)</b>	<b>%</b>	<b>(n)</b>	<b>%</b>	<b>(n)</b>	<b>%</b>	<b>(n)</b>
<b>Indiana</b>	Applicants	0.8	( 12)	0.6	( 8)	0.4	( 4)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Iowa</b>	Applicants	0.9	( 15)	0.8	( 10)	1.1	( 10)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.5	( 1)	0.0	( 0)
<b>Kansas</b>	Applicants	0.3	( 5)	0.3	( 4)	0.5	( 5)	0.6	( 5)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	1.0	( 2)
<b>Kentucky</b>	Applicants	0.0	( 0)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Louisiana</b>	Applicants	0.3	( 5)	0.2	( 2)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Maine</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Maryland</b>	Applicants	0.7	( 11)	0.3	( 4)	1.1	( 10)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Massachusetts</b>	Applicants	1.3	( 21)	0.7	( 9)	1.3	( 12)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Michigan</b>	Applicants	2.7	( 43)	1.9	( 24)	2.2	( 21)	1.9	( 15)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Minnesota</b>	Applicants	49.5	( 784)	63.5	( 809)	52.1	( 494)	55.7	( 438)
	Matriculants	92.5	( 221)	96.2	( 229)	95.3	( 184)	91.8	( 180)
<b>Mississippi</b>	Applicants	0.1	( 2)	0.2	( 3)	0.0	( 0)	0.1	( 1)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Missouri</b>	Applicants	0.7	( 11)	0.2	( 3)	0.5	( 5)	0.6	( 5)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Montana</b>	Applicants	0.3	( 4)	0.1	( 1)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Nebraska</b>	Applicants	0.9	( 14)	0.3	( 4)	1.1	( 10)	0.8	( 6)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)

### State of Residence (Cont'd)

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Nevada	Applicants	0.2	( 3)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New Hampshire	Applicants	0.1	( 1)	0.0	( 0)	0.3	( 3)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New Jersey	Applicants	1.1	( 17)	0.6	( 8)	1.5	( 14)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	1.0	( 2)	0.0	( 0)
New Mexico	Applicants	0.4	( 7)	0.5	( 6)	0.5	( 5)	0.1	( 1)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New York	Applicants	4.3	( 68)	1.9	( 24)	2.3	( 22)	2.7	( 21)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
North Carolina	Applicants	0.3	( 5)	0.3	( 4)	0.3	( 3)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
North Dakota	Applicants	0.8	( 12)	0.5	( 7)	0.8	( 8)	1.0	( 8)
	Matriculants	0.0	( 0)	0.0	( 0)	1.6	( 3)	1.5	( 3)
Ohio	Applicants	1.3	( 21)	0.5	( 7)	0.6	( 6)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Oklahoma	Applicants	0.4	( 7)	0.2	( 3)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Oregon	Applicants	0.2	( 3)	0.2	( 2)	0.2	( 2)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Pennsylvania	Applicants	1.6	( 26)	0.5	( 6)	0.6	( 6)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Rhode Island	Applicants	0.1	( 1)	0.1	( 1)	0.2	( 2)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
South Carolina	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
South Dakota	Applicants	1.6	( 26)	1.0	( 13)	0.8	( 8)	1.3	( 10)
	Matriculants	0.0	( 0)	0.8	( 2)	0.0	( 0)	0.5	( 1)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**State of Residence (Cont'd)**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Tennessee</b>	Applicants	0.3	( 5)	0.2	( 2)	0.4	( 4)	0.4	( 3)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.0	( 0)
<b>Texas</b>	Applicants	2.5	( 39)	0.5	( 6)	1.4	( 13)	1.7	( 13)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Utah</b>	Applicants	0.5	( 8)	0.2	( 3)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Vermont</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Virginia</b>	Applicants	0.6	( 9)	0.1	( 1)	0.4	( 4)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Washington</b>	Applicants	0.4	( 6)	0.6	( 8)	1.1	( 10)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.5	( 1)
<b>West Virginia</b>	Applicants	0.1	( 2)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Wisconsin</b>	Applicants	3.9	( 61)	2.7	( 35)	4.6	( 44)	2.7	( 21)
	Matriculants	0.8	( 2)	0.4	( 1)	0.5	( 1)	1.5	( 3)
<b>Wyoming</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>U.S. Territories</b>	Applicants	0.1	( 1)	0.1	( 1)	0.6	( 6)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Foreign</b>	Applicants	0.5	( 8)	0.1	( 1)	0.9	( 9)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## Size of Hometown

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Large City (inner)	Applicants	6.5	( 103)	7.8	( 99)	6.3	( 60)	6.9	( 54)
	Matriculants	4.6	( 11)	5.5	( 13)	4.1	( 8)	2.0	( 4)
Large City (other)	Applicants	8.2	( 130)	5.8	( 74)	4.0	( 38)	5.1	( 40)
	Matriculants	7.9	( 19)	5.0	( 12)	2.6	( 5)	3.1	( 6)
Large City Suburb	Applicants	19.0	( 301)	20.7	( 264)	23.9	( 227)	24.4	( 192)
	Matriculants	20.1	( 48)	25.6	( 61)	31.1	( 60)	32.1	( 63)
Moderate City	Applicants	14.4	( 228)	14.4	( 184)	13.9	( 132)	13.1	( 103)
	Matriculants	10.9	( 26)	15.5	( 37)	8.3	( 16)	13.8	( 27)
Moderate City Suburb	Applicants	6.2	( 98)	7.9	( 101)	6.0	( 57)	5.1	( 40)
	Matriculants	7.5	( 18)	10.5	( 25)	6.7	( 13)	4.1	( 8)
Small City	Applicants	13.8	( 219)	13.0	( 166)	12.5	( 119)	13.4	( 105)
	Matriculants	11.3	( 27)	11.8	( 28)	11.9	( 23)	10.2	( 20)
Town	Applicants	8.6	( 136)	8.5	( 109)	9.5	( 90)	8.7	( 68)
	Matriculants	6.3	( 15)	6.7	( 16)	7.3	( 14)	10.7	( 21)
Small Town	Applicants	5.4	( 85)	6.2	( 79)	6.5	( 62)	5.2	( 41)
	Matriculants	6.7	( 16)	6.7	( 16)	10.4	( 20)	8.7	( 17)
Rural Area	Applicants	4.1	( 65)	3.7	( 47)	3.3	( 31)	2.3	( 18)
	Matriculants	2.1	( 5)	2.1	( 5)	6.7	( 13)	2.6	( 5)
Unknown	Applicants	13.8	( 219)	11.9	( 152)	14.0	( 133)	15.9	( 125)
	Matriculants	22.6	( 54)	10.5	( 25)	10.9	( 21)	12.8	( 25)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## Citizenship

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
U.S. Citizen	Applicants	99.1	( 1,570)	99.8	( 1,272)	99.4	( 943)	99.4	( 781)
	Matriculants	100.0	( 239)	100.0	( 238)	100.0	( 193)	100.0	( 196)
Non U.S. Citizen	Applicants	0.9	( 14)	0.2	( 3)	0.6	( 6)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Unknown	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)



**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Undergraduate Major**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Biological Sciences</b>	Applicants	53.7	( 850)	53.3	( 680)	56.4	( 535)	57.1	( 449)
	Matriculants	49.4	( 118)	49.6	( 118)	47.2	( 91)	49.5	( 97)
<b>Physical Sciences</b>	Applicants	20.8	( 330)	20.1	( 256)	19.0	( 180)	18.8	( 148)
	Matriculants	22.6	( 54)	24.8	( 59)	27.5	( 53)	26.0	( 51)
<b>Social Sciences</b>	Applicants	10.3	( 163)	9.6	( 123)	10.1	( 96)	8.7	( 68)
	Matriculants	11.3	( 27)	10.1	( 24)	11.4	( 22)	9.2	( 18)
<b>Humanities</b>	Applicants	3.5	( 55)	3.6	( 46)	3.9	( 37)	4.2	( 33)
	Matriculants	6.3	( 15)	4.2	( 10)	4.1	( 8)	5.6	( 11)
<b>Mathematics Statistics</b>	Applicants	1.4	( 22)	0.9	( 12)	0.6	( 6)	1.0	( 8)
	Matriculants	0.8	( 2)	2.1	( 5)	0.0	( 0)	1.0	( 2)
<b>Health Sciences</b>	Applicants	5.3	( 84)	6.4	( 82)	3.0	( 28)	3.4	( 27)
	Matriculants	4.6	( 11)	4.2	( 10)	2.1	( 4)	2.6	( 5)
<b>Other</b>	Applicants	5.0	( 79)	6.0	( 76)	7.1	( 67)	6.7	( 53)
	Matriculants	5.0	( 12)	5.0	( 12)	7.8	( 15)	6.1	( 12)
<b>Unknown</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Highest Degree**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Bachelor's</b>	Applicants	89.5	( 1,417)	89.6	( 1,143)	90.3	( 857)	90.8	( 714)
	Matriculants	92.5	( 221)	90.8	( 216)	89.1	( 172)	91.8	( 180)
<b>Master's</b>	Applicants	8.1	( 129)	7.6	( 97)	7.0	( 66)	7.0	( 55)
	Matriculants	5.4	( 13)	6.3	( 15)	8.3	( 16)	6.6	( 13)
<b>Doctorate</b>	Applicants	1.8	( 28)	2.0	( 26)	2.4	( 23)	1.8	( 14)
	Matriculants	2.1	( 5)	2.5	( 6)	2.6	( 5)	1.5	( 3)
<b>Other</b>	Applicants	0.6	( 10)	0.7	( 9)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

# Science Grade Point Average

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Below 2.01	Applicants	2.3	( 36)	2.0	( 26)	2.5	( 24)	1.4	( 11)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
2.01 - 2.50	Applicants	8.0	( 126)	9.2	( 117)	8.3	( 79)	8.5	( 67)
	Matriculants	2.1	( 5)	2.1	( 5)	1.6	( 3)	1.0	( 2)
2.51 - 2.75	Applicants	8.1	( 128)	7.7	( 98)	10.1	( 96)	9.5	( 75)
	Matriculants	3.3	( 8)	2.1	( 5)	4.1	( 8)	3.6	( 7)
2.76 - 3.00	Applicants	12.5	( 198)	12.8	( 163)	12.9	( 122)	12.5	( 98)
	Matriculants	8.4	( 20)	8.8	( 21)	9.3	( 18)	8.7	( 17)
3.01 - 3.25	Applicants	16.9	( 268)	18.8	( 240)	16.5	( 157)	15.9	( 125)
	Matriculants	13.0	( 31)	17.2	( 41)	11.4	( 22)	16.3	( 32)
3.26 - 3.50	Applicants	19.4	( 308)	18.6	( 237)	20.5	( 195)	18.1	( 142)
	Matriculants	18.4	( 44)	21.8	( 52)	26.9	( 52)	21.9	( 43)
3.51 - 3.75	Applicants	17.7	( 281)	16.9	( 215)	14.6	( 139)	18.1	( 142)
	Matriculants	21.8	( 52)	23.9	( 57)	24.9	( 48)	27.6	( 54)
3.76 - 4.00	Applicants	12.7	( 201)	13.7	( 175)	14.4	( 137)	15.4	( 121)
	Matriculants	20.9	( 50)	23.9	( 57)	21.8	( 42)	20.4	( 40)
Unknown	Applicants	2.4	( 38)	0.3	( 4)	0.0	( 0)	0.6	( 5)
	Matriculants	12.1	( 29)	0.0	( 0)	0.0	( 0)	0.5	( 1)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	3.20		3.20		3.18		3.21	
	Matriculants	3.43		3.45		3.43		3.43	
Standard Deviation	Applicants	0.50		0.52		0.52		0.52	
	Matriculants	0.40		0.38		0.37		0.36	

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Grade Point Average**

**Overall Grade Point Average**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Below 2.01</b>	<b>Applicants</b>	0.3	( 4)	0.5	( 6)	0.4	( 4)	0.5	( 4)
	<b>Matriculants</b>	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>2.01 - 2.50</b>	<b>Applicants</b>	4.9	( 77)	4.9	( 63)	4.6	( 44)	4.8	( 38)
	<b>Matriculants</b>	1.7	( 4)	0.4	( 1)	1.0	( 2)	0.0	( 0)
<b>2.51 - 2.75</b>	<b>Applicants</b>	7.3	( 116)	7.0	( 89)	6.7	( 64)	7.4	( 58)
	<b>Matriculants</b>	1.3	( 3)	1.7	( 4)	0.5	( 1)	2.0	( 4)
<b>2.76 - 3.00</b>	<b>Applicants</b>	11.6	( 183)	10.6	( 135)	12.8	( 121)	10.7	( 84)
	<b>Matriculants</b>	5.4	( 13)	4.6	( 11)	7.8	( 15)	6.1	( 12)
<b>3.01 - 3.25</b>	<b>Applicants</b>	17.7	( 280)	19.7	( 251)	18.2	( 173)	16.9	( 133)
	<b>Matriculants</b>	13.8	( 33)	16.0	( 38)	10.4	( 20)	13.8	( 27)
<b>3.26 - 3.50</b>	<b>Applicants</b>	23.4	( 371)	21.7	( 277)	22.8	( 216)	23.7	( 186)
	<b>Matriculants</b>	22.2	( 53)	24.8	( 59)	27.5	( 53)	27.0	( 53)
<b>3.51 - 3.75</b>	<b>Applicants</b>	20.5	( 324)	21.9	( 279)	20.3	( 193)	19.6	( 154)
	<b>Matriculants</b>	22.2	( 53)	28.2	( 67)	31.1	( 60)	32.1	( 63)
<b>3.76 - 4.00</b>	<b>Applicants</b>	12.1	( 192)	13.5	( 172)	14.1	( 134)	15.8	( 124)
	<b>Matriculants</b>	21.3	( 51)	24.4	( 58)	21.8	( 42)	18.4	( 36)
<b>Unknown</b>	<b>Applicants</b>	2.3	( 37)	0.2	( 3)	0.0	( 0)	0.6	( 5)
	<b>Matriculants</b>	12.1	( 29)	0.0	( 0)	0.0	( 0)	0.5	( 1)
<b>Total</b>	<b>Applicants</b>	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	<b>Matriculants</b>	--	( 239)	--	( 238)	--	( 193)	--	( 196)
<b>Mean</b>	<b>Applicants</b>	3.28		3.29		3.29		3.30	
	<b>Matriculants</b>	3.47		3.50		3.49		3.48	
<b>Standard Deviation</b>	<b>Applicants</b>	0.43		0.43		0.43		0.44	
	<b>Matriculants</b>	0.34		0.32		0.31		0.30	

## Biology

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	18.9	( 300)	13.9	( 177)	10.4	( 99)	10.8	( 85)
	Matriculants	4.2	( 10)	2.9	( 7)	0.5	( 1)	1.5	( 3)
7 - 8	Applicants	26.2	( 415)	24.5	( 313)	24.1	( 229)	22.3	( 175)
	Matriculants	16.3	( 39)	17.2	( 41)	15.0	( 29)	17.9	( 35)
9 - 11	Applicants	44.9	( 712)	52.5	( 669)	53.3	( 506)	53.6	( 421)
	Matriculants	56.5	( 135)	66.8	( 159)	68.9	( 133)	61.7	( 121)
12 - 15	Applicants	6.3	( 99)	8.3	( 106)	11.6	( 110)	12.6	( 99)
	Matriculants	10.0	( 24)	13.0	( 31)	15.5	( 30)	18.9	( 37)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.46		8.88		9.19		9.23	
	Matriculants	9.68		9.82		10.06		10.05	
Standard Deviation	Applicants	2.18		2.14		2.05		2.10	
	Matriculants	1.71		1.63		1.45		1.60	

## Chemistry

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	20.3	( 322)	14.1	( 180)	14.0	( 133)	12.6	( 99)
	Matriculants	3.3	( 8)	1.3	( 3)	1.0	( 2)	1.0	( 2)
7 - 8	Applicants	24.1	( 381)	25.8	( 329)	25.5	( 242)	25.6	( 201)
	Matriculants	10.5	( 25)	13.9	( 33)	15.5	( 30)	14.8	( 29)
9 - 11	Applicants	40.0	( 633)	46.1	( 588)	47.0	( 446)	48.1	( 378)
	Matriculants	52.3	( 125)	60.5	( 144)	61.7	( 119)	64.3	( 126)
12 - 15	Applicants	12.0	( 190)	13.2	( 168)	13.0	( 123)	13.0	( 102)
	Matriculants	20.9	( 50)	24.4	( 58)	21.8	( 42)	19.9	( 39)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.58		8.97		9.00		9.04	
	Matriculants	10.19		10.32		10.06		10.13	
Standard Deviation	Applicants	2.50		2.26		2.19		2.17	
	Matriculants	1.83		1.63		1.59		1.55	

**Proportion and Number of Applicants and Matriculants  
for Selected Years by MCAT Areas of Assessment**

**Physics**

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	18.7	( 296)	17.0	( 217)	13.0	( 123)	12.0	( 94)
	Matriculants	6.7	( 16)	3.4	( 8)	1.0	( 2)	0.5	( 1)
7 - 8	Applicants	27.3	( 432)	25.5	( 325)	27.4	( 260)	25.2	( 198)
	Matriculants	12.1	( 29)	16.0	( 38)	13.0	( 25)	14.3	( 28)
9 - 11	Applicants	39.5	( 625)	43.8	( 558)	43.5	( 413)	46.1	( 362)
	Matriculants	47.7	( 114)	58.4	( 139)	63.2	( 122)	58.2	( 114)
12 - 15	Applicants	10.9	( 173)	12.9	( 165)	15.6	( 148)	16.0	( 126)
	Matriculants	20.5	( 49)	22.3	( 53)	22.8	( 44)	27.0	( 53)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.54		8.90		9.11		9.16	
	Matriculants	9.80		10.13		10.21		10.40	
Standard Deviation	Applicants	2.34		2.33		2.36		2.37	
	Matriculants	2.10		1.82		1.71		1.76	

**Science Problems**

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	19.1	( 303)	14.9	( 190)	14.9	( 141)	11.7	( 92)
	Matriculants	3.3	( 8)	1.3	( 3)	2.6	( 5)	1.0	( 2)
7 - 8	Applicants	23.7	( 376)	26.0	( 331)	27.8	( 264)	27.4	( 215)
	Matriculants	10.5	( 25)	13.0	( 31)	16.6	( 32)	10.2	( 20)
9 - 11	Applicants	44.3	( 702)	47.0	( 599)	44.6	( 423)	47.1	( 370)
	Matriculants	56.5	( 135)	67.2	( 160)	60.1	( 116)	68.4	( 134)
12 - 15	Applicants	9.2	( 145)	11.4	( 145)	12.2	( 116)	13.1	( 103)
	Matriculants	16.7	( 40)	18.5	( 44)	20.7	( 40)	20.4	( 40)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.69		8.87		8.92		9.04	
	Matriculants	10.04		10.17		10.04		10.14	
Standard Deviation	Applicants	2.32		2.29		2.24		2.21	
	Matriculants	1.78		1.67		1.75		1.65	

### Skills Analysis: Reading

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants Matriculants	14.8 5.4	( 235) ( 13)	16.2 4.6	( 207) ( 11)	15.6 4.7	( 148) ( 9)	16.7 4.6	( 131) ( 9)
7 - 8	Applicants Matriculants	32.1 16.3	( 509) ( 39)	26.7 18.1	( 340) ( 43)	29.7 21.2	( 282) ( 41)	26.8 20.9	( 211) ( 41)
9 - 11	Applicants Matriculants	44.6 57.7	( 707) ( 138)	52.2 69.3	( 665) ( 165)	51.0 68.9	( 484) ( 133)	52.0 69.4	( 409) ( 136)
12 - 15	Applicants Matriculants	4.7 7.5	( 75) ( 18)	4.2 8.0	( 53) ( 19)	3.2 5.2	( 30) ( 10)	3.7 5.1	( 29) ( 10)
Unknown	Applicants Matriculants	3.7 13.0	( 58) ( 31)	0.8 0.0	( 10) ( 0)	0.5 0.0	( 5) ( 0)	0.8 0.0	( 6) ( 0)
Total	Applicants Matriculants	-- --	( 1,584) ( 239)	-- --	( 1,275) ( 238)	-- --	( 949) ( 193)	-- --	( 786) ( 196)
Mean	Applicants Matriculants	8.42 9.50		8.45 9.43		8.37 9.34		8.37 9.31	
Standard Deviation	Applicants Matriculants	2.15 1.70		2.09 1.61		2.24 1.58		2.24 1.59	

### Skills Analysis: Quantitative

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants Matriculants	18.5 4.6	( 293) ( 11)	21.4 6.3	( 273) ( 15)	21.8 7.3	( 207) ( 14)	18.7 4.1	( 147) ( 8)
7 - 8	Applicants Matriculants	22.5 9.6	( 357) ( 23)	27.4 16.8	( 349) ( 40)	30.3 25.9	( 288) ( 50)	30.7 21.9	( 241) ( 43)
9 - 11	Applicants Matriculants	46.7 54.4	( 740) ( 130)	42.0 60.1	( 535) ( 143)	36.5 51.3	( 346) ( 99)	42.2 61.7	( 332) ( 121)
12 - 15	Applicants Matriculants	8.6 18.4	( 136) ( 44)	8.5 16.8	( 108) ( 40)	10.9 15.5	( 103) ( 30)	7.6 12.2	( 60) ( 24)
Unknown	Applicants Matriculants	3.7 13.0	( 58) ( 31)	0.8 0.0	( 10) ( 0)	0.5 0.0	( 5) ( 0)	0.8 0.0	( 6) ( 0)
Total	Applicants Matriculants	-- --	( 1,584) ( 239)	-- --	( 1,275) ( 238)	-- --	( 949) ( 193)	-- --	( 786) ( 196)
Mean	Applicants Matriculants	8.61 10.02		8.44 9.71		8.39 9.37		8.47 9.57	
Standard Deviation	Applicants Matriculants	2.34 1.84		2.32 1.81		2.40 1.98		2.24 1.73	

ROBERT WOOD JOHNSON MINORITY MEDICAL FACULTY DEVELOPMENT PROGRAM

The Robert Wood Johnson's Minority Medical Faculty Development Program, started in 1983, offers four-year, post doctoral research fellowships to minority physicians who are committed to careers in academic medicine and biomedical research. Each of up to 16 Fellows selected over the next 2 years will receive an annual stipend of up to \$35,000, complemented by a \$25,000 annual grant toward research activities. Each Fellow will study and conduct research under the supervision of a senior faculty member at an academic center of biomedical research. To date the program has awarded 40 fellowships, with 8 awards due soon in 1988.

The Commonwealth Fund Fellowship program in Academic Medicine for Minority Students, started in 1984, sponsors a program (managed by NMF, Inc.) to help academically gifted minority medical students prepare for and begin careers in academic medicine and biomedical research. The Fellowship can be used either during the summer following the 3rd year in medical school or during the 4th year. Each Fellow works in a major biomedical research laboratory under the personal guidance of a leading biomedical scientist for 8 to 12 weeks. Each Fellowship award is \$5,000. To date this program has awarded 81 fellowships, including 21 Fellows in 1987.

## AAMC Proposal on the Advancement of Women in Academic Medicine

Many questions continue to be raised about why women are not advancing more quickly into leadership positions in academic medicine. Data indicating that proportionally fewer women than men faculty are on tenure track and that overall women are less involved in research than their male peers deserve further investigation. Deans also have concerns about affirmative action and the recruitment of women faculty and general concerns about faculty productivity and development. Janet Bickel, Senior Staff Associate, AAMC Division of Institutional Planning and development has received internal clearance to seek foundation support for a proposal to develop strategies for increasing the number of women who will progress into leadership positions in academic medicine. The proposal's scope of work includes linking AAMC's student and faculty databases to examine faculty characteristics. Its main focus, however, is interviews with women and men department chairs and clinical researchers based on a theoretical framework which social scientists have developed from an examination of gender differences in scientific productivity. A better understanding of gender differences in career development in academic medicine and of institutional characteristics contributing to women's advancement will result in strategies that deans can adapt to address institutional needs.



**FUTURE MEETING DATES**

**1988 Meeting Dates:**

***Executive Council/COD Admin. Board -***

June 22-23  
September 7-8

***AAMC Annual Meeting -***

November 12-17  
Chicago Marriott & the Palmer  
House  
Chicago, Illinois

**1989 Meeting Dates:**

***COD Spring Meeting***

April 11-16  
Fess Parker's Red Lion Resort  
Santa Barbara, CA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1988 Council of Deans Spring Meeting

The Hotel Inter-Continental  
Hilton Head, South Carolina

March 19-23, 1988

Schedule of Events

Saturday, March 19

MORNING/AFTERNOON: Amy Eldridge to speak with both Tim Ruether  
and Tom in catering.

PM

Early Arrivals -- approx. 100 individuals

6:30 pm - 7:30 pm  
Pool Terrace

**NEW DEANS & SPOUSES RECEPTION**

- set up: as appropriate for 80 pp
- menu: cherry tomatoes w/ caviar  
mini croissant sandwiches  
crab pastry puffs  
mini kabobs of lamb, beef, chicken  
italian sausage in puff pastry  
stuffed redskin potatoes
- food set up at: 6:00 p.m.
- bartenders and bar set up
- price per drink = 3.50

MONDAY, MARCH 21

7:15 am - 8:30 am  
Elliot Room

**SOUTHERN DEANS MEETING**

--set up: round tables/45  
--menu: Juice  
French Toast  
Pastries  
Fruit Garnish  
coffee/tea  
--begin coffee service at 6:45 am

8:30 am - 9:00 am  
Barnwell

**COD PROGRAM SESSION I**

--set up: same requirements as Saturday;  
except coffee service at 8:00 am and  
refreshed at the Break at 10:30 am  
Take small group discussion books

8:30 am - 9:00 am  
Danner West

**SPOUSES HOSPITALITY**

--set up: informal seating for 40 pp  
--menu: buffet/Light Continental Breakfast  
--guarantee:  
**GUEST RELATIONS to orient spouses**

9:30 - 11:30 am

**COLOR ME BEAUTIFUL SESSION -- \$400.00**  
neel lavalier mic; skirted table  
**TAKE CHECK TO PRESENTATION**

9:00 am - 10:30 am

**COD DISCUSSION GROUPS**

Elliot	Drayton
Lady Davis	Sampson
Archer E E	Archer W W
Danner East	Camellia

--set up: circle of 15 chairs at each room  
--equipment: easal w/ flip chat

**SAME SET UP REQUIREMENTS FOR EACH SESSION**

10:30 am - 11:00 am  
Barnwell

**COFFEE BREAK**

--set up: refresh from 8:00 am set-up  
--fresh cookies/brownies

TUESDAY, MARCH 22

7:15 AM - 8:30 AM  
Elliot Room

**MIDWEST DEANS BREAKFAST**

--set up: square tables/35 pp  
--menu: Cheddar Omelette  
Canadian Bacon  
Fresh Fruit  
--begin coffee service at 6:45 am

7:15 am - 8:30 am  
Camellia Boardroom

**WESTERN DEANS' BREAKFAST**

Guarantee: 12  
Silver Dollar Pancakes  
Strawberry/Blueberry Topping  
Assorted Pastries

8:30 am - 9:00 am  
Drayton

**SPOUSES HOSPITALITY**

--Continental Breakfast

9:30 - 12:30

Spouses' Tour of Hilton Head \$15.00 pp

8:30 am - 9:00 am  
Archer E & W  
Danner E & W

**COD PROGRAM SESSIONS (4)**

--set up: circle of 35 chairs in each room  
--equipment: easel w/ flip chart  
WE NEED PODIUMS IN EACH ROOM

SAME REQUIREMENTS FOR EACH SESSION  
Take Sign Up Sheets and Post

9:00 am - 10:30 am

**COD DISCUSSION GROUPS**

--same set up as above

10:30 am - 11:00 am  
Savannah Foyer

**COFFEE BREAK**

--refresh coffee service from 8:00 am  
--finger fruit w/ coffee

11:00 am - 11:30 am

**COD PROGRAM SESSIONS (REPEATED)**

--same requirements as 8:30 am

11:30 am - 1:00 pm

**COD DISCUSSION GROUPS**

1:15 pm - 2:30 pm  
Camellia Boardroom

**COD ADMINISTRATIVE BOARD LUNCHEON**

--set up: conference style for 20 pp

--menu: Minestrone Soup

Sliced Turkey

2 pasta salads

Raspberry Sorbet

Take 1990 Spring Meeting Info

5:00 - 6:00 pm  
Archer East

**CHAIRMAN'S RECEPTION**

Per Carol Butler's Instructions

5:45 pm - 11:30 pm  
Wexford Country Club

**THEME DINNER (off location)**

Low Country to pick up at 5:45

Take Check to Dinner

**WEDNESDAY, MARCH 23**

8:30 am - 12:00 pm  
Archer E & W

**COD BUSINESS MEETING**

--set up: schoolroom style for 150

--refreshments: -coffee for 75

-tea and sanko for 20

-soft drinks for 20

-water in room

--begin coffee service at 8:00 am

Take extra business meeting agendas

Take Badge Boxes to pick up any badges

RECEIVED  
MAR 15 1988  
RECEIVED

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**  
**SPRING BUSINESS MEETING OF THE COUNCIL OF DEANS**

**MINUTES**

March 23, 1988  
8:30 a.m. - 11:30 a.m.  
Archer East and West

The Hotel Inter-Continental  
Hilton Head, South Carolina

**I. CALL TO ORDER AND QUORUM CALL**

The meeting was called to order at 8:30 a.m. by William T. Butler, M.D., Chairman. Dr. Butler introduced guests and welcomed all present.

**II. APPROVAL OF THE MINUTES**

The minutes of the Council of Deans Annual Business Meeting of Monday, November 9, 1987 were approved.

**II. REPORT OF THE PRESIDENT**

Dr. Butler, introducing President Robert G. Petersdorf, M.D., asked him to include the dues increase. Dr. Butler reminded the Council of Dr. Petersdorf's presentation to the Executive Committee (functioning as the AAMC Finance Committee) which rejected his original proposal and asked for a larger dues increase. As a result, the revised budget was upwards. "If there is blame to share," said Dr. Butler, "I want you to know that it is not solely on the shoulders of Bob Petersdorf but really on the shoulders of the Finance Committee of the organization who is committed to provide the resources necessary to carry out the mandate of the programs of the organization."

Dr. Petersdorf then reported as follows:

o **Strategic Planning:**

The Association's executive staff has been working to develop a strategic plan. This plan will identify major programmatic priority areas and new activities for a five (5) year period. The plan will be presented at the December officers retreat; be taken to each Council for discussion; and to the Executive Council for approval in February 1989. Dr. Petersdorf invited the deans to send ideas to the Vice Presidents, or to him directly.

o **Housestaff Hours:**

The AAMC is not alone among professional societies taking up this issue. As an umbrella organization for medical education it is essential to address the issues arising from the public debate. The AAMC final document was adopted by the Executive Council on February 25th. Attention on graduate medical education was prompted by a 1984 case in which a young woman was admitted to a major New York City teaching hospital where she died in less than twenty-four (24) hours. A Grand Jury investigation returned no indictments, but did make several recommendations concerning emergency room staffing, the supervision of residents in training, and the hours assigned to residents. In response, the New York State Commissioner of Health, David Axelrod, M.D., appointed an ad hoc advisory committee on emergency services to analyze the Grand Jury's recommendations. Dr. Petersdorf noted that the Association meticulously debated the content of its position paper at three Executive Council meetings, at the Annual Meetings of the three constituent councils and at the officers retreat. Dr. Petersdorf emphasized the importance to the medical education community of the public's perception of how we conduct our professional education. It is essential for the AAMC to make a public statement concerning these important issues of supervision and training. To summarize, Dr. Petersdorf stated the Association's consensus on the following points:

**First,** the AAMC supports efforts to examine the working hours of housestaff and agrees with attempts to alter these consistent with the primary educational goals of graduate medical education. An eighty (80) hour work week averaged over four (4) weeks permits residency programs to meet these goals.

**Second,** the AAMC supports the need for graded supervision of housestaff in emergency rooms, in-patient areas and ambulatory settings. As housestaff advance in training their ability increases but at each level the opportunity to make independent decisions must be preserved as an integral part of the educational process. Faculty must devote adequate time and emphasis to housestaff supervision, with the most intense focus at the PGY-1 and PGY-2 levels.

**Third,** the AAMC wants to be certain that whatever changes are made, the educational services and



fiscal implications of these changes are considered.

Fourth, the AAMC recommends that changes be made gradually consistent with preserving educational goals of training programs and with the least disruption to patient care.

Finally, the AAMC asks accrediting authorities, medical school teaching hospitals, residency programs directors and faculty to work actively to halt the practice of moonlighting.

Much of the Association's constituency debate has centered on the on-call hours. The approved document emphasizes eighty working hours per week and not eighty on-call or eighty scheduled hours. Surgical programs can accommodate these limitations with this interpretation.

The problem in internal medicine is not the week's total working hours. The medical housestaff are on call in most instances only every fourth night, but work nearly all of the twenty four hours. This is accommodated in an eighty hour work week schedule. Redistribution of work from the first two P-G years to the third year might alleviate other problems of stress in internal medicine training.

Some argued that the specification of any number for hours would create a ceiling to be enforced in contracts or negotiated downward. Others expressed fear that a resident providing care after the specified number of hours had been reached could be in legal jeopardy if an adverse patient outcome occurred. Dr. Petersdorf argued that an AAMC position without recognition of the public concern for long hours leading to resident fatigue and poor patient care would cause the other issues of the AAMC position to be dismissed. Supervision of residents is a much more important concern and should receive our immediate and personal attention.

o Minority Affairs

Dr. Petersdorf continued by noting a more vigorous program is needed to increase participation in medicine by underrepresented minorities. Previous efforts by the Association and its members have been effective, but much remains to be accomplished. Demographers report minority segments of the population are the fastest growing. Underrepresented minorities in medicine will soon comprise about one-third of our future population, and potentially one-third of our applicant pool. The Association is planning to upgrade its own minority affairs activities

through a new office headed by a vice president to be recruited shortly. Programmatic activities for this office are already under discussion with various foundations. Dr. Petersdorf is confident we will be able to undertake this effort immediately without waiting for a dues increase or for funds to support the new office and its work.

o Awards

Help is needed in providing nomination for various Association awards. The Association's Flexner Award recognizes outstanding contributions to American medical education. Since 1947, the Association has recognized a faculty member for Distinguished Research in the Biomedical Sciences. The Association scored a real coup by giving it to Brown and Goldstein just months before they received the Nobel Prize. Dr. Petersdorf urged each dean to stimulate interest in this award by nominating someone from their school. The AOA and the AAMC will initiate a new award recognizing two distinguished teachers each year--one from the basic sciences and another from the clinical sciences. The formal announcement of this award will be made by the end of this month. A positive response will assure that this award becomes a prestigious way of recognizing the outstanding teachers in our institutions.

o Association Dues

The Sunday night presentation provided detailed information on the Association's financial status. Dr. Petersdorf reviewed a few key points.

**First**, the Association derives about forty five percent (45%) of revenues from special student services such as the MCAT exam and the AMCAS program, compared to only thirty percent (30%) from dues. The affect of the change in dues structure will increase the dues proportion to about fifty percent (50%) of revenues and in the first year of a new dues structure special student services will provide thirty three percent (33%) of our revenue. This will subsequently come down to thirty percent (30%) by fiscal year 1994.

**Second**, although salary increases account for twenty nine percent (29%) of the increase expenditure in fiscal year 1988-89, the total salary increase in the Association is five to six percent (5-6%).

Finally, the philosophy for the use of the Association's reserves and the interest from our investments was explained. Dr. Petersdorf stated the dues are meant to raise \$4.6 million. This will take care of the following items:

- o \$1.3 million to compensate for the deficit in the 1988-89 budget. The 1988-89 budget with its deficit has already been approved by the Executive Committee and the Executive Council.
- o \$700,000 dollars this year was taken out of designated reserve funds and set aside by the Executive Council for various programmatic activities, mainly for updating of the MCATs. This expenditure is now part of the permanent operating budget.
- o \$1.2 million is interest income now annualized for operations. We need to be able to get along without using interest income as part of our operating budget.
- o \$1.4 million is for new programs, plus inflation. This is about ten percent (10%) of next year's \$14 million operating budget.

Related to the Association's reserve funds is the need for space. The situation at 1 Dupont Circle is not entirely stable. The American Council of Education owns the building but has been looking at different space in order to bring in more members of the educational community. We believe ACE will eventually sell the building. For that reason we have prolonged the leases for only three years instead of the usual five years. Now we need space for the following reasons:

First, the Association's space is both inadequate in quantity and in functional quality. Further, we are in two locations. Student services are located at 1776 Massachusetts Avenue where we'll rent an additional 10,000 square feet in November 1988. We need more space, need better space and need to bring the operations together. The issue of safety is also important. And finally, the image of the AAMC space should be commensurate with our image.

The proposed dues increase will not go to build new space. The dues increase will save the \$1.2 million interest income for space efforts. It works in the following way. If the dues increase is approved and becomes effective in the summer of 1989, which is the earliest that it can, for the first several years the interest income will be put aside for a down payment probably on a new building. After considerable study with several consultants, we have

determined that long-term leasing is not the best option for us. We spend over a million dollars annually for rent now; however, we ought to be able to leave our successors a building in which the AAMC has equity. The lease at 1 Dupont Circle ends January 1, 1992. At that point we want to be prepared to move into new quarters housing the entire organization. Should we move into the suburbs as other organizations have? It's our feeling, firstly, that Bethesda, the most desirable suburb, is as expensive as central Washington. Secondly, central Washington is an address we feel we should have and not bury ourselves among the condominiums of Alexandria and Arlington. We think we will be able to purchase a D.C. building in 1992.

Commenting on programmatic changes, Dr. Petersdorf said we need and have added senior staff to the Council of Deans and will add to the Council of Teaching Hospitals and other important areas such as communications and biomedical research. We want to expand our minority activities. We want to do a curriculum study to followup the recommendations of the GPEP report. We want to revise and expand the Journal of Medical Education. We have created the group on faculty practice.

Commenting on the reserves in relation to the dues increase, Dr. Petersdorf noted we have \$15 million in reserve but we were unable to purchase a very attractive building a few months ago. Needing \$1.2 million from the interest income on that \$15 million reserve to operate, we couldn't afford the building payments. Ultimately it seems reasonable to keep the reserves of the Association at roughly one-year's operating expenses.

Commenting on other sources of revenue, Dr. Petersdorf said we still have a significant amount of income from AMCAS. While AMCAS revenue is large, the profit margin is only about \$750,000 over \$6 million in expenses. We would be better off if less dependent on that source of income.

There have been concerns about the size of the dues increase. Could it be phased in over a longer period of time? This would not meet our immediate needs. We already have an operating deficit of \$1.3 million, plus the \$700,000 from the designated accounts and this will have to be continued. The time is limited to build the capital funds for new quarters before the expiration of our lease in December 1991.

Should dues from members of the Council of Deans be set at a flat rate? Should there be a sliding scale? Should a two or three tiered system be considered? The Association's staff considered these possibilities, but recommended a flat fee for several reasons: First, medical schools get basically the same services from the Association regardless

of size. Second, picking an appropriate base for a sliding fee would be difficult. Third, if some schools pay less than the \$32,500 proposed others will have to pay more to produce the same level of dues income needed by the organization. However, if the Council of Deans still wishes a tiered or a sliding scale system, the staff will develop alternatives to present to the Administrative Board in June. As long as the required bottom line is reached, any number of proposals to meet that goal can be considered.

Dr. Butler then pointed out that the Executive Committee meeting discussed location. Two other factors made central Washington attractive. One was ease of access from the airport by visitors to Washington. The other was the vast majority of the employees wishing to be near a metro stop.

John Colloton, as a member of the Finance Committee, assured the Council of three things: First, the Association is behind on a dues increase because we have relied on interest income, MCAT fees and other such student service income to support the services the constituency receives. Compared to the \$80,000 a year Iowa University Hospital pays to the American Hospital Association, the relative benefits received from the AAMC for the three or four thousand dollars dues is totally disproportionate. Second, the proposed dues increases are for programs the constituency wants the Association to provide. The dues increase is not for new building space. Third, there is a very critical space problem, both in quality and quantity. Comparing the AAMC to the AHA, the AMA and even state associations, it's really quite an embarrassment. Fortunately, we are in a position to solve the problem by accruing the reserve interest income between 1988 and 1992.

### **III. LEGISLATIVE UPDATE**

Dr. Richard Knapp presented a legislative update. He first called attention to the AAMC's published comprehensive legislative and regulatory update. Specific items were then updated. First, the National Institute of Health's reauthorization process concerns. There are five issues: Fetal research; the proposed deafness institute; the proposed center for rehabilitation research; health research facilities construction; and the use of animals in research.

Concerning construction, there is some optimism. Drs. Richard Janeway and Louis Kettel made a presentation before a special advisory panel at NIH on February 9th. We worked with and endorsed the Association of American Universities and the National Association of State Universities and Land Grant Colleges testimony before Congressman Waxman on March 4th. We and others have been working with Senator Kennedy's staff. Currently in the NIH reauthorization bill there is a health facilities research construction provision with an

initial authorization for \$150 million. This is an area in support in dealings with dean's congressional delegations.

The role of animals in research will be on the agenda again. Congressman Waxman's Health Subcommittee will devote time to hearings on the issue. The mail is very one sided mostly opposing using animals in research. Showing your congressional delegation how you deal with animals and indicating the importance of animals in research would be useful. The animal rights bill now has over a hundred co-sponsors. You might want to see whether your Congressman is a co-sponsor.

The Health Manpower Act expires during this fiscal year. Of concern are student financial assistance, minority recruitment in the form of the HCOP program and categorical programs devoted to support of family medicine, general internal medicine, and geriatrics. Dr. George Bryan testified before Congressman Waxman last week. We are working closely with Senator Kennedy's staff on a similar bill.

"Independent students" is the status of all medical students for loan purposes. Language included in the higher education act led the Department of Education to exclude allowance for dependents in constructing the budget of an independent student. This form of calculation for the student yields less financial assistance. Dr. Petersdorf has sent a memorandum asking medical school financial aide officers to write letters about this.

Medical licensure discrimination toward foreign medical graduates has prompted two House bills. Dr. Kettel appeared before Congressman Waxman's committee ten days ago. This issue is related to the Uniform Examination Pathway to Licensure.

Without AIDS, the NIH budget is projected to increase 5.4%. With the AIDS money, the increase is 6.8%. Dr. D. Kay Clawson will testify before Congressman Natcher on May 4th. Some matters such as BRSG funding need specific attention. Mail to your own Congressman and to Congressman Natcher is in order.

The Veterans Administration as a cabinet department is being held up over the matter of judicial review of disputes about coverage. Dr. Butler, as Chairman of the Special Medical Advisory Group, and Dr. Petersdorf have been very active on the issue of eliminating politics from the appointment of the Chief Medical Director.

The National Academy of Sciences was to do a study on age discrimination through required retirement. It has not been funded yet, although there is a million dollars in the

President's budget for it. You are aware that Universities may require retirement at a specified age through 1993. Dr. Robert Jones on Joe Keyes' staff has communicated with those of you who are in states who have similar statutes.

A report from Congressman Pickel's oversight committee on unrelated business income tax should be released shortly. We will analyze it and make it available to you.

Regulations were due in February 1988 for the non-discrimination requirements of 403(b) pension plans. The statute is to take effect on January 1, 1989. Congressman Matsui's bill would merely delay the issue until January 1, 1990. It is doubtful we can do anything to delay this further.

The report of the Physician Payment Review Commission is due April 1st. The Harvard Study report on relative value scales is due in July. We have been trying to get Dr. Kenneth Shine, Dean at UCLA, on the Physician Payment Review Commission.

#### IV. DISCUSSION ITEMS

##### A. Small Group Discussions

1. Dr. William Deal summarized the discussion and recommendations from the groups attending the sessions on "A Declining Applicant Pool: How Can We Preserve Affirmative Action?" as follows:

- o The AAMC should work to increase federal, other public and private support of:
  - . improvement of general education in primary and secondary school systems;
  - . minority students enrolled in professional schools.
- o The AAMC should:
  - . develop public relations and communications programs directed to the several levels of recruiting needed, i.e. elementary, secondary, and premedical schools, especially the largest contributors to the pool. Such programs should include faculties and parents;
  - . regularize data collection and distribution directed to realistic targets of accomplishment;
  - . identify successful recruitment programs, and through workshops and

other means bring them to the attention of the constituency;

- . develop communication links and coalitions among communities, families, and premedical educators and advisors and the schools such as magnet programs working in this area.

o Education institutions should:

- . work to decrease student debt burdens including loan forgiveness programs;
- . enhance education of educators particularly in the sciences and mathematics;
- . recruit role models as administrators and faculty;
- . focus on all underrepresented groups including native Americans and the various subsets of Latins while not neglecting the largest numbers of Hispanics and Blacks;
- . develop enrichment programs at junior high, high school and college levels;
- . develop enrichment programs for underrepresented and majority group marginal performers (MCAT Scores: 4-7) to bring them into the pool.

2. Dr. John Naughton summarized the discussion and recommendations from the groups attending the session on "Development of Women and Minority Faculty Members--How are We Doing?" as follows:

o The AAMC should:

- . continue to support programs and provide assistance to its members in faculty development especially for women and minorities;
- . study the women and minority faculty cohort in more detail so strategies for action can be developed;
- . support legislation and other plans for debt forgiveness as an incentive to enter academia;
- . identify successful programs and bring these models to the attention of our constituency;
- . distribute the facts of the minority and women faculty pool size and its inequities to the constituency as a means of educating and sensitizing.



- o Medical schools should review institutional policies and practices regarding:
  - . promotion and tenure results and the time frame of actions;
  - . involvement of women and minority faculty in search and P&T processes;
  - . salary equity;
  - . facility equity;
  - . mentoring systems for these faculty;
  - . existing basic science doctoral and MD/PhD programs for their potential of attracting women and underrepresented groups to future academic positions.
- 3. Dr. Henry Russe presented the report and recommendations from the groups attending the sessions on "Graduate Medical Education: How Should It Be Supported in the Future?" by first noting that the proposal that postgraduate trainees be paid in the form of a loan which would be forgiven for various forms of service including service to medical schools as well as hospitals was received with low enthusiasm. All groups recognized the present burden for the cost of GME is largely borne by hospitals including large amounts covered federally through Medicare and the VA. This may well change in the future. The recommendations were that the AAMC:
  - o study the possibility and ramifications of classifying house officers as students; and
  - o continue to support the present system of funding as long as possible.
- 4. Dr. Robert Friedlander presented the report and recommendations from the groups attending the sessions on "International Medical Education: What are the U.S. Roles and Responsibilities?" as follows:
  - o The AAMC should:
    - . provide models which resolve regulatory problems, including: the scope of activities; licensure and various forms of residency accreditation;
    - . with the International Medical Scholars Program (IMSP) and its parent organizations:
      - .. develop a way of coordinating/centralizing funding for programs;

- .. embark on a public awareness program;
    - .. define categories of institutions in addition to medical schools who would be eligible to receive international medical scholars; and
    - .. d e f i n e t h e t e r m s 'fellow'/'scholars' and the length of such experiences.
  - . systematically gather and distribute information on needs and how these might be fulfilled by international scholars on our campuses.
- o The IMSP should:
- . develop a communication system, perhaps in the form of a newsletter and/or conference, on the experiences and methods developed;
  - . serve as a facilitator for foreign governments, schools and agencies who wish to become involved;
  - . serve as a match maker for resources and needs.
- o Programs and institutions should:
- . focus on primary care offerings and limit the use of tertiary care education since few third world and underdeveloped countries are unable to provide these high technology. When tertiary care education is offered there should be an effort to provide or assure that the resources for implementation are available upon return of the trainee to the country of referral;
  - . develop a certificate or other type of recognition award to signify completion of the program.
5. Dr. Robert Tranquada presented the report and recommendations of the groups that attended the sessions on "Continuing Medical Education: Who is responsible for its Quality?" as follows:
- o The AAMC, recognizing 1) that the continuum of education is within its prerogative, 2) knowing that there is great diversify of activity and 3) noting that relicensing and recertification are realities and provide both an opportunity and a need for medical school involvement, should:

- . convene a Task Force to review the role of medical schools in CME, the role of the AAMC, the ACCME and the medical schools in the issue of recertification and relicensure;
  - . reexamine earlier decisions regarding relationships with the Society of Directors of Continuing Medical Education.
6. Dr. Phillip Forman after commending Dr. John Gronvall on his openness and candor reported and made recommendations from the groups attending the sessions on "Strengthening the VA-Medical School Relationship" as follows:
- o The AAMC and the deans should:
    - . support increased funding of VA research;
    - . advocate language in the legislation proposing VA cabinet status that will buffer the VA from politicization.
  - o The COD should:
    - . consider meeting with VA administrators at each AAMC Annual Meeting;
    - . consider a special orientation program for new deans from schools with VA affiliations.
  - o The individual school deans are encouraged:
    - . to invite VA Central Office professional staff to help and advise on issues and problems in the VA-Medical School relationship;
    - . to involve veteran's service organizations at the local level in VA-medical school affairs;
    - . to become familiar with the VA conflict of interest policies (available on request from the VACO or Amy Eldridge at the AAMC).
- B. The MEDLOANS program was reviewed by Dr. Robert Beran. The AAMC originated a student loan program about two years ago. The first full academic year of the program occurs in June. The AAMC loan program allows a student to apply to the four available student loans through one single application. They write one check for payback payments. It is a privately insured loan

not requiring the student to have a co-signer. The interest rate today is about six tenths of a percent above prime. The bank has been extraordinarily receptive and has consented to allow students or residents to refinance their last loans to take advantage of some new options. Others such as AMSA have similar loan programs. A number of the states have changed their terms and conditions also. This new market has made the student the benefactor.

C. Revision of AAMC Recommendations Concerning Medical School Acceptance Procedures, so-called "Traffic Rules."

Dr. Beran described the "traffic rules" as those understandings among schools for handling students with multiple acceptances, and the dates of completion for certain steps in the admission cycle. The proposed rules establish March 15th as the date schools offer enough positions to fill their class. Students holding multiple acceptances are asked to choose by April 15th. Lastly, the proposed rules reaffirm standards; for example, if an acceptance deposit is required, it should be \$100 with a refundable date of June 30.

There were no objections to these proposals raised by the Council.

D. Individual School Applicant/Matriculant Analyses

Paul Jolly referred to the publication, Trends in Medical School Applicants and Matriculants. The local data which provided the aggregate material in this publication is available to individual schools. The cost is \$300.

V. NEW BUSINESS

Mr. Keyes reviewed the implications of tax law revisions on tuition, scholarships and waivers of payback. Dr. Butler asked that available summaries of this information be distributed to medical schools. (Current information has been distributed in the form of Blue Memos.)

VI. ADJOURNMENT



# association of american medical colleges

## "Traffic Rules" Revisions February 1988

### Introduction

A revision of the Recommendations Concerning Medical School Acceptance Procedures ("traffic rules") has been developed by the Group on Student Affairs Committee on Admissions. Suggested changes to the traffic rules, in the form of previous drafts, were discussed during the 1987 GSA Spring regional meetings. The attached revision represents the results of these discussions and also the results of a survey of admissions officers conducted in early 1988.

The revised traffic rules will be presented for approval at each of the 1988 GSA Spring regional meetings and to the COD Administrative Board and Executive Council at their Fall 1988 meeting.

### Brief Summary of Revision

- A. Establishment of March 15 as the date that all schools should have offered a total number of acceptances **at least** equal to the size of their entering class.
  - 1) The March 15 date is **two months** earlier than the date in the present version of the traffic rules.
  - 2) This change represents the most significant departure from the present set of traffic rules. It is clearly intended to move the first point in the decision making process (schools and students) earlier in the year.
  - 3) Of the 83 schools responding to the survey, over 50% indicated their present schedule is such that the March 15 date is realistic.
  - 4) In addition, 40 schools suggested moving the date earlier than May 15 with March 15 being the clear preference.
- B. By April 15, an applicant who has received offers of admission from more than one school should choose the one school he or she prefers and withdraw from all other schools to which he or she has been accepted.

Coupled with the observance of March 15, the acceptance of the practice of requiring students holding multiple acceptances to decide by April 15 will reduce considerably the problems that now exist during the summer prior to the beginning of classes.

- C. Recommended Amount of Acceptance Deposit Remains at \$100.00
  - 1) Survey of admissions officers indicated that 52 of the 83 respondents require a deposit, most at \$100.00.
  - 2) Forty-six of the schools responding wanted the deposit amount stated in the current traffic rules (\$100.00) to remain the same and 20 schools wanted it to be increased.
  - 3) Twenty-eight schools wanted the deposit to remain refundable until June 15, with 10 schools preferring dates prior to April 15, 11 schools preferring dates from April 16 - May 15, and 7 schools preferring dates from May 16 - June 14.

## Traffic Rules Discussion

- I. Date by which schools offer acceptances equal to class size. Evidence:
- A. Need for students and schools to have earlier deadline than May 15 (the date stated in the current traffic rules).
  - B. Need date late enough to allow schools time to process and interview a sufficient number of applicants.
  - C. Need date early enough to permit schools adequate time to offer additional acceptances as students narrow their choices.
  - D. Several rounds of making offers can be accomplished prior to the summer.
  - E. Support from the traffic rules survey showed:
    - < 51 schools had begun processing applications by July 15.
    - < 52 schools had begun interviewing by September 15.
    - < 58 schools had offered their first acceptance by November 15.
- Thus, it was felt that an adequate number of schools had sufficient processing time to fill their classes by March 15.
- F. Traffic rules survey showed that 47 of the 83 schools responding had filled their classes by March 15.
  - G. In addition, 40 of the schools suggested a date earlier than May 15, the most frequently suggested date being March 15.
  - H. Schools should be notified prior to March 15 that according to AMCAS records they have not offered acceptances equal to their class size.
  - I. Schools need a mechanism that encourages compliance with these rules, such as support from the COD.
- II. Date by which applicant must choose the one school that he/she prefers and withdraw from all other schools at which he/she has been accepted.
- A. More than two weeks after a March 15 deadline is required for a student to receive offers made in March, since the offer may have to be forwarded to an address other than home.
  - B. This date gives sufficient time for several rounds of acceptances/withdrawals prior to the summer.
  - C. Applicants have two weeks to respond to offers, up until April 15. After that time, students may be expected to decide on an offer faster. This should increase the turn around time and lessen problems during the summer.

### III. Acceptance Deposit

A. The function of the acceptance deposit is to increase an applicant's motivation to drop multiple acceptances.

B. Survey showed that most schools that responded to the survey required an acceptance deposit (52 of the 83).

< The amount of the deposit was most often \$100.

✓ < 46 of schools responding wanted the deposit amount stated in the current traffic rules (\$100) to remain the same and 20 schools wanted it to be increased.

✓ < 28 schools wanted the deposit to remain refundable until June 15, with 10 schools preferring dates prior to April 15, 11 schools preferring dates from April 16 - May 15, and 7 schools preferring dates from May 16 - June 14.

IV. June 1 as date after which schools seeking to admit an accepted applicant should advise that school of its intent.

< Because acceptance process is being moved earlier in the year, June 1 is a realistic date. At that time, phone calls, etc. to other schools would not be so numerous as to be a burden.

V. Acceptance offers made to students after they have enrolled

< The respondents to the questionnaire overwhelmingly felt that the traffic rules should continue to include this statement (81 of 83).

< Most felt that some enforcement was necessary.

VI. Why committee suggests eliminating AMCAS February Master Acceptance list?

**AAMC Recommendations Concerning  
Medical School Acceptance Procedures for  
First Year Entering Students**

For the information of prospective medical students and their advisors, the recommended procedures for offering acceptance to medical school and for student responses to those offers are as follows:

1. Each school of medicine should prepare and distribute to applicants and college advisors a detailed schedule of its application and acceptance procedures and should adhere to this schedule unless it is publicly amended.
2. Each school of medicine should agree not to notify its applicants (except for those applying via Early Decision Program (EDP)) of acceptance prior to October 15 of each admission cycle.
3. By March 15 of the year of matriculation, each school of medicine should have issued a number of acceptances at least equal to the size of its first year entering class.
4. By April 15 of the year of matriculation, an applicant who has received offers of admission from more than one school should choose the one school that he or she prefers and withdraw from all other schools to which he or she has been accepted.
5. Only after April 15 are schools free to make appropriate rules for dealing with accepted applicants who, without adequate explanation, hold one or more places in other schools. These rules should recognize the problems of the applicant who has multiple offers and also of those applicants who have not yet been accepted.
6. Prior to April 15 of the year of matriculation, an applicant should be given at least two weeks to reply to an offer of admission. After April 15, schools may require applicants to respond to acceptance offers in less than two weeks. An applicant may be required to file a statement of intent, or a deposit or both. The statement of intent should provide freedom to withdraw if the applicant is later accepted by a school that he or she prefers.
7. It is recommended that the acceptance deposit not exceed \$100 and be refundable until May 15. After that date, a school may retain the deposit as a late withdrawal fee. If the applicant matriculates at the school, the school is encouraged to credit the deposit toward tuition.
8. Subsequent to June 1, a school of medicine seeking to admit an applicant already known to be accepted by another school for that entering class should advise that school of its intent. Because of the administrative problems involved in filling a place vacated just prior to the commencement of the academic year, schools should communicate fully with each other with respect to anticipated late roster changes in order to keep misunderstandings at a minimum.
9. After an applicant has enrolled in a U.S. school of medicine or begun a brief orientation program contiguous to enrollment, no further acceptances should be offered to that individual. Once enrolled in a school, students have an obligation to withdraw their applications promptly from all other schools. Enrollment is defined as being officially registered as a member of the first year entering class at a school.





**association of american  
medical colleges**

March 18, 1988

MEMORANDUM

TO: Attendees - Council of Dean's Spring Meeting

FROM: Dr. Robert G. Petersdorf

SUBJECT: Latest Draft CoGME Conclusions and Recommendations

CoGME, aiming to submit its first official Report before July 1, 1988, once again reviewed and refined the conclusions and recommendations for their Report at a meeting held on February 18-19, 1988. The draft minutes of that meeting are attached.

## COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

### MINUTES

February 18-19, 1988

#### Members in Attendance:

Dipali V. Apte  
Lawrence U. Haspel, D.O.  
John K. Kittredge  
Janet P. Kramer, M.D.  
Stuart J. Marylander  
Harry L. Metcalf, M.D.  
Laird Miller  
James A. Pittman, Jr., M.D.  
Rene F. Rodriguez, M.D.  
Sheldon W. Samuels

Cecil O. Samuelson, Jr., M.D.  
David Satcher, M.D., Ph.D.  
Neal A. Vanselow, M.D.  
Michael E. Whitcomb, M.D.  
C. Ross Anthony, Ph.D.\*  
Daphne Hare, M.D., Ph.D.\*\*  
David N. Sundwall, M.D.\*\*\*  
F. Lawrence Clare, M.D., M.P.H.+  
Paul M. Schwab++

\*Designee for Administrator, Health Care Financing Administration

\*\*Representing Peter Regan, M.D., Designee for Chief Medical  
Director, Veterans Administration

\*\*\*Designee for Assistant Secretary for Health

+Program Staff Coordinator, COGME

++Executive Secretary, COGME

#### THURSDAY MORNING SESSION - February 18, 1988

#### Call to Order and Council Business

The meeting was called to order by Neal A. Vanselow, M.D., Council Chairperson. It was announced that Dr. Peter Regan, Chief Medical Director for Academic Affairs, is the new Veterans Administration designee to the Council.

Introduced to the Council was J. Jarrett Clinton, M.D., new Director of the Bureau of Health Professions, HRSA. Also announced were the appointments of Mr. Thomas Hatch to the post of Associate Administrator for Policy Coordination, HRSA, and Mr. Paul Schwab to the post of Deputy Director, Bureau of Health Professions. Also attending the Council's meeting were Grant Mitchell, M.D., former member of COGME, and Mr. John Kelso, Deputy Administrator, HRSA.

A summary of the public hearing held in November was approved as presented.

Dr. Vanselow reviewed the purpose of the 2-day plenary session. In brief, the full committee was scheduled to review final reports of the Council's Subcommittees, as well as selected staff papers. Plans called

for the full committee to reach tentative conclusions and recommendations. (Note: The final COGME conclusions and recommendations may differ in content or wording from those presented in this set of minutes. At the time of this writing, a May 2-3, 1988 meeting has been scheduled for the Council to approve its first report to the Secretary, DHHS, and to the Congress.)

### COGME Principles

Council members reviewed the list of ten COGME principles that had been developed during earlier sessions. After discussion of the list, with some modifications, the Council endorsed the following overall set of principles:

1. The primary concern of the Council must be the health of the American people. There must be assured access for all to quality health care. Concern for the well-being of the health professions, medical schools, and teaching hospitals, while important, must be secondary to the above concerns.
2. The Council should consider the diverse needs of the various geographic areas and segments of the population, such as rural and inner city areas, and minority and disadvantaged populations.
3. A goal of the Council is increased representation of minorities in the health professions. Targeted programs are appropriate and a necessary means of achieving this objective.
4. The Council must consider the interrelationship between services provided by physicians and those provided by other health professions.
5. The Council will favor the use of private sector solutions, recognizing that government or other interventions have been and may continue to be needed to address specific problems of distribution, quality, and access to health care.
6. The Council should be concerned about effects on total health care costs in the Nation. The Council must also take into account the financial and programmatic impact of its recommendations on the Federal budget in both the short and long term.
7. The Council recognizes that health care in the U.S. is not a "closed" system, and therefore its deliberations must be guided by an international perspective.

8. The Council must take into account changes in demographics (e.g., the aging population), disease patterns (e.g., increasing prevalence of AIDS), patterns of health care delivery (e.g., increased emphasis on ambulatory care), and the unmet needs for prevention and care.
9. The Council believes that a strong system of medical education must be maintained in order to expand medical knowledge and provide access to quality medical care through an adequate supply of appropriately educated physicians.
10. American medical education should provide a basis for physicians of the future to be able to deliver continually improving patient care through a better understanding of disease processes and their clinical manifestations. The education system should prepare physicians to appropriately apply new techniques of diagnosis, treatment, and prevention in a compassionate and cost-effective manner.

#### Access

A staff paper on access to health care was discussed for inclusion in the Council's final report. Council members acknowledged that an important interrelationship exists between access, educational programs, and medical manpower. At the same time, recognition existed that the Council's charge did not encompass all issues and policies regarding the Nation's health care system.

It was noted that any changes in national policies regarding access to quality care can have significant effects on important aspects of medical education and the supply of health professionals. All COGME members believed that sensitivity to access concerns needs to be a continuing, pervasive theme for Council deliberations.

#### Report of the Subcommittee on Physician Manpower

Conclusions and recommendations were presented by Harry L. Metcalf, M.D., Subcommittee chairperson, for the Council's approval. The discussion by the full Council focused on several specific issues and concerns. These included: 1) the degree to which conclusions and recommendations were supported by existing data and "independent" sources of information; 2) current evidence regarding the implications of any oversupply of physicians; 3) the appropriateness of proposals to influence the overall supply of physicians; and 4) the complexity involved in attempting to remedy problems involved with the geographic distribution of physicians. A tentative consensus was reached regarding major manpower issues — aggregate and primary care manpower supply, geriatrics, preventive medicine, and geographic distribution. Associated financing recommendations were deferred to consideration of the report from the Subcommittee on GME Programs and Financing.

Based on the report of the Subcommittee on Physician Manpower, the full Council adopted a tentative set of conclusions and recommendations. A number of members noted the importance of relating appropriate narrative and supportive rationale to these conclusions/recommendations in the Council's final report. Agreement was reached on a tentative basis regarding the following areas:

## I. AGGREGATE SUPPLY

### CONCLUSIONS:

- A. Given the assumptions of existing studies and testimony presented, there now is or soon will be an oversupply of physicians in the U.S.
- B. The extent of an oversupply is impossible to quantify at the present time.
- C. There is conflicting evidence whether the increasing physician supply which the Council has determined to be an oversupply based on currently used supply-demand models, will necessarily lead to socially undesirable consequences.

### RECOMMENDATIONS:

- 1. At the present time, the Federal Government should not attempt to influence physician manpower supply in the aggregate. However, it should focus its efforts in influencing clearly identified problems such as specialty shortages, quality of care, the geographic maldistribution of physicians, and the continued underrepresentation of minorities in medicine.
- 2. The number of first-year positions in GME should not be used to reduce the supply of licensed physicians in the aggregate.

## II. SPECIALTY SUPPLY

### CONCLUSIONS:

- A. There is evidence of an undersupply of certain primary care physicians together with an oversupply in some non-primary care specialties.
- B. There is an undersupply of physicians in family practice.
- C. There appears to be an impending undersupply of physicians in general internal medicine.
- D. There appears to be an adequate supply of physicians in pediatrics at present.

RECOMMENDATIONS:

1. The subcommittee recommends that allopathic and osteopathic school graduates should be strongly encouraged to enter training in primary care, particularly in family practice and general internal medicine.
2. It will be necessary to continue Federal and State support to these programs, as well as expand organized private sector incentives. For example, existing Title VII primary care grant programs should be continued.

III. GEOGRAPHIC DISTRIBUTION OF PHYSICIANSCONCLUSIONS:

- A. There is a geographic maldistribution of physicians with too few physicians in many rural and inner city areas.
- B. While there continues to be an inadequate number of physicians in many rural and inner city areas, this problem is not as severe as it has been in the recent past and may well be ameliorated, at least in part, as the overall supply of physicians increases.
- C. Nevertheless, maldistribution remains a serious problem, requiring solutions more broadly based than those focusing exclusively on medical education.

RECOMMENDATIONS:

1. Existing activities that increase the likelihood that physicians will locate and remain in shortage areas should be continued and strengthened, such as:
  - a. recruitment and selection of students entering medical schools likely to locate in shortage areas;
  - b. medical school programs including preceptorships in shortage areas;
  - c. student financial support, such as loan repayment in exchange for service;
  - d. practice incentives, e.g., differential reimbursement, professional and community support; and
  - e. existing programs, federally and state supported, such as the National Health Service Corps, to meet the needs of underserved communities.

- B. More research and evaluation should be conducted on factors relating to the geographic distribution of physicians to assure that a broad range of existing and new strategies are directed to this complex problem.

THURSDAY AFTERNOON SESSION - February 18, 1988

Report of the Subcommittee on Foreign Medical Graduates (FMGs)

Following the lunch recess, the Foreign Medical Graduate Subcommittee Report was presented by Subcommittee Chairperson Michael E. Whitcomb, M.D., for the Council's approval.

The discussion by the full Council focused on several specific issues and concerns. These included: 1) an apparent discrepancy between Subcommittees regarding treatment of applicants for residency positions under conditions of fewer available positions than available applicants; 2) the rationale for any proposals designed to limit access to graduate medical education; 3) current developments regarding examinations used to determine the qualifications of foreign medical graduate applicants to GME; and 4) considerations related to determining the quality of medical schools outside of the U.S. and Canada. The Council chose not to adopt specific Subcommittee recommendations regarding the availability of physician assistants.

As the Council did not complete its deliberations on the FMG Subcommittee Report, a decision was reached to continue the review of the report on the next day's session.

The meeting was recessed at at 5:00 p.m.

FRIDAY MORNING SESSION - February 19, 1988

David Sundwall, M.D., and Ross Anthony, Ph.D., gave a brief summary of the Administration's fiscal year '89 budget recommendations for the Department of Health and Human Services (specifically, for the Health Resources and Services Administration and the Health Care Financing Administration). Discussion briefly focused on matters pertinent to health professions authorities and Medicare financing of graduate medical education.

Representation of Minorities in Medicine

A staff paper regarding the issue of representation of minorities in medicine was reviewed by the Council. Discussion considered the extent of minority underrepresentation, factors accounting for this situation, desired objectives, and potential actions to remedy imbalances. All data reviewed indicated a continuing underrepresentation of minorities in

medicine and supported the desirability of increasing the numbers of minorities. Particular attention was directed to the need to increase the applicant pool of underrepresented minorities, which included the need to expand the pool of pre-college qualified students. Several recommendations were reviewed to address this situation.

Following Council discussion, a decision was made to establish a subcommittee to review the staff paper in detail and propose recommendations. Dr. Vanselow announced that the subcommittee would be chaired by Mr. Stuart Marylander, with members including Dr. David Satcher, Dr. Janet Kramer, and Ms. Dipali Apte.

Report of Subcommittee on Foreign Medical Graduates (FMG-) -- Continued

The Council returned to a consideration of the Subcommittee Report on Foreign Medical Graduates. After a lengthy discussion, the following tentative conclusions and recommendations were reached (subject to further consideration by the Council at the May meeting):

I. ACCESS TO CARE, GRADUATE MEDICAL EDUCATION, AND FMG-DEPENDENT TEACHING HOSPITALS<sup>1</sup>

CONCLUSIONS

- A. Exclusion of foreign medical graduates from GME programs will reduce the ability of a small number of hospitals serving a disproportionate share of the poor to provide certain essential hospital-based medical services unless alternative systems for providing care are established first. Ambulatory services will be most immediately and severely impacted.
- B. Nonphysician health care providers can perform some of the tasks now provided by residents. However, the degree to which nonphysician providers can perform tasks usually provided by residents varies markedly depending on the nature of the specialty and the level of care provided.

<sup>1</sup>FMG-dependent teaching hospitals, for purposes of this report, are hospitals with 10 or more residents, of which 25 percent or more are graduates of foreign medical schools.



### RECOMMENDATION:

1. If the Federal Government and/or the private sector were to develop policies which would reduce the number of FMGs in GME, alternative systems for delivering hospital-based medical care should be established first in hospitals serving a disproportionate share of the poor.

### CONSIDERATION SHOULD BE GIVEN TO THE FOLLOWING:

- o A transition period should be allowed to enable hospitals to make necessary adjustments in GME programs. Temporary waivers should be provided for programs which offer high quality education and provide primary care in an underserved area or are serving a large indigent population since these programs may require more time to increase the complement of alternative full-time health care providers.
- o Federal and State governments and the private sector should provide financial incentives to assist hospitals in replacing FMG residents with full-time physicians, residents who are graduates of U.S. medical schools graduates or other appropriate health care providers (e.g., educational loan repayment, bonus for tenure, partial payment of malpractice insurance).

## II. ISSUES RELATED TO QUALIFICATIONS REVIEW

### CONCLUSIONS:

- A. The current system for testing and evaluating the basic medical knowledge of FMGs prior to entering GME is generally adequate. With the expected addition of testing of clinical competence and the addition of the test of spoken English, current concerns regarding preparedness for entry into GME will have been addressed to the degree possible. It should be noted that there continues to be controversy about the validity and fairness of this evaluation process.
- B. It would be both presumptuous and unwise for either the government or the private sector to attempt to establish procedures for accrediting medical schools outside its own territory.

### RECOMMENDATIONS:

1. For creditability purposes, it would be desirable to resolve the controversy centered on the comparability of the FMGEMS and NBME Parts I and II examinations. There should be consideration given to allowing FMGs to take the NBME if this is the only means to resolve the issue.

2. If a clinical skills assessment examination is introduced for general applicability for entry into GME, one examination should be used in evaluating all candidates.
3. The private sector should be sensitive to bias in clinical knowledge testing which may be caused by use of testing technology.
4. Neither the government nor the private sector should establish a system for accreditation of foreign medical schools.
5. The private sector should endorse and assist foreign countries engaged in regional efforts to establish standards and procedures which will improve medical education in their medical schools.

### III. DIFFERENTIATION AMONG MEDICAL SCHOOL GRADUATES AND ACCESS TO GRADUATE MEDICAL EDUCATION

#### CONCLUSIONS:

- A. It is highly desirable that all graduates of U.S. allopathic and osteopathic medical schools be able to obtain a PGY-1 position in a GME program. However, U.S. medical school graduates should not be granted automatic priority over the qualified graduates of non-domestic medical schools as a means of achieving this goal.
- B. U.S. medical schools are obligated to provide the best possible education, which will allow all graduates to compete effectively for GME positions and to carefully evaluate all students and graduate only those considered unequivocally qualified for GME.
- C. For the purpose of limiting access to GME, differentiation of FMGs on the basis of citizenship or immigration status is contrary to U.S. tradition, ethical code, and law.

#### RECOMMENDATIONS:

1. Selection into Graduate Medical Education programs should be based on the relative qualifications of the individual applicants, not on group or institutional associations.
2. For the purpose of limiting access to GME, the Federal government should not establish policy which would discriminate against medical schools' graduates on the basis of citizenship, immigration status, or medical school location.

#### IV. INTERNATIONAL RELATIONS AND PHYSICIAN TRAINING

##### CONCLUSIONS:

- A. There is strong evidence that GME programs which have traditionally provided training for exchange visitor physicians who return to their home countries will have to reduce their efforts if foreign physicians are excluded from stipend/salary reimbursements.
- B. Some countries seeking U.S. assistance for development of their physician manpower are financially able to support these efforts; others, with less resources, are not. Participation in the exchange visitor program of the United States by physicians from this latter group of countries has been steadily decreasing in the last decade.
- C. There is a need to expand and modify the educational opportunities for exchange visitor physicians to better meet the health care delivery needs of the home country, and to enhance international relations with developing countries.

##### RECOMMENDATIONS:

1. Exchange visitors in traditional GME should continue to be supported like all other participants in GME. Patient care funds should continue to support the proportion of activities that actually provide patient care. Home country, trainee's own funds, foreign aid funds, or any other sources of funds available should be used to support non-traditional educational experiences of the exchange visitor.
2. To encourage reestablishment in the home country, the two-year return home requirement should be modified to increase the number of years. This would contribute to a longer period of time for reacclturation before reentry possibilities into the United States are available.
3. The public and private sector should support the efforts underway to implement the international medical scholars program. This support should be both monetary and programmatic.
4. Since training in traditional GME may not be appropriate for many exchange visitors, alternative programs should be developed. All appropriate bodies, both in the public and private sectors, should assist with the development of programs which would be broader than or different from classic clinical training. Although more expensive (but probably more effective), training assistance for alternative programs should be conducted in settings which involve both the home country and the U.S.; funding sources for this effort should be sought from the U.S. government and home country governments, international corporations, and private foundations.

Report of Subcommittee on GME Programs and Financing

James A. Pittman, Jr., M.D., presented the Report of the Committee on GME Programs and Financing. Council discussion addressed a wide range of issues, including: 1) clarification of views regarding the desirability of any major changes to GME financing; 2) the appropriateness of demonstrations and study in addressing specific disincentives to reaching certain priority manpower objectives (e.g., increased training in ambulatory settings); and 3) issues pertinent to overall GME financing versus specific concerns regarding the existing Medicare program. The Council adopted a tentative set of conclusions and recommendations in this area, although time was not sufficient for consideration of all areas presented by the Subcommittee. The discussion extended into the afternoon session.

FRIDAY AFTERNOON SESSION - February 19, 1988Report of Subcommittee on GME Programs and Financing -- Continued

Following the lunch recess, Council members continued with their consideration of the Subcommittee report. The conclusions and recommendations of the Subcommittee on GME Programs and Financing, approved as amended, follow.

I. OVERALL FINANCING OF GRADUATE MEDICAL EDUCATIONCONCLUSION:

- A. The sources of support for financing of graduate medical education are eroding as payments for patient care are constricted. Substitute sources are not developing to take their place.

RECOMMENDATIONS:

1. Funds to finance graduate medical education should continue to come primarily from present sources.
2. The Council recommends against making any major and precipitous changes in the way in which GME is financed.
3. If changes are made in the way that GME is financed from any particular source, such changes should take place gradually.
4. Medicare payments for direct costs of GME should be continued through existing mechanisms, utilizing current sources, conduits, and recipients, except as modified by later recommendations.

5. The Council places the highest priority on reimbursement of residency training stipends and fringe benefit costs and on training in those primary care specialties which are in short supply, preventive medicine, geriatrics, and programs in underserved communities and for training of minorities. If reductions of direct costs should be made, these aspects of GME should be sheltered from the impact.

## II. FINANCING OF AMBULATORY TRAINING AND TRAINING IN PRIMARY CARE AND GERIATRIC MEDICINE

### CONCLUSIONS:

- A. Graduate medical education in ambulatory settings is increasingly necessary in many specialties for optimal training and preparation for practice. There are difficulties in financing graduate medical education in ambulatory settings, related to lower levels of payment by third parties and to increased logistical problems of teaching in such settings. The current financing of graduate medical education results in disincentives for ambulatory training and little or no support for non-hospital based residency programs such as preventive and occupational medicine. These factors are especially significant in the case of primary care and geriatrics, where providers receive lower incomes for their services apart from the financing of medical education.
- B. Financial incentives tend to produce a concentration in what may be oversupplied specialties. These incentives are the result of (1) differentials by specialty in reimbursements to physicians for services apart from medical education payments, and (2) differentials by specialty in benefits to hospitals for the use of inpatient hospitalization and other hospital services.

### RECOMMENDATIONS:

1. Medicare and private organizations should carry out demonstrations of alternative methods of payment for GME in non-traditional settings, such as differential payment methods as incentives to encourage and facilitate medical education in ambulatory and long-term care sites.
2. Primary care, preventive medicine, and geriatric training should be encouraged. It will be necessary for Federal and State support to these programs to be continued, as well as expand organized private sector incentives. For example, existing Title VII primary care grant programs should be continued.

3. The Council supports the conclusions of the Physician Payment Review Commission that reimbursement for non-technical services in general, and primary care services in particular, should be increased relative to surgical and technical services. By doing so, financing of primary care training should be improved, and more physicians may be attracted into primary care training.
4. In order to facilitate the expansion of ambulatory/outpatient GME, and to encourage innovative program development and growth, all approved GME programs, including those based in ambulatory/outpatient settings, should be eligible for Medicare GME reimbursement. A methodology for reimbursement of direct and indirect costs for ambulatory training should be developed.

### III. MEDICARE FINANCING OF GRADUATE MEDICAL EDUCATION

#### III.A. DIRECT MEDICAL EDUCATION PAYMENTS

##### CONCLUSION:

- A. There are substantial variations among hospitals in per-resident direct costs that are not fully explained.

##### RECOMMENDATIONS:

1. The Secretary should study programs with per-resident costs well above the mean to define appropriate limits. Programs with lower pre-resident costs should be studied to understand the reasons for the lower costs.

#### III.B. INDIRECT MEDICAL EDUCATION PAYMENTS

##### CONCLUSION:

1. Current payments associated with the GME indirect cost adjustments are used to compensate for higher costs per case associated with teaching hospitals that are generally attributed to greater severity of illness within DRG, greater use of diagnostic tests, etc.

##### RECOMMENDATION:

1. The reasons for the higher costs of teaching hospitals should be analyzed further with the goal of paying for those costs, where justified, from appropriate sources. The Council believes that any changes should be cognizant of the overall effect on teaching hospitals.

#### IV. DIFFUSION OF RESPONSIBILITIES

##### CONCLUSION:

- A. Those who bear the cost of GME, including payers and institutions, have had little to say about the length or content of training programs. Length or content requirements can be added without the input of individual institutions or payers, even though this results in increased costs per resident graduating from the program.

##### RECOMMENDATIONS:

1. With respect to cost and other financial implications, certifying and accrediting bodies should provide maximum early opportunity for input from institutions and payers in considering changes that will increase the length and content of training requirements in graduate medical education.
2. In view of educational and other concerns that relate directly to their professional future, medical students and residents should also be given the same opportunity for early input.

#### V. STRUCTURE AND FUNCTION OF GRADUATE MEDICAL EDUCATION

The following matters were discussed by the Council, but due to lack of time they were tabled until the May session of the Council.

##### CONCLUSION:

- A. It is not clear that the current system of undergraduate and graduate medical education is the most effective or the most efficient method of producing appropriate numbers and specialties of physicians. Neither is it clear that the outputs of the system are optimal in meeting the medical care needs of the American people.

##### RECOMMENDATION:

1. The Council recommends a major broad-based study of the structure and content of undergraduate and graduate medical education. The study should be conducted and financed primarily in the private sector.

The review should be overseen by an organization or committee representing not only those involved in medical education, but also consumers and those both private and governmental who pay directly or indirectly for the costs of the education.

The review should lead to recommendations for the structure and content of such education, recognizing the changing nature of medicine and the sites where services are provided, the rapidly increasing costs of education and medical care, and the needs for additional physicians by specialty and geographic distribution.

#### CONCLUSION:

- B. There exist some GME programs in which the quality of the education has been negatively impacted by excessive service requirements. This includes a number of programs which are highly dependent on FMGs.

#### RECOMMENDATIONS:

1. Residency approval bodies should pay particular attention to excessive service loads.
2. The Federal Government and the private philanthropic sector should provide resources to study and develop alternative teaching/service models (e.g., utilizing other health professionals to reduce the number of residents) in service intensive settings. Successful models should be shared with the medical community and institutionalization of these models encouraged.

#### Other Issues

The Council briefly discussed conclusions and recommendations regarding data and research needs, as well as considerations for its long-term agenda. This area was deferred until the next meeting of COGME. Members concluded that an April meeting was unnecessary. It was decided that May 4 would be added as a contingency to the May 2-3 session, should extra time be needed.

#### Public Comment Period

The Council meeting was opened for public comment. The first speaker was Mr. Jack Ginzburg, manager of research and policy analysis, American College of Physicians, who stated that he was pleased that the Subcommittee on Physician Manpower reflected the newer data computed by Lewin Associates in projecting the supply of physicians in general internal medicine. He also commented that, given the recommendations of the FMG Subcommittee, there would remain only a "domestic lever" to try to balance the overall physician supply with manpower need.

The second speaker, Bill Finerfrock, Director of Federal Affairs for the American Academy of Physician Assistants (PAs), commented on the significance of a specific proposal advanced by the Subcommittee on FMGs



that had not been endorsed by the full Council. The proposal regarded inclusion of physician assistants to HEAL loan eligibility, as one of several steps to be taken if funding support for FMGs in residency programs were terminated and health service needs were to be adequately met. Mr. Finnerfrock provided testimony in support of such a proposal.

Concern was again expressed by members of the Council regarding the tentative conclusions about pediatric manpower, and it was agreed to consider this once more at the next Council meeting.

Following the public comment section, the meeting was adjourned.

*Neal A. Vanselow / P.S.*

Neal A. Vanselow, M.D.

March 1988



# association of american medical colleges

## SCHEDULE OF SMALL GROUP MEETINGS

Being held in conjunction with the COD Spring Meeting

### Saturday, March 19

6:30 pm 7:30 pm  
*Pool Terrace*

NEW DEANS & SPOUSES RECEPTION

### Sunday, March 20

8:00 am - 9:00 am  
*Archer West*

NEW DEANS & SPOUSES BREAKFAST

9:00 am - 12:00 pm  
*Archer East*

NEW DEANS MEETING

9:00 am - 12:00 pm  
*Archer West*

NEW DEANS' SPOUSES MEETING

10:00 am - 3:00 pm  
*Camellia Boardroom*

DEANS OF PRIVATE-FREESTANDING SCHOOLS MEETING

### Monday, March 21

7:15 am - 8:30 am  
*Elliot Room*

SOUTHERN DEANS BREAKFAST

1:15 pm - 2:30 pm  
*Danner West*

COMMUNITY-BASED DEANS LUNCHEON

4:00 pm - 5:00 pm  
*Camellia Boardroom*

NOMINATING COMMITTEE MEETING

### Tuesday, March 22

7:15 am - 8:30 am  
*Elliot Room*

MIDWEST-GREAT PLAINS DEANS BREAKFAST

7:15 am - 8:30 am  
*Camellia Boardroom*

WESTERN DEANS BREAKFAST

1:15 pm - 2:30 pm  
*Camellia Boardroom*

COD ADMINISTRATIVE BOARD LUNCHEON

**Association of American Medical Colleges**

**Council of Deans**

**1988 Spring Meeting**

**The Hotel Inter-Continental**

**Hilton Head Island, South Carolina**

**March 19-23, 1988**

**List of Participants**

## Deans

*Karl P. Adler*  
Joan Adler  
New York Medical College

*Stephen M. Ayres*  
Dee 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

*Charles M. Baugh*  
Ebby Baugh  
University of South Alabama  
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

*Louis J. Bernard*  
Lois Bernard  
Meharry Medical College  
School of Medicine

*George M. Bernier*  
University of Pittsburgh  
School of Medicine

*Samuel H. Black*  
Elisabeth Zandveld Black  
Texas A&M University  
College of Medicine

*Stuart Bondurant*  
Peg Bondurant  
University of North Carolina  
School of Medicine

*L. Thompson Bowles*  
Judy Bowles  
George Washington University  
School of Medicine

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

*David M. Brown*  
Sandra 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

*Michel A. Bureau*  
Universite de Sherbrooke  
Faculty of Medicine

*Gerard N. Burrow*  
UC - San Diego  
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*  
University of Virginia  
School of Medicine

*John E. Chapman*  
Judy Chapman  
Vanderbilt University  
School of Medicine

*D. Kay Clawson*  
Janet S. Clawson  
University of Kansas  
School of Medicine

*Jordan Cohen*  
SUNY at Stony Brook Health  
Sciences Ctr Sch of Medicine

*Stuart D. Cook*  
Josepha Cook  
Univ of Medicine & Dentistry  
New Jersey Medical School

*Richard A. Cooper*  
Medical College of Wisconsin

*Thomas S. Cottrell*  
Jane Cottrell  
SUNY at Stony Brook Health  
Sciences Ctr Sch of Medicine

*Richard L. Cruess*  
McGill University  
Faculty of Medicine

*Robert W.P. Cutler*  
Marjorie Cutler  
Stanford University  
School of Medicine

*Walter J. Daly*  
Joan B. Daly  
Indiana University  
School of Medicine

*Robert S. Daniels*  
Vikki Daniels  
Louisiana State University  
Sch of Medicine in New Orleans

*Robert M. Daugherty*  
Sandra Daugherty  
University of Nevada  
School of Medicine

*Nydia R. de Jesus*  
University of Puerto Rico  
School of Medicine

*William B. Deal*  
Elizabeth W. Deal  
University of Florida  
College of Medicine

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

*Richard A. DeVaul*  
Mary DeVaul  
West Virginia University  
School of Medicine

*John W. Eckstein*  
University of Iowa  
College of Medicine

*Norman H. Edelman*  
Ida Nadel Edelman  
UMDNJ-Robert Wood Johnson  
Medical School

*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

*Bernard J. Fogel*  
Judy Fogel  
University of Miami  
School of Medicine

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

*Robert L. Friedlander*  
Mary Lou Friedlander  
Albany Medical College

*Vincent Fulginiti*  
Shirley Fulginiti  
University of Arizona  
College of Medicine

*Martin Goldberg*  
Marion Lindblad-Goldberg  
Temple University  
School of Medicine

*Doyle G. Graham*  
Lea O'Quinn, M.D.  
Duke University  
School of Medicine

*David S. Greer*  
Marion Greer  
Brown University  
Program in Medicine

*James T. Hamlin*  
Mary Hamlin  
Tulane University  
School of Medicine

*J. Barry Hanshaw*  
Chris Hanshaw  
University of Massachusetts  
Medical School

*J. Ted Hartman*  
Texas Tech University  
School of Medicine

*Jane Henney*  
University of Kansas  
School of Medicine

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

*John J. Hutton*  
University of Cincinnati  
College of Medicine

*Eugene D. Jacobson*  
Laura Jacobson  
University of Colorado  
School of Medicine

*Edwin C. James*  
University of North Dakota  
School of Medicine

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

*Joseph E. Johnson*  
Judy Johnson  
University of Michigan  
Medical School

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

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

*Donald G. Kassebaum*  
University of Oklahoma  
College of Medicine

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

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

*Donald R. Kmetz*  
Joan Kmetz  
University of Louisville  
School of Medicine

*Franklyn G. Knox*  
Anne Knox  
Mayo Medical School

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

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

*Richard G. Lester*  
Louise Lester  
Eastern VA Medical School

*John O. Lindower*  
Doris Lindower  
Wright State University  
School of Medicine

*William H. Luginbuhl*  
University of Vermont  
School of Medicine

*Russell L. Miller*  
Daryl Miller  
Howard University  
College of Medicine

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

*Jock Murray*  
Dalhousie Medical School

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

*John Naughton*  
Margaret Naughton  
SUNY-Buffalo School of  
Medicine & Biomedical Sciences

*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

*Edward J. Quilligan*  
Betty Quilligan  
UC - Irvine  
California College of Medicine

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

*Stanford A. Roman*  
Ngina Lythcott, Ph.D.  
Morehouse School of Medicine

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

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

*Henry P. Russe*  
Pastora Cafferty, Ph.D.  
Rush Medical College  
of Rush University

*Luis F. Sala*  
Judith Sala  
Ponce School of Medicine

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

*Jay P. Sanford*  
Lorrie Sanford  
Unif Serv Univ of Hlth Sci  
F. Edward Hebert Sch of Med

*Rudi Schmid*  
Sonja Schmid  
UC - San Francisco  
School of Medicine

*Richard H. Schwarz*  
Patricia Schwarz  
SUNY Health Science Center at  
Brooklyn, College of Medicine

*Charlie W. Scott*  
Jeanette Scott  
University of Alabama  
School of Medicine

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

*Eugene M. Sigman*  
June Sigman  
University of Connecticut  
School of Medicine

*W. Douglas Skelton*  
Jane Skelton  
Mercer University  
School of Medicine

*Frank G. Standaert*  
Joan Standaert  
Medical College of Ohio

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

*Hugh Stephenson*  
Sally Stephenson  
Univ of Missouri - Columbia  
School of Medicine

*William Stoneman*  
Bette Stoneman  
Saint Louis University  
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*Robert L. Summitt*  
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*Alton I. Sutnick*  
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*Robert C. Talley*  
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Medical College of Georgia  
School of Medicine

*Daniel C. Tosteson*  
Harvard Medical School

*Robert E. Tranquada*  
Janet Tranquada  
Univ of Southern California  
School of Medicine

*Manuel Tzagournis*  
Madeline Tzagournis  
Ohio State University  
College of Medicine

*John G. Wade*  
Marilyn Wade  
University of Manitoba  
Faculty of Medicine

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

*Irwin M. Weiner*  
SUNY Health Science Center at  
Syracuse, College of Medicine

*W. Donald Weston*  
Ms. Patricia Butch  
Michigan State University  
College of Human Medicine

*Darryl M. Williams*  
Susan Williams  
LSU - Shreveport  
School of Medicine

*Emery A. Wilson*  
Clara Wilson  
University of Kentucky  
College of Medicine

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Betty Grove

*Robert L. Van Citters*  
Mary Van Citters

## Guests

*John W. Colloton*  
University of Iowa  
Hospitals and Clinics

*Douglas E. Kelly*  
Univ of Southern California  
School of Medicine

*Harry S. Jonas*  
American Medical Association  
LCME Secretary

## **Speakers**

*John A. Gronvall*  
**Veterans Administration**

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**A SPECIAL PROGRAM**

**FOR**

**SPOUSES AND GUESTS**

**At the Council of Deans Spring Meeting**

**March 19-23, 1988**

**THE HOTEL INTER-CONTINENTAL**

**Hilton Head Island, South Carolina**

PROGRAM

FOR

SPOUSES & GUESTS

At the Council of Deans' Meeting  
March 20-23, 1988

The Hotel Inter-Continental  
Hilton Head, South Carolina

DATE: Monday, March 21, 1988  
TIME: 8:30 - 11:00 a.m., including Continental Breakfast  
PLACE: Danner West

- I. Introduction & Comments Carol Butler
- II. The Hotel Inter-Continental Guest Relations Rep will discuss the facilities
- III. COLOR ME BEAUTIFUL\* (beginning at 9:30 am)

Ms. Phyllis Busch, a certified *Color Me Beautiful* consultant, will give a ninety minute presentation that demonstrates the effects of wearing the right and wrong colors of clothing and makeup. Ms. Busch has given over 150 programs and lectures regularly on cruise ships. Ladies from the audience will be selected as models, and everyone will instantly be able to see the positive results!

Ms. Busch will conclude her program by packing 23 outfits into a small briefcase, demonstrating the art of being able to coordinate a complete wardrobe. This class will be both entertaining and informative.

**PLEASE NOTE:** Enrollment for this class is limited.  
Please sign up early at the AAMC registration table if you wish to participate.

\* Cost for this exciting program will be just \$10.00 per person.

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Spouse and Guest Program -continued-

DATE: Tuesday, March 21st  
TIME: 8:30 - 12:30 (including continental breakfast)  
PLACE: DRAYTON ROOM

TOUR OF HILTON HEAD ISLAND

I. Continental Breakfast

II. Tour of Hilton Head Island

Hilton Head is one of the most beautiful of the "Sea Islands," which stretch along 250 miles of coastline, from the Carolinas to northern Florida.

This tour is your chance to really see the beauty of Hilton Head. Low Country Adventures will take you on a island visit that will be interesting, informative and fun. Their guides are island experts, proud of the rich cultural heritage and charm of the Low Country.

The tour will begin with a drive through the present day plantation developments, each a showplace of beautiful homes and gardens. You will also visit numerous sites of historical significance, and finally wind up in charming Harbour Town. Harbour Town, with its unique complex of shops and marina is a picturesque island "village." The landmark lighthouse overlooks the Calibogue Sound. Reminiscent of a Mediterranean seaside village, Harbour Town is both memorable and delightful. The tour will allow ample time for shopping and refreshments before departing back to the Inter-Continental.

\*Cost for this enjoyable island tour is just \$15.00. Please sign up at the AAMC registration table.





# association of american medical colleges

February 11, 1988

## MEMORANDUM

TO: The Council of Deans

FROM: Louis J. Kettel *[Signature]*, Associate Vice President for Academic Affairs

SUBJECT: 1988 COD Spring Meeting in Hilton Head

The 1988 COD Spring Meeting is quickly approaching, and the number of deans planning to attend is reaching a new record. I am confident that this year's meeting will be one of our best ever.

Enclosed is an invitation to the Council's annual Spring Meeting dinner. This year's dinner is being held at Wexford Plantation Country Club, noted as the most elegant club on Hilton Head. The natives have informed me that Wexford has the best food on the entire island, so I hope that you will plan on taking part in this special evening. To reserve a place for both you and your guest, please return the peach colored reservation form directly to Amy Eldridge at the AAMC. **Reservations must be received by March 5, 1988. Tickets will not be sold at the meeting.**

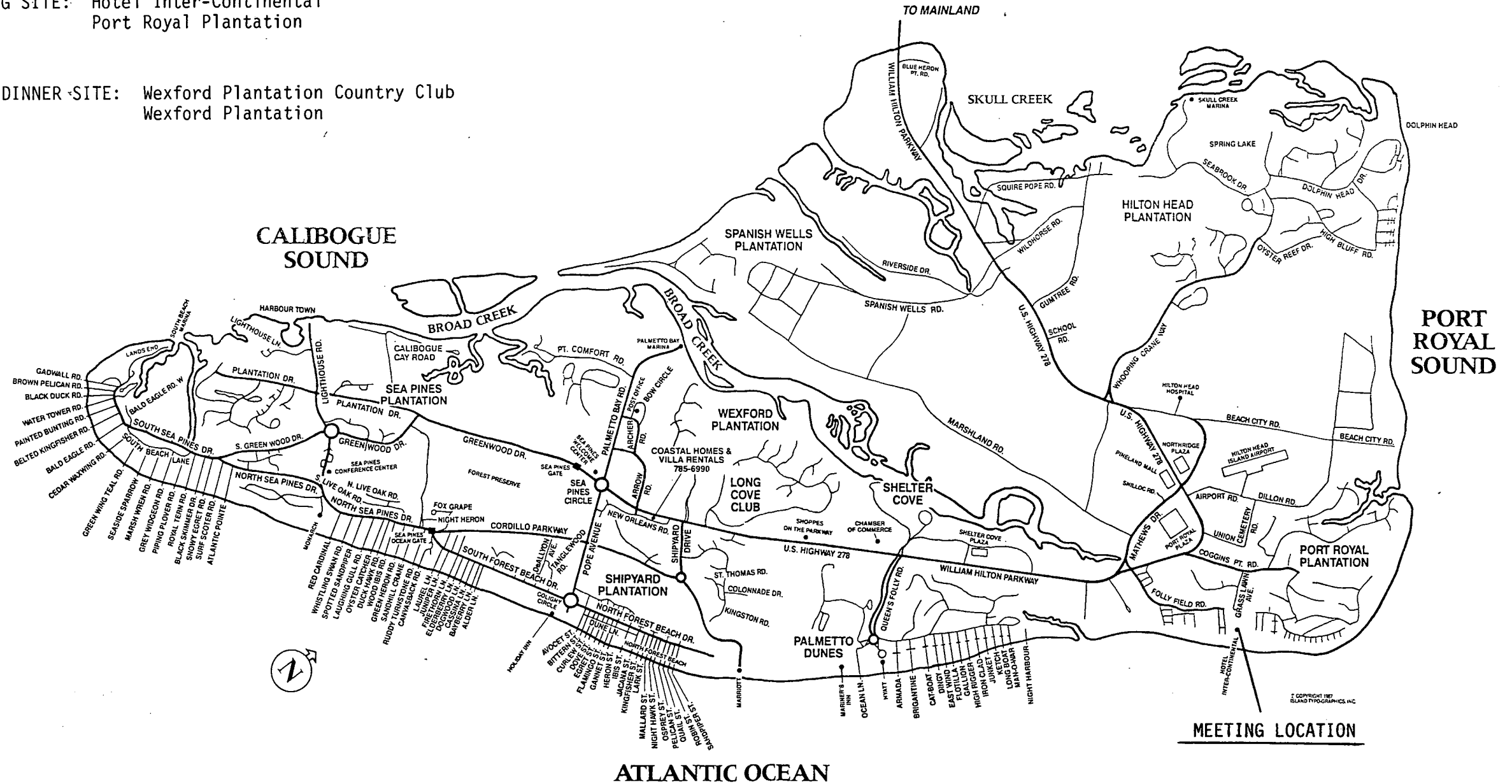
Also enclosed is a yellow colored reservation request form from Low Country Adventures. Please mail the card with your flight arrival time to them if **you will require limo service to the hotel.** Low Country will then meet your flight and take you immediately to the hotel. We have arranged for a discounted price of \$28.00 **roundtrip** from the Savannah Airport, and \$8.00 roundtrip from Hilton Head Airport.

The final meeting program and background materials will be mailed to you shortly. I look forward to seeing you in Hilton Head.

# MAP OF HILTON HEAD ISLAND

MEETING SITE: Hotel Inter-Continental  
Port Royal Plantation

THEME DINNER SITE: Wexford Plantation Country Club  
Wexford Plantation



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ISLAND TYPOGRAPHICS, INC.

*An Invitation*

*to*

*the 1988 Council of Deans*

*Spring Meeting Dinner*

*March 22, 1988*

*Wexford Plantation Country Club*

*Hilton Head, SC*

### 1988 Council of Deans Spring Meeting Dinner

This year's Council of Deans Spring Meeting dinner will be held at the elegant and distinctive Wexford Plantation Country Club. Located on a quiet harbourfront and styled in the classic British Colonial style, the Clubhouse is generally not open to the public, but we are fortunate to be able to offer this evening to the Council of Deans.

The reception and dinner will be held on Tuesday, March 22nd, from 6:30 - 11:30 p.m. Entertainment will be provided by the Ken James Band, an 8-piece orchestra specializing in the "Big Band" sound. The evening will begin with cocktails served throughout the Clubhouse and rear veranda of the club. At 7:30, the buffet will be served, with seating overlooking the harbour under a canopy tent. At 9:00, the dancing begins, with music and after dinner drinks in the Clubhouse.

Cost per person for this special evening will be \$75.00. Tickets will not be sold in Hilton Head. Your reservation must be received by March 5, 1988. Please make checks payable to the AAMC, and mail the enclosed response form with your check to:

Amy Eldridge  
AAMC  
One Dupont Circle, NW  
Suite 200  
Washington, DC 20036

### Hors D'oeuvres

Fillets of beef on toast rounds Montepellier  
Shrimp wrapped in bacon  
Baby crepes filled with apple and Boursin cheese  
Pastry puffs filled with chicken, tarragon & red bell peppers  
Roasted loin of lamb on toast points with fennel and tomato

### Appetizers

Scallops St. Jacques  
Shrimp Cocktail

### Salads

Caesar Salad with fresh garlic croutons, plum tomatoes and tangy Caesar dressing  
Boston, Mache and Radicchio Salad, with wild mushrooms and choice of sweet mustard vinaigrette or creamy herb dressing

### Entrees

Blackened Salmon with a fennel and garlic butter  
Roast Tenderloin with light shallot and mushroom demi-glace

### Accompaniments

Roasted New Potatoes  
Fresh Steamed Green Beans  
Carrot Almondine

### Desserts

Strawberry and Raspberry Romanoff  
Triple Chocolate Mousse Torte



**association of american  
medical colleges**

**AGENDA**  
**FOR**  
**COUNCIL OF DEANS**

**SPRING BUSINESS MEETING**

**WEDNESDAY, MARCH 23, 1988**

**8:30 AM - 12:00 PM**

**ARCHER EAST & WEST**

**THE HOTEL INTER-CONTINENTAL**

**HILTON HEAD, SOUTH CAROLINA**

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

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Albany Medical College  
47 New Scotland Avenue  
Albany, NY 12208

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

SPRING BUSINESS MEETING

The Hotel Inter-Continental  
Hilton Head, South Carolina

AGENDA

Wednesday, March 23, 1988

8:30 a.m. - 12:00 p.m.

Archer East & West

I. Call to Order	<u>Page</u>
II. Quorum Call	
III. Approval of the Minutes .....	1
IV. Chairman's Report --- William T. Butler, M.D.	
V. President's Report --- Robert G. Petersdorf, M.D.	
VI. Legislative Update --- Richard M. Knapp, Ph.D.	
VII. Discussion Items	
A. Small Group Discussion Reports	
B. Medloans Program..... (See insert enclosed)	7
C. Revision of AAMC Recommendations Concerning Medical School Acceptance Procedures.....	9
D. Individual School Applicant/Matriculant Analyses .....	11

COD Spring Meeting Agenda -continued-

VIII. Information Items

- A. Robert Wood Johnson Minority Medical  
Faculty Development Program.....29
- B. AAMC Proposal on the Advancement of Women  
in Academic Medicine.....31

XI. Old Business

X. New Business

XI. Adjournment



# ASSOCIATION OF AMERICAN MEDICAL COLLEGES

## COUNCIL OF DEANS ANNUAL BUSINESS MEETING

Monday, November 9, 1987  
2:30 - 5:00 p.m.  
Georgetown East & West  
Washington Hilton Hotel  
Washington, DC

### I. CALL TO ORDER

Louis J. Kettel, M.D., Chairman, called the meeting to order at 2:34 pm. He declared the presence of a quorum.

### II. PRESIDENT'S REPORT

Robert G. Petersdorf, M.D. began his discussion with the AAMC recommendations and guidelines on housestaff supervision. He first explained the reasoning behind the AAMC entering this policy debate. The AAMC plays an integral role in the structure of graduate medical education, and therefore should take a leadership position on this public issue. Additionally, many other medical organizations are beginning to address the problem. Dr. Petersdorf explained that due to major changes in medical technology, shorter hospital stays, etc., the exposure of housestaff to both teaching and service has been radically altered. The AAMC's position needs to stress the importance of enhancing quality care for patients while at the same time preserving the educational ambience. Dr. Petersdorf stressed that the cornerstone of graduate medical education is the increasing amount of responsibility a resident receives. This responsibility must be directly correlated to a resident's gradual acquisition of skills, knowledge and confidence, and this increase in competence needs to be both demonstrated and supervised. Program directors and faculty must work with the administration to set up a system whereby the delegation of responsibility of the housestaff is clearly outlined. This institutional responsibility should then be monitored by the ACGME's residency review committees. Dr. Petersdorf noted that the problem of excessive workloads is mainly found in the medicine, surgery, pediatrics, and OB/GYN specialties. He then highlighted several key points of the AAMC recommendation paper: Residents should be scheduled for no more than 80 hours per week of work time, in concert with the state of New York's recommendations. Each resident should be allowed one 24-hour period per week of unscheduled time, and housestaff should not be allowed to moonlight. Dr. Petersdorf agreed that the financial implications of such guidelines could be staggering, since more residents and faculty would be needed. The state of New York's model, for example, shows a large cost increase. Several deans expressed concern over stating a specific number of hours that a resident can

work. Dr. Petersdorf emphasized that the document would be significantly weakened if the number of hours were not specifically stated. The state of New York's guidelines would then become the leading political document, and other state legislatures might then decide their own "ideal" number of hours a resident would be allowed to work. Dr. Petersdorf reiterated the importance of the AAMC taking a timely position on this issue in an effort to forestall state legislation. Several deans suggested that a clearer distinction needed to be made between assigned and unassigned hours. The number of "hours" recommended in the document are really "working hours", time actually spent taking care of patients. A backup document, not distributed, explains in great detail the issue of sleep hours vs. work hours, etc. Dr. Petersdorf stressed that the 80 stated hours are not a cut-and-dry mandatory rule. The concern is not over whether a resident works 84 hours a week, but rather if he works 120 hours a week. Many deans expressed agreement that the educational experience does suffer when the number of work hours is too demanding. Dr. Petersdorf particularly emphasized that the AAMC appreciates the diversity of each teaching hospital. The document presented is simply meant as a "guideline", not as an absolute "prescription". One suggestion was to amend the document by adding that the AAMC is presenting a "model" to the hospitals, strongly recommending that each institution come up with their own guidelines that follow the general pattern. On motion, seconded and unanimously approved, the Council encouraged Dr. Petersdorf and the AAMC to proceed as needed with the housestaff position paper.

### III. OSR REPORT

Vicki Darrow, M.D. reviewed several of the OSR activities during the past year. She reported that the OSR has been trying to expand the leadership of student representation within the policy making groups of medical education, particularly by increasing the student voice on AAMC committees. The OSR also succeeded in adding a question to the 1988 Graduation Questionnaire on the use of discriminating questions during the interview process. Dr. Darrow noted that the OSR is continuing to work towards PASS/FAIL reporting of the National Boards, for housestaff participation within the AAMC, and for computerization of the OSR for faster networking. One new goal of the OSR is to encourage attending faculty to return to the bedside for clinical instruction. They are also going to assist in improving the Universal Application Form. The OSR still wants the AAMC to make a public statement regarding indigent care, and Dr. Darrow reported that at the 1987 OSR Annual Meeting, students were encouraged to be socially conscious and socially responsible physicians. Dr. Darrow also announced a new look for the former OSR Report. The newsletter has been completely revised and is now distributed as Progress Notes.

### IV. LEGISLATIVE UPDATE

Dr. Richard Knapp reviewed the Association's interest in current legislative matters affecting health care. He reported that there is currently strong support for biomedical and behavior research, exhibited by the appropriations measures adopted by Congress. However, while there is community support, the financial resources needed are not available in the current budgetary environment. Legislative problems to

face in 1988 include the issues of animals and fetuses in research. Dr. Knapp stressed that the strength of the opposition on these issues is remarkable and asked the deans for their support. He also reminded the Council that Title 7, the Health Manpower Act, is up for renewal, with important issues such as student loans, primary care residencies and geriatrics at stake. Finally, Dr. Knapp urged the deans to continue to make Congressional visits whenever they are in Washington.

#### V. REPORT OF THE NOMINATING COMMITTEE

Dr. Richard Moy presented the report of the COD Nominating Committee. For the deans' information, he announced that L. Thompson Bowles, M.D., Ph.D., Dean for Academic Affairs at George Washington University and Robert E. Tranquada, M.D., Dean of the University of Southern California would be nominated the next day to the Assembly to fill two three-year terms on the Executive Council. Henry P. Russe, M.D., Vice President for Medical Affairs and Dean, Rush Medical College, would be nominated to fill a Council vacancy for a two-year term, and W. Donald Weston, M.D., Dean at Michigan State University College of Human Medicine would be nominated to fill a Council vacancy for a one-year term. D. Kay Clawson would be recommended for nomination as Chairman-Elect of the Assembly. Dr. Moy then moved the nominations of William B. Deal, M.D. for Chairman-Elect of the Council of Deans, and of Robert L. Friedlander, M.D., Phillip M. Forman, M.D., and George T. Bryan, M.D. for members-at-large of the COD Administrative Board. The motion was seconded and unanimously approved.

#### VI. DISCUSSION ITEMS

##### A. Transition from Medical School to Residency

##### Status Report & Determination of Uniform Date for Release of Deans' Letters for 1988

Dr. Robert Beran reviewed the 1987 experiences of the first uniform date for the release of deans' letters. With relatively few exceptions, most schools held firm to the AAMC's decision not to release deans' letters prior to November 1. A major problem encountered concerned the "type" of information that could or could not be sent to program directors. Many programs requested transcripts, faculty letters, etc. in an attempt to circumvent the November 1 decision. Most of the problems stemmed from the AAMC's rather late announcement of the uniform date last year. The vast majority of specialties, however, did try to change their application deadline dates, even including most of the surgical subspecialties. Dr. Beran emphasized that an early decision by the deans on the 1988 uniform date would allow the program directors sufficient time to plan their selection schedules accordingly, thus eliminating the majority of the problems encountered this past year. Overall, the first year of implementation went extraordinarily well, and Dr. Beran thanked the Council for their effective networking in enforcing the November 1 decision.

Dr. Joseph Gonella reported on a special transition forum that was held on November 6 involving program directors invited from each of the

matching specialties. The forum was well represented, and the majority of program directors emphasized the importance of retaining November 1 as the 1988 uniform date to prevent even further changes in submission deadlines, interview schedules and application literature. Dr. Gonella asked the Council to return to their institutions with a resolution to encourage their own program directors to comply with the uniform release date.

ACTION:

On motion, seconded and carried, the Council cast a majority vote to establish November 1, 1988 as the uniform date for the release of deans' letters. One "no" vote was recorded.

B. Report of the ad hoc Committee on Housestaff Participation in the AAMC

Dr. Joseph Johnson reported on the establishment of an Organization of Resident Representatives within the AAMC. The ad hoc Committee on Housestaff Participation recommended that a more formal mechanism for representation by housestaff within the AAMC structure should be implemented. The ORR would be analogous to the OSR. One resident representative would be selected from each full member COTH hospital, through a process determined locally. Funding for the representatives would come from the hospitals, with the AAMC funding the expenses of the ORR Administrative Board. Since the hospitals will be providing the funds for their delegates' participation, the ORR would be linked to the Council of Teaching Hospitals. The ORR will also have a formal linkage to the Council of Academic Societies because of the representation of its disciplines. The exact working mechanism of that relationship will have to be evolved. Several deans questioned why the ORR could not be chosen by the medical schools and linked to the Council of Deans. It was decided that this issue would be discussed more in depth at the Council's Spring Meeting in Hilton Head.

C. Where are the resources for extended ambulatory clinical education for medical students?

Ms. Nancy Seline described the recent AAMC study on the transition of medical education from the hospitals into ambulatory settings. The project was a year-long study funded by the Health Resources and Services Administration, dealing with such issues as funding and the availability of resources. During the course of the study, nine institutions were visited that were believed to be innovators in the area of ambulatory education. In the nine centers, there was an idiosyncratic blend of support for medical education; most programs depended upon a variety of government funds, patient care revenues and support from volunteers and faculty practice plans. Ms. Seline commented that most of these funding mechanisms were found to be fragile, dependent on local resources, and any major changes in the federal or local government could threaten their existence. The study concluded that many variables were present that determined the funding of such a program. Costs varied significantly for several reasons, not the least of which was the number of learners that each institution

attempted to integrate into the program. The more learners that were integrated, the greater the cost, and it rose exponentially. The level of learner that was integrated (medical students vs. resident), and how many learners actively participated versus observed also played key roles in determining the cost. Many institutions felt, however, that while costs were minimized when learners merely observed, so was the educational benefit. Learners were integrated into a wide variety of settings, including hospital clinics, private physicians' offices and small group practices. The major cost of integrating the learners into these settings was the change in the efficiency of the operation. This impact differed by specialty; those specialties dependent upon seeing a large volume of patients were more directly affected by the integration of medical students because the efficiency levels were decreased much more significantly. The largest success was seen in primary care situations in which the medical students were spread over a broad base of clinical settings so that each faculty member was responsible for only 1-2 learners. In each setting, there was a definite cost to be faced; however, Ms. Seline stressed that the successful facilities had discovered ways to accept the reduced income generated.

#### D. Trends in the Applicant Pool

Dr. August Swanson reported on the steady decline of the number of students applying to U.S. medical schools. The applicant pool has been steadily decreasing since its peak in 1981, currently reaching a 1.7 ratio of applicants to positions. If the average annual fall in applicants and positions continues, by 1990 a 1.28 ratio will be reached. The question of the quality of these students must then be raised, as a shift to the left for both GPAs and MCAT scores is occurring. A suggestion was made to do an institutional profile for each school showing its applicant/matriculant/position data in comparison to the national ratios. Dr. Paul Jolly agreed that this could be a helpful instrument. The Council expressed a desire to continue the applicant discussion at the Spring Meeting.

### VI. NEW BUSINESS

Dr. Kettel commented on the success and popularity of the AAMC's Management Education Programs and encouraged the deans to participate in the courses. Amy Eldridge confirmed the location and time of the COD dinner at the Old Ebbitt Grill.

### VII. INSTALLATION OF CHAIRMAN

Dr. Kettel thanked the deans for their participation and enthusiasm in making the Council such a vigorous power within the AAMC. He then presented William T. Butler, M.D., President of Baylor College of Medicine, as the new Chairman of the Council of Deans. In his first action as chair, Dr. Butler recognized the Administrative Board members who were retiring from the Board: Hibbard E. Williams, M.D. (UC-Davis School of Medicine), D. Kay Clawson, M.D. (University of Kansas School of Medicine), and Robert S. Daniels, M.D., (LSU-New Orleans School of Medicine) (not present). Dr. Butler then presented Dr. Kettel with a

gavel and thanked him for his successful leadership of the Council of Deans. Dr. Butler also reminded the deans about the 1988 Spring Meeting in Hilton Head, South Carolina and encouraged their input into the program planning.

VIII. ADJOURNMENT

The meeting was adjourned at 5:04 p.m.

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

# **MEDLOANS<sup>SM</sup>**

The Association of American Medical Colleges (AAMC) has instituted MEDLOANS<sup>SM</sup>, a comprehensive student loan program designed to assist qualified medical students in obtaining the funds necessary to finance their medical education. The MEDLOANS program provides access to four different sources of educational loans: the Guaranteed Student Loan (GSL), Supplemental Loans for Students (SLS), the Health Education Assistance Loan (HEAL) and the Alternative Loan Program (ALP).

MEDLOANS streamlines the loan application procedure by enabling students to submit just one application to access GSL, SLS, HEAL, and ALP simultaneously. While the program is designed to allow students to apply for all of these loan types at once, students may choose to initially apply for only one loan type and later apply for other loan types with a new MEDLOANS application if and when the need arises.

## **SPECIAL FEATURES OF MEDLOANS**

- A single application form allows access to four different sources of assistance
- No co-signer is required for any program
- No application fee is required
- No current or prior banking relationship is required with the lender
- Graduated repayment plans will be available which will be sensitive to a modest income during the early years of medical practice
- Loan consolidation and combined repayment options are available
- All loans will be held by a single lender, and all communications and repayments will be made to a single organization
- The program is tailored for and available only to allopathic medical students attending U.S. medical schools
- Each of the four loan components under MEDLOANS include terms that are as competitive, and in several cases more competitive, than any existing national lending program

MEDLOANS applications and additional information about MEDLOANS, (i.e., specific eligibility requirements, application procedures, interest rates), and other aid administered by the individual medical school may be obtained directly from the medical school's office of financial aid. MEDLOANS applications may also be obtained from the AAMC by calling 202/828-0600 or writing the AAMC at the address listed below.

**Suite 301/1776 Massachusetts Avenue, N.W., Washington, DC 20036-1989**

## Revision of AAMC Recommendations Concerning Medical School Acceptance Procedures

The decline in the number of individuals applying to medical school is beginning to change the behavior of both our medical schools and applicants. Medical schools in their quest to enroll the best and the brightest from a dwindling source of talent are starting to engage in practices that are creating a state of disorganization for the community of medical schools. Applicants, on the other hand, now realize they are participating in a buyer's market and are starting to emulate our professional athletes by holding out (or negotiating) for the best available contract. While the goals of both the schools and the applicants are not in question, the nature of the pre-selection and pre-decision activities is resulting in a student selection process that extends later in the year, is more expensive for the schools, and produces a chaotic summer for admissions offices.

For example:

- For the 1987 entering class, 1,101 applicants were holding more than one acceptance on July 21, 1987.
- For this same class, 610 applicants were holding more than one acceptance on **August 18**.
- During the last two years, the number of cases reported where a student was offered a position at one school **after they had already matriculated at another school** have increased.
- Schools are now in a situation where an increasing percentage of their entering classes are being filled **after June 1**.

The Recommendations Concerning Medical School Acceptance Procedures (commonly referred to as the "traffic rules") represents a set of guidelines and understandings for offering acceptances to medical schools that were adopted by the AAMC Executive Council in the early 1970's. The "traffic rules" were developed to serve as a code of ethics among the schools regarding policies and procedures for such items as notifying students of acceptance, the size and refundability of acceptance deposits, and the ground rules regarding the processing of students holding multiple acceptances. The intent of the traffic rules is to provide a set of minimum standards and procedures that **all** schools will agree to observe in their process of selecting students.

The reports of "violations to the traffic rules" have increased dramatically during the last several years. The Group on Student Affairs Committee on Admissions has developed a revision to the traffic rules that will be presented to the Executive Council at their Fall 1988 meeting. The committee feels strongly that the medical schools, either individually or collectively, do not have to sacrifice ethical standards to cope with the changes precipitated by the decline in the number of applicants. In order to enhance the sense of cooperativeness among schools and also restore order to our system of student selection, it is necessary for **all** schools to agree on an acceptable set of basic guidelines.



The traffic rules seek uniformity of practice in areas such as:

- amount of acceptance deposit
- deadline date for full refund of deposit
- date when schools should have offered acceptances at least equal to the size of its entering class
- responsibilities of applicants in responding to offers of acceptance
- schools' responsibilities in processing applicants holding more than one acceptance.

The revision will be available for discussion during the business meeting.

## **Trends in Applicants & Matriculants:**

### **A Report from**

#### **The Student and Applicant Information Management System**

On the following pages is a report showing the trends in applicants and matriculants at the University of Minnesota Medical School - Minneapolis. This individualized school report is derived from the Association's Student and Applicant Information Management System (SAIMS). It follows the format of the Association's annual publication, Trends in Medical School Applicants and Matriculants 1978-1987, prepared by Cynthia Tudor, Director of Student Studies and distributed last month. Identical reports can be provided for each school on request. The price is \$300.00. Contact Charles D. Killian (202)828-0412.

The Student and Applicant Information Management System (SAIMS) is a collection of interrelated databases containing comprehensive longitudinal information of all MCAT registrants and examinees; all MSKP registrants and examinees; the application materials of all applicants to U.S. medical schools; matriculation and other status change records of enrollment, transferral, withdrawal, leaves of absence, and graduation; Matriculating Student Questionnaire data; Graduation Questionnaire data; Graduate Medical Education records of specialty choice and residency location. Fourth generation computer languages are used to maintain these various databases and to extract research files.

Many other possibilities for research and reporting exist with SAIMS. Among the reports recently prepared from SAIMS is one summarizing the qualifications and characteristics of state residents who applied only to schools outside the state. Counts of these individuals can be made by school of matriculation, undergraduate institution, MCAT scores, and undergraduate GPAs for example. Another report recently prepared from SAIMS summarizes the application and matriculation patterns of under-represented minorities. Examples of some of these reports are available and AAMC staff are prepared to assist you with the identification of data best able to address your particular research needs.

# **Trends in Medical School Applicants and Matriculants 1978-1987**

**UNIVERSITY OF MINNESOTA MEDICAL SCHOOL-MINNEAPOLIS**

**Association of American Medical Colleges**

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Sex**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Male</b>	Applicants	75.0	( 1,188)	69.3	( 883)	64.4	( 611)	65.6	( 516)
	Matriculants	74.1	( 177)	65.5	( 156)	62.2	( 120)	67.3	( 132)
<b>Female</b>	Applicants	24.9	( 395)	30.7	( 392)	35.6	( 338)	34.4	( 270)
	Matriculants	25.9	( 62)	34.5	( 82)	37.8	( 73)	32.7	( 64)
<b>Unknown</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Age**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Under 21</b>	Applicants	0.9	( 15)	0.3	( 4)	0.6	( 6)	0.6	( 5)
	Matriculants	0.4	( 1)	0.4	( 1)	0.0	( 0)	0.5	( 1)
<b>21 - 23</b>	Applicants	63.4	( 1,004)	54.8	( 699)	54.4	( 516)	57.9	( 455)
	Matriculants	65.7	( 157)	58.8	( 140)	50.8	( 98)	58.7	( 115)
<b>24 - 27</b>	Applicants	25.9	( 410)	32.0	( 408)	29.9	( 284)	25.6	( 201)
	Matriculants	25.9	( 62)	29.4	( 70)	33.7	( 65)	27.0	( 53)
<b>28 - 31</b>	Applicants	7.6	( 120)	9.5	( 121)	8.0	( 76)	8.4	( 66)
	Matriculants	6.7	( 16)	8.0	( 19)	7.8	( 15)	9.2	( 18)
<b>32 - 37</b>	Applicants	2.0	( 32)	3.0	( 38)	6.0	( 57)	6.0	( 47)
	Matriculants	1.3	( 3)	3.4	( 8)	5.7	( 11)	3.6	( 7)
<b>Over 37</b>	Applicants	0.2	( 3)	0.4	( 5)	1.1	( 10)	1.5	( 12)
	Matriculants	0.0	( 0)	0.0	( 0)	2.1	( 4)	1.0	( 2)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
<b>Mean</b>	Applicants	23.66		24.25		24.48		24.50	
	Matriculants	23.67		24.14		24.69		24.24	
<b>Standard Deviation</b>	Applicants	2.76		3.04		3.67		3.84	
	Matriculants	2.48		2.78		3.67		3.27	

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Ethnicity/Race**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>White</b>	Applicants	79.9	( 1,266)	80.2	( 1,022)	74.8	( 710)	76.3	( 600)
	Matriculants	90.0	( 215)	94.5	( 225)	91.2	( 176)	89.3	( 175)
<b>Black</b>	Applicants	7.6	( 121)	6.6	( 84)	7.3	( 69)	7.5	( 59)
	Matriculants	2.5	( 6)	0.8	( 2)	0.5	( 1)	1.0	( 2)
<b>Other Under-represented Minority</b>	Applicants	8.0	( 127)	7.1	( 90)	6.7	( 64)	4.7	( 37)
	Matriculants	5.0	( 12)	2.1	( 5)	0.0	( 0)	0.5	( 1)
<b>Other</b>	Applicants	3.5	( 56)	5.0	( 64)	10.4	( 99)	10.6	( 83)
	Matriculants	0.8	( 2)	1.7	( 4)	7.8	( 15)	8.7	( 17)
<b>Unknown</b>	Applicants	0.9	( 14)	1.2	( 15)	0.7	( 7)	0.9	( 7)
	Matriculants	1.7	( 4)	0.8	( 2)	0.5	( 1)	0.5	( 1)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Marital Status**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Never Married</b>	Applicants	70.1	( 1,110)	73.4	( 936)	76.5	( 726)	72.5	( 570)
	Matriculants	65.3	( 156)	73.1	( 174)	80.8	( 156)	76.5	( 150)
<b>Married</b>	Applicants	12.8	( 202)	12.1	( 154)	8.0	( 76)	8.8	( 69)
	Matriculants	8.4	( 20)	12.6	( 30)	8.3	( 16)	9.2	( 18)
<b>Separated</b>	Applicants	0.4	( 7)	0.5	( 6)	0.0	( 0)	0.3	( 2)
	Matriculants	0.0	( 0)	0.8	( 2)	0.0	( 0)	0.0	( 0)
<b>Divorced</b>	Applicants	1.7	( 27)	1.2	( 15)	1.3	( 12)	2.0	( 16)
	Matriculants	2.5	( 6)	1.7	( 4)	0.5	( 1)	1.0	( 2)
<b>Widowed</b>	Applicants	0.1	( 2)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	14.9	( 236)	12.8	( 163)	14.1	( 134)	16.4	( 129)
	Matriculants	23.4	( 56)	11.8	( 28)	10.4	( 20)	13.3	( 26)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Father's Occupation**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Physician</b>	Applicants	10.9	( 173)	10.4	( 133)	14.3	( 136)	11.7	( 92)
	Matriculants	10.0	( 24)	7.6	( 18)	10.9	( 21)	16.8	( 33)
<b>Health Professional/Worker</b>	Applicants	3.4	( 54)	3.5	( 45)	3.7	( 35)	4.2	( 33)
	Matriculants	2.1	( 5)	3.4	( 8)	3.6	( 7)	3.1	( 6)
<b>Professional</b>	Applicants	14.6	( 231)	18.9	( 241)	17.2	( 163)	18.3	( 144)
	Matriculants	17.2	( 41)	22.3	( 53)	21.2	( 41)	15.8	( 31)
<b>Manager</b>	Applicants	12.9	( 205)	11.2	( 143)	11.0	( 104)	11.3	( 89)
	Matriculants	14.2	( 34)	14.3	( 34)	13.5	( 26)	13.3	( 26)
<b>Sales</b>	Applicants	7.1	( 112)	6.7	( 86)	7.1	( 67)	6.5	( 51)
	Matriculants	7.1	( 17)	9.2	( 22)	7.8	( 15)	7.7	( 15)
<b>Small Business</b>	Applicants	6.7	( 106)	7.5	( 95)	6.3	( 60)	5.5	( 43)
	Matriculants	5.0	( 12)	8.0	( 19)	7.8	( 15)	7.7	( 15)
<b>Clerical</b>	Applicants	1.3	( 20)	1.1	( 14)	0.2	( 2)	0.5	( 4)
	Matriculants	1.7	( 4)	0.8	( 2)	0.5	( 1)	0.0	( 0)
<b>Homemaker</b>	Applicants	0.0	( 0)	0.1	( 1)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Student</b>	Applicants	0.0	( 0)	0.1	( 1)	0.2	( 2)	0.1	( 1)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.5	( 1)
<b>Skilled Worker</b>	Applicants	7.5	( 119)	7.0	( 89)	5.7	( 54)	4.6	( 36)
	Matriculants	5.0	( 12)	6.3	( 15)	6.7	( 13)	3.1	( 6)
<b>Unskilled Worker</b>	Applicants	5.2	( 82)	5.9	( 75)	4.6	( 44)	4.7	( 37)
	Matriculants	3.3	( 8)	4.2	( 10)	4.1	( 8)	4.1	( 8)
<b>Unemployed/Retired/Deceased</b>	Applicants	15.6	( 247)	14.4	( 184)	15.6	( 148)	15.6	( 123)
	Matriculants	11.7	( 28)	11.3	( 27)	13.5	( 26)	12.8	( 25)
<b>Unknown</b>	Applicants	14.8	( 235)	13.2	( 168)	14.1	( 134)	16.9	( 133)
	Matriculants	22.6	( 54)	12.2	( 29)	10.4	( 20)	15.3	( 30)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Mother's Occupation**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Physician</b>	Applicants	0.6	( 9)	0.7	( 9)	1.5	( 14)	0.9	( 7)
	Matriculants	0.0	( 0)	0.4	( 1)	1.6	( 3)	2.0	( 4)
<b>Health Professional/ Worker</b>	Applicants	8.5	( 135)	11.1	( 141)	10.4	( 99)	11.1	( 87)
	Matriculants	6.7	( 16)	10.9	( 26)	15.0	( 29)	11.7	( 23)
<b>Professional</b>	Applicants	8.3	( 132)	10.6	( 135)	9.6	( 91)	11.3	( 89)
	Matriculants	8.4	( 20)	17.6	( 42)	9.8	( 19)	12.2	( 24)
<b>Manager</b>	Applicants	1.6	( 26)	2.6	( 33)	3.3	( 31)	3.6	( 28)
	Matriculants	1.3	( 3)	0.4	( 1)	2.6	( 5)	4.1	( 8)
<b>Sales</b>	Applicants	5.1	( 80)	5.9	( 75)	7.7	( 73)	5.5	( 43)
	Matriculants	4.2	( 10)	4.6	( 11)	5.2	( 10)	5.1	( 10)
<b>Small Business</b>	Applicants	1.9	( 30)	2.4	( 31)	3.5	( 33)	3.3	( 26)
	Matriculants	0.8	( 2)	4.6	( 11)	4.7	( 9)	4.1	( 8)
<b>Clerical</b>	Applicants	8.5	( 134)	7.8	( 100)	9.1	( 86)	8.8	( 69)
	Matriculants	7.1	( 17)	9.2	( 22)	9.3	( 18)	9.7	( 19)
<b>Homemaker</b>	Applicants	29.9	( 474)	24.9	( 317)	19.9	( 189)	19.1	( 150)
	Matriculants	32.2	( 77)	26.1	( 62)	22.3	( 43)	21.4	( 42)
<b>Student</b>	Applicants	0.1	( 1)	0.4	( 5)	0.7	( 7)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.5	( 1)	0.5	( 1)
<b>Skilled Worker</b>	Applicants	1.8	( 28)	1.9	( 24)	1.5	( 14)	1.9	( 15)
	Matriculants	2.1	( 5)	0.4	( 1)	0.5	( 1)	1.0	( 2)
<b>Unskilled Worker</b>	Applicants	3.6	( 57)	4.4	( 56)	3.3	( 31)	2.5	( 20)
	Matriculants	2.5	( 6)	4.2	( 10)	3.1	( 6)	2.0	( 4)
<b>Unemployed/ Retired/ Deceased</b>	Applicants	15.9	( 252)	14.7	( 188)	15.6	( 148)	15.3	( 120)
	Matriculants	12.6	( 30)	10.9	( 26)	14.0	( 27)	12.2	( 24)
<b>Unknown</b>	Applicants	14.3	( 226)	12.6	( 161)	14.0	( 133)	16.3	( 128)
	Matriculants	22.2	( 53)	10.5	( 25)	11.4	( 22)	13.8	( 27)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## State of Residence

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Alabama	Applicants	0.2	( 3)	0.1	( 1)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Alaska	Applicants	0.1	( 1)	0.1	( 1)	0.2	( 2)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Arizona	Applicants	0.8	( 12)	0.9	( 11)	0.8	( 8)	0.4	( 3)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.5	( 1)
Arkansas	Applicants	0.1	( 2)	0.1	( 1)	0.2	( 2)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
California	Applicants	12.9	( 204)	14.4	( 184)	12.6	( 120)	12.0	( 94)
	Matriculants	4.2	( 10)	2.1	( 5)	1.0	( 2)	1.5	( 3)
Colorado	Applicants	0.6	( 9)	0.4	( 5)	0.6	( 6)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	1.0	( 2)
Connecticut	Applicants	0.6	( 9)	0.4	( 5)	0.3	( 3)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Delaware	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
District of Columbia	Applicants	0.4	( 7)	0.2	( 3)	0.3	( 3)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Florida	Applicants	1.0	( 16)	0.9	( 11)	1.4	( 13)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Georgia	Applicants	0.8	( 13)	0.3	( 4)	0.2	( 2)	0.3	( 2)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Hawaii	Applicants	0.1	( 2)	0.1	( 1)	0.2	( 2)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Idaho	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Illinois	Applicants	2.5	( 39)	1.9	( 24)	3.0	( 28)	4.6	( 36)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)



**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**State of Residence (Cont'd)**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Indiana</b>	Applicants	0.8	( 12)	0.6	( 8)	0.4	( 4)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Iowa</b>	Applicants	0.9	( 15)	0.8	( 10)	1.1	( 10)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.5	( 1)	0.0	( 0)
<b>Kansas</b>	Applicants	0.3	( 5)	0.3	( 4)	0.5	( 5)	0.6	( 5)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	1.0	( 2)
<b>Kentucky</b>	Applicants	0.0	( 0)	0.1	( 1)	0.1	( 1)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Louisiana</b>	Applicants	0.3	( 5)	0.2	( 2)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Maine</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Maryland</b>	Applicants	0.7	( 11)	0.3	( 4)	1.1	( 10)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Massachusetts</b>	Applicants	1.3	( 21)	0.7	( 9)	1.3	( 12)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Michigan</b>	Applicants	2.7	( 43)	1.9	( 24)	2.2	( 21)	1.9	( 15)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Minnesota</b>	Applicants	49.5	( 784)	63.5	( 809)	52.1	( 494)	55.7	( 438)
	Matriculants	92.5	( 221)	96.2	( 229)	95.3	( 184)	91.8	( 180)
<b>Mississippi</b>	Applicants	0.1	( 2)	0.2	( 3)	0.0	( 0)	0.1	( 1)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Missouri</b>	Applicants	0.7	( 11)	0.2	( 3)	0.5	( 5)	0.6	( 5)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Montana</b>	Applicants	0.3	( 4)	0.1	( 1)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Nebraska</b>	Applicants	0.9	( 14)	0.3	( 4)	1.1	( 10)	0.8	( 6)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)

## State of Residence (Cont'd)

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Nevada	Applicants	0.2	( 3)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New Hampshire	Applicants	0.1	( 1)	0.0	( 0)	0.3	( 3)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New Jersey	Applicants	1.1	( 17)	0.6	( 8)	1.5	( 14)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	1.0	( 2)	0.0	( 0)
New Mexico	Applicants	0.4	( 7)	0.5	( 6)	0.5	( 5)	0.1	( 1)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
New York	Applicants	4.3	( 68)	1.9	( 24)	2.3	( 22)	2.7	( 21)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
North Carolina	Applicants	0.3	( 5)	0.3	( 4)	0.3	( 3)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
North Dakota	Applicants	0.8	( 12)	0.5	( 7)	0.8	( 8)	1.0	( 8)
	Matriculants	0.0	( 0)	0.0	( 0)	1.6	( 3)	1.5	( 3)
Ohio	Applicants	1.3	( 21)	0.5	( 7)	0.6	( 6)	1.1	( 9)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Oklahoma	Applicants	0.4	( 7)	0.2	( 3)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Oregon	Applicants	0.2	( 3)	0.2	( 2)	0.2	( 2)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Pennsylvania	Applicants	1.6	( 26)	0.5	( 6)	0.6	( 6)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Rhode Island	Applicants	0.1	( 1)	0.1	( 1)	0.2	( 2)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
South Carolina	Applicants	0.1	( 1)	0.1	( 1)	0.1	( 1)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
South Dakota	Applicants	1.6	( 26)	1.0	( 13)	0.8	( 8)	1.3	( 10)
	Matriculants	0.0	( 0)	0.8	( 2)	0.0	( 0)	0.5	( 1)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**State of Residence (Cont'd)**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Tennessee</b>	Applicants	0.3	( 5)	0.2	( 2)	0.4	( 4)	0.4	( 3)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.0	( 0)
<b>Texas</b>	Applicants	2.5	( 39)	0.5	( 6)	1.4	( 13)	1.7	( 13)
	Matriculants	0.4	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Utah</b>	Applicants	0.5	( 8)	0.2	( 3)	0.3	( 3)	0.3	( 2)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Vermont</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Virginia</b>	Applicants	0.6	( 9)	0.1	( 1)	0.4	( 4)	0.4	( 3)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Washington</b>	Applicants	0.4	( 6)	0.6	( 8)	1.1	( 10)	0.9	( 7)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.5	( 1)
<b>West Virginia</b>	Applicants	0.1	( 2)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Wisconsin</b>	Applicants	3.9	( 61)	2.7	( 35)	4.6	( 44)	2.7	( 21)
	Matriculants	0.8	( 2)	0.4	( 1)	0.5	( 1)	1.5	( 3)
<b>Wyoming</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>U.S. Territories</b>	Applicants	0.1	( 1)	0.1	( 1)	0.6	( 6)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Foreign</b>	Applicants	0.5	( 8)	0.1	( 1)	0.9	( 9)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## Size of Hometown

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Large City (inner)	Applicants	6.5	( 103)	7.8	( 99)	6.3	( 60)	6.9	( 54)
	Matriculants	4.6	( 11)	5.5	( 13)	4.1	( 8)	2.0	( 4)
Large City (other)	Applicants	8.2	( 130)	5.8	( 74)	4.0	( 38)	5.1	( 40)
	Matriculants	7.9	( 19)	5.0	( 12)	2.6	( 5)	3.1	( 6)
Large City Suburb	Applicants	19.0	( 301)	20.7	( 264)	23.9	( 227)	24.4	( 192)
	Matriculants	20.1	( 48)	25.6	( 61)	31.1	( 60)	32.1	( 63)
Moderate City	Applicants	14.4	( 228)	14.4	( 184)	13.9	( 132)	13.1	( 103)
	Matriculants	10.9	( 26)	15.5	( 37)	8.3	( 16)	13.8	( 27)
Moderate City Suburb	Applicants	6.2	( 98)	7.9	( 101)	6.0	( 57)	5.1	( 40)
	Matriculants	7.5	( 18)	10.5	( 25)	6.7	( 13)	4.1	( 8)
Small City	Applicants	13.8	( 219)	13.0	( 166)	12.5	( 119)	13.4	( 105)
	Matriculants	11.3	( 27)	11.8	( 28)	11.9	( 23)	10.2	( 20)
Town	Applicants	8.6	( 136)	8.5	( 109)	9.5	( 90)	8.7	( 68)
	Matriculants	6.3	( 15)	6.7	( 16)	7.3	( 14)	10.7	( 21)
Small Town	Applicants	5.4	( 85)	6.2	( 79)	6.5	( 62)	5.2	( 41)
	Matriculants	6.7	( 16)	6.7	( 16)	10.4	( 20)	8.7	( 17)
Rural Area	Applicants	4.1	( 65)	3.7	( 47)	3.3	( 31)	2.3	( 18)
	Matriculants	2.1	( 5)	2.1	( 5)	6.7	( 13)	2.6	( 5)
Unknown	Applicants	13.8	( 219)	11.9	( 152)	14.0	( 133)	15.9	( 125)
	Matriculants	22.6	( 54)	10.5	( 25)	10.9	( 21)	12.8	( 25)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

## Citizenship

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
U.S. Citizen	Applicants	99.1	( 1,570)	99.8	( 1,272)	99.4	( 943)	99.4	( 781)
	Matriculants	100.0	( 239)	100.0	( 238)	100.0	( 193)	100.0	( 196)
Non U.S. Citizen	Applicants	0.9	( 14)	0.2	( 3)	0.6	( 6)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Unknown	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.1	( 1)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Demographic Variables**

**Undergraduate Major**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Biological Sciences</b>	Applicants	53.7	( 850)	53.3	( 680)	56.4	( 535)	57.1	( 449)
	Matriculants	49.4	( 118)	49.6	( 118)	47.2	( 91)	49.5	( 97)
<b>Physical Sciences</b>	Applicants	20.8	( 330)	20.1	( 256)	19.0	( 180)	18.8	( 148)
	Matriculants	22.6	( 54)	24.8	( 59)	27.5	( 53)	26.0	( 51)
<b>Social Sciences</b>	Applicants	10.3	( 163)	9.6	( 123)	10.1	( 96)	8.7	( 68)
	Matriculants	11.3	( 27)	10.1	( 24)	11.4	( 22)	9.2	( 18)
<b>Humanities</b>	Applicants	3.5	( 55)	3.6	( 46)	3.9	( 37)	4.2	( 33)
	Matriculants	6.3	( 15)	4.2	( 10)	4.1	( 8)	5.6	( 11)
<b>Mathematics Statistics</b>	Applicants	1.4	( 22)	0.9	( 12)	0.6	( 6)	1.0	( 8)
	Matriculants	0.8	( 2)	2.1	( 5)	0.0	( 0)	1.0	( 2)
<b>Health Sciences</b>	Applicants	5.3	( 84)	6.4	( 82)	3.0	( 28)	3.4	( 27)
	Matriculants	4.6	( 11)	4.2	( 10)	2.1	( 4)	2.6	( 5)
<b>Other</b>	Applicants	5.0	( 79)	6.0	( 76)	7.1	( 67)	6.7	( 53)
	Matriculants	5.0	( 12)	5.0	( 12)	7.8	( 15)	6.1	( 12)
<b>Unknown</b>	Applicants	0.1	( 1)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

**Highest Degree**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Bachelor's</b>	Applicants	89.5	( 1,417)	89.6	( 1,143)	90.3	( 857)	90.8	( 714)
	Matriculants	92.5	( 221)	90.8	( 216)	89.1	( 172)	91.8	( 180)
<b>Master's</b>	Applicants	8.1	( 129)	7.6	( 97)	7.0	( 66)	7.0	( 55)
	Matriculants	5.4	( 13)	6.3	( 15)	8.3	( 16)	6.6	( 13)
<b>Doctorate</b>	Applicants	1.8	( 28)	2.0	( 26)	2.4	( 23)	1.8	( 14)
	Matriculants	2.1	( 5)	2.5	( 6)	2.6	( 5)	1.5	( 3)
<b>Other</b>	Applicants	0.6	( 10)	0.7	( 9)	0.3	( 3)	0.4	( 3)
	Matriculants	0.0	( 0)	0.4	( 1)	0.0	( 0)	0.0	( 0)
<b>Unknown</b>	Applicants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)

# Science Grade Point Average

		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
Below 2.01	Applicants	2.3	( 36)	2.0	( 26)	2.5	( 24)	1.4	( 11)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
2.01 - 2.50	Applicants	8.0	( 126)	9.2	( 117)	8.3	( 79)	8.5	( 67)
	Matriculants	2.1	( 5)	2.1	( 5)	1.6	( 3)	1.0	( 2)
2.51 - 2.75	Applicants	8.1	( 128)	7.7	( 98)	10.1	( 96)	9.5	( 75)
	Matriculants	3.3	( 8)	2.1	( 5)	4.1	( 8)	3.6	( 7)
2.76 - 3.00	Applicants	12.5	( 198)	12.8	( 163)	12.9	( 122)	12.5	( 98)
	Matriculants	8.4	( 20)	8.8	( 21)	9.3	( 18)	8.7	( 17)
3.01 - 3.25	Applicants	16.9	( 268)	18.8	( 240)	16.5	( 157)	15.9	( 125)
	Matriculants	13.0	( 31)	17.2	( 41)	11.4	( 22)	16.3	( 32)
3.26 - 3.50	Applicants	19.4	( 308)	18.6	( 237)	20.5	( 195)	18.1	( 142)
	Matriculants	18.4	( 44)	21.8	( 52)	26.9	( 52)	21.9	( 43)
3.51 - 3.75	Applicants	17.7	( 281)	16.9	( 215)	14.6	( 139)	18.1	( 142)
	Matriculants	21.8	( 52)	23.9	( 57)	24.9	( 48)	27.6	( 54)
3.76 - 4.00	Applicants	12.7	( 201)	13.7	( 175)	14.4	( 137)	15.4	( 121)
	Matriculants	20.9	( 50)	23.9	( 57)	21.8	( 42)	20.4	( 40)
Unknown	Applicants	2.4	( 38)	0.3	( 4)	0.0	( 0)	0.6	( 5)
	Matriculants	12.1	( 29)	0.0	( 0)	0.0	( 0)	0.5	( 1)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	3.20		3.20		3.18		3.21	
	Matriculants	3.43		3.45		3.43		3.43	
Standard Deviation	Applicants	0.50		0.52		0.52		0.52	
	Matriculants	0.40		0.38		0.37		0.36	

**Proportion and Number of Applicants and Matriculants  
for Selected Years by Grade Point Average**

**Overall Grade Point Average**

		<b>1978</b>		<b>1981</b>		<b>1986</b>		<b>1987</b>	
		%	(n)	%	(n)	%	(n)	%	(n)
<b>Below 2.01</b>	Applicants	0.3	( 4)	0.5	( 6)	0.4	( 4)	0.5	( 4)
	Matriculants	0.0	( 0)	0.0	( 0)	0.0	( 0)	0.0	( 0)
<b>2.01 - 2.50</b>	Applicants	4.9	( 77)	4.9	( 63)	4.6	( 44)	4.8	( 38)
	Matriculants	1.7	( 4)	0.4	( 1)	1.0	( 2)	0.0	( 0)
<b>2.51 - 2.75</b>	Applicants	7.3	( 116)	7.0	( 89)	6.7	( 64)	7.4	( 58)
	Matriculants	1.3	( 3)	1.7	( 4)	0.5	( 1)	2.0	( 4)
<b>2.76 - 3.00</b>	Applicants	11.6	( 183)	10.6	( 135)	12.8	( 121)	10.7	( 84)
	Matriculants	5.4	( 13)	4.6	( 11)	7.8	( 15)	6.1	( 12)
<b>3.01 - 3.25</b>	Applicants	17.7	( 280)	19.7	( 251)	18.2	( 173)	16.9	( 133)
	Matriculants	13.8	( 33)	16.0	( 38)	10.4	( 20)	13.8	( 27)
<b>3.26 - 3.50</b>	Applicants	23.4	( 371)	21.7	( 277)	22.8	( 216)	23.7	( 186)
	Matriculants	22.2	( 53)	24.8	( 59)	27.5	( 53)	27.0	( 53)
<b>3.51 - 3.75</b>	Applicants	20.5	( 324)	21.9	( 279)	20.3	( 193)	19.6	( 154)
	Matriculants	22.2	( 53)	28.2	( 67)	31.1	( 60)	32.1	( 63)
<b>3.76 - 4.00</b>	Applicants	12.1	( 192)	13.5	( 172)	14.1	( 134)	15.8	( 124)
	Matriculants	21.3	( 51)	24.4	( 58)	21.8	( 42)	18.4	( 36)
<b>Unknown</b>	Applicants	2.3	( 37)	0.2	( 3)	0.0	( 0)	0.6	( 5)
	Matriculants	12.1	( 29)	0.0	( 0)	0.0	( 0)	0.5	( 1)
<b>Total</b>	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
<b>Mean</b>	Applicants	3.28		3.29		3.29		3.30	
	Matriculants	3.47		3.50		3.49		3.48	
<b>Standard Deviation</b>	Applicants	0.43		0.43		0.43		0.44	
	Matriculants	0.34		0.32		0.31		0.30	

## Biology

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	18.9	( 300)	13.9	( 177)	10.4	( 99)	10.8	( 85)
	Matriculants	4.2	( 10)	2.9	( 7)	0.5	( 1)	1.5	( 3)
7 - 8	Applicants	26.2	( 415)	24.5	( 313)	24.1	( 229)	22.3	( 175)
	Matriculants	16.3	( 39)	17.2	( 41)	15.0	( 29)	17.9	( 35)
9 - 11	Applicants	44.9	( 712)	52.5	( 669)	53.3	( 506)	53.6	( 421)
	Matriculants	56.5	( 135)	66.8	( 159)	68.9	( 133)	61.7	( 121)
12 - 15	Applicants	6.3	( 99)	8.3	( 106)	11.6	( 110)	12.6	( 99)
	Matriculants	10.0	( 24)	13.0	( 31)	15.5	( 30)	18.9	( 37)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.46		8.88		9.19		9.23	
	Matriculants	9.68		9.82		10.06		10.05	
Standard Deviation	Applicants	2.18		2.14		2.05		2.10	
	Matriculants	1.71		1.63		1.45		1.60	

## Chemistry

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	20.3	( 322)	14.1	( 180)	14.0	( 133)	12.6	( 99)
	Matriculants	3.3	( 8)	1.3	( 3)	1.0	( 2)	1.0	( 2)
7 - 8	Applicants	24.1	( 381)	25.8	( 329)	25.5	( 242)	25.6	( 201)
	Matriculants	10.5	( 25)	13.9	( 33)	15.5	( 30)	14.8	( 29)
9 - 11	Applicants	40.0	( 633)	46.1	( 588)	47.0	( 446)	48.1	( 378)
	Matriculants	52.3	( 125)	60.5	( 144)	61.7	( 119)	64.3	( 126)
12 - 15	Applicants	12.0	( 190)	13.2	( 168)	13.0	( 123)	13.0	( 102)
	Matriculants	20.9	( 50)	24.4	( 58)	21.8	( 42)	19.9	( 39)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.58		8.97		9.00		9.04	
	Matriculants	10.19		10.32		10.06		10.13	
Standard Deviation	Applicants	2.50		2.26		2.19		2.17	
	Matriculants	1.83		1.63		1.59		1.55	



**Proportion and Number of Applicants and Matriculants  
for Selected Years by MCAT Areas of Assessment**

**Physics**

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	18.7	( 296)	17.0	( 217)	13.0	( 123)	12.0	( 94)
	Matriculants	6.7	( 16)	3.4	( 8)	1.0	( 2)	0.5	( 1)
7 - 8	Applicants	27.3	( 432)	25.5	( 325)	27.4	( 260)	25.2	( 198)
	Matriculants	12.1	( 29)	16.0	( 38)	13.0	( 25)	14.3	( 28)
9 - 11	Applicants	39.5	( 625)	43.8	( 558)	43.5	( 413)	46.1	( 362)
	Matriculants	47.7	( 114)	58.4	( 139)	63.2	( 122)	58.2	( 114)
12 - 15	Applicants	10.9	( 173)	12.9	( 165)	15.6	( 148)	16.0	( 126)
	Matriculants	20.5	( 49)	22.3	( 53)	22.8	( 44)	27.0	( 53)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.54		8.90		9.11		9.16	
	Matriculants	9.80		10.13		10.21		10.40	
Standard Deviation	Applicants	2.34		2.33		2.36		2.37	
	Matriculants	2.10		1.82		1.71		1.76	

**Science Problems**

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants	19.1	( 303)	14.9	( 190)	14.9	( 141)	11.7	( 92)
	Matriculants	3.3	( 8)	1.3	( 3)	2.6	( 5)	1.0	( 2)
7 - 8	Applicants	23.7	( 376)	26.0	( 331)	27.8	( 264)	27.4	( 215)
	Matriculants	10.5	( 25)	13.0	( 31)	16.6	( 32)	10.2	( 20)
9 - 11	Applicants	44.3	( 702)	47.0	( 599)	44.6	( 423)	47.1	( 370)
	Matriculants	56.5	( 135)	67.2	( 160)	60.1	( 116)	68.4	( 134)
12 - 15	Applicants	9.2	( 145)	11.4	( 145)	12.2	( 116)	13.1	( 103)
	Matriculants	16.7	( 40)	18.5	( 44)	20.7	( 40)	20.4	( 40)
Unknown	Applicants	3.7	( 58)	0.8	( 10)	0.5	( 5)	0.8	( 6)
	Matriculants	13.0	( 31)	0.0	( 0)	0.0	( 0)	0.0	( 0)
Total	Applicants	--	( 1,584)	--	( 1,275)	--	( 949)	--	( 786)
	Matriculants	--	( 239)	--	( 238)	--	( 193)	--	( 196)
Mean	Applicants	8.59		8.87		8.92		9.04	
	Matriculants	10.04		10.17		10.04		10.14	
Standard Deviation	Applicants	2.32		2.29		2.24		2.21	
	Matriculants	1.78		1.67		1.75		1.65	

### Skills Analysis: Reading

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants Matriculants	14.8 5.4	( 235) ( 13)	16.2 4.6	( 207) ( 11)	15.6 4.7	( 148) ( 9)	16.7 4.6	( 131) ( 9)
7 - 8	Applicants Matriculants	32.1 16.3	( 509) ( 39)	26.7 18.1	( 340) ( 43)	29.7 21.2	( 282) ( 41)	26.8 20.9	( 211) ( 41)
9 - 11	Applicants Matriculants	44.6 57.7	( 707) ( 138)	52.2 69.3	( 665) ( 165)	51.0 68.9	( 484) ( 133)	52.0 69.4	( 409) ( 136)
12 - 15	Applicants Matriculants	4.7 7.5	( 75) ( 18)	4.2 8.0	( 53) ( 19)	3.2 5.2	( 30) ( 10)	3.7 5.1	( 29) ( 10)
Unknown	Applicants Matriculants	3.7 13.0	( 58) ( 31)	0.8 0.0	( 10) ( 0)	0.5 0.0	( 5) ( 0)	0.8 0.0	( 6) ( 0)
Total	Applicants Matriculants	-- --	( 1,584) ( 239)	-- --	( 1,275) ( 238)	-- --	( 949) ( 193)	-- --	( 786) ( 196)
Mean	Applicants Matriculants	8.42 9.50		8.45 9.43		8.37 9.34		8.37 9.31	
Standard Deviation	Applicants Matriculants	2.15 1.70		2.09 1.61		2.24 1.58		2.24 1.59	

### Skills Analysis: Quantitative

Scaled Score		1978		1981		1986		1987	
		%	(n)	%	(n)	%	(n)	%	(n)
1 - 6	Applicants Matriculants	18.5 4.6	( 293) ( 11)	21.4 6.3	( 273) ( 15)	21.8 7.3	( 207) ( 14)	18.7 4.1	( 147) ( 8)
7 - 8	Applicants Matriculants	22.5 9.6	( 357) ( 23)	27.4 16.8	( 349) ( 40)	30.3 25.9	( 288) ( 50)	30.7 21.9	( 241) ( 43)
9 - 11	Applicants Matriculants	46.7 54.4	( 740) ( 130)	42.0 60.1	( 535) ( 143)	36.5 51.3	( 346) ( 99)	42.2 61.7	( 332) ( 121)
12 - 15	Applicants Matriculants	8.6 18.4	( 136) ( 44)	8.5 16.8	( 108) ( 40)	10.9 15.5	( 103) ( 30)	7.6 12.2	( 60) ( 24)
Unknown	Applicants Matriculants	3.7 13.0	( 58) ( 31)	0.8 0.0	( 10) ( 0)	0.5 0.0	( 5) ( 0)	0.8 0.0	( 6) ( 0)
Total	Applicants Matriculants	-- --	( 1,584) ( 239)	-- --	( 1,275) ( 238)	-- --	( 949) ( 193)	-- --	( 786) ( 196)
Mean	Applicants Matriculants	8.61 10.02		8.44 9.71		8.39 9.37		8.47 9.57	
Standard Deviation	Applicants Matriculants	2.34 1.84		2.32 1.81		2.40 1.98		2.24 1.73	

## ROBERT WOOD JOHNSON MINORITY MEDICAL FACULTY DEVELOPMENT PROGRAM

The Robert Wood Johnson's Minority Medical Faculty Development Program, started in 1983, offers four-year, post doctoral research fellowships to minority physicians who are committed to careers in academic medicine and biomedical research. Each of up to 16 Fellows selected over the next 2 years will receive an annual stipend of up to \$35,000, complemented by a \$25,000 annual grant toward research activities. Each Fellow will study and conduct research under the supervision of a senior faculty member at an academic center of biomedical research. To date the program has awarded 40 fellowships, with 8 awards due soon in 1988.

The Commonwealth Fund Fellowship program in Academic Medicine for Minority Students, started in 1984, sponsors a program (managed by NMF, Inc.) to help academically gifted minority medical students prepare for and begin careers in academic medicine and biomedical research. The Fellowship can be used either during the summer following the 3rd year in medical school or during the 4th year. Each Fellow works in a major biomedical research laboratory under the personal guidance of a leading biomedical scientist for 8 to 12 weeks. Each Fellowship award is \$5,000. To date this program has awarded 81 fellowships, including 21 Fellows in 1987.

## AAMC Proposal on the Advancement of Women in Academic Medicine

Many questions continue to be raised about why women are not advancing more quickly into leadership positions in academic medicine. Data indicating that proportionally fewer women than men faculty are on tenure track and that overall women are less involved in research than their male peers deserve further investigation. Deans also have concerns about affirmative action and the recruitment of women faculty and general concerns about faculty productivity and development. Janet Bickel, Senior Staff Associate, AAMC Division of Institutional Planning and development has received internal clearance to seek foundation support for a proposal to develop strategies for increasing the number of women who will progress into leadership positions in academic medicine. The proposal's scope of work includes linking AAMC's student and faculty databases to examine faculty characteristics. Its main focus, however, is interviews with women and men department chairs and clinical researchers based on a theoretical framework which social scientists have developed from an examination of gender differences in scientific productivity. A better understanding of gender differences in career development in academic medicine and of institutional characteristics contributing to women's advancement will result in strategies that deans can adapt to address institutional needs.

**FUTURE MEETING DATES**

**1988 Meeting Dates:**

***Executive Council/COD Admin. Board -***

June 22-23  
September 7-8

***AAMC Annual Meeting -***

November 12-17  
Chicago Marriott & the Palmer  
House  
Chicago, Illinois

**1989 Meeting Dates:**

***COD Spring Meeting***

April 11-16  
Fess Parker's Red Lion Resort  
Santa Barbara, CA



# association of american medical colleges

## "Traffic Rules" Revisions February 1988

### Introduction

A revision of the Recommendations Concerning Medical School Acceptance Procedures ("traffic rules") has been developed by the Group on Student Affairs Committee on Admissions. Suggested changes to the traffic rules, in the form of previous drafts, were discussed during the 1987 GSA Spring regional meetings. The attached revision represents the results of these discussions and also the results of a survey of admissions officers conducted in early 1988.

The revised traffic rules will be presented for approval at each of the 1988 GSA Spring regional meetings and to the COD Administrative Board and Executive Council at their Fall 1988 meeting.

### Brief Summary of Revision

- A. Establishment of March 15 as the date that all schools should have offered a total number of acceptances **at least** equal to the size of their entering class.
  - 1) The March 15 date is **two months** earlier than the date in the present version of the traffic rules.
  - 2) This change represents the most significant departure from the present set of traffic rules. It is clearly intended to move the first point in the decision making process (schools and students) earlier in the year.
  - 3) Of the 83 schools responding to the survey, over 50% indicated their present schedule is such that the March 15 date is realistic.
  - 4) In addition, 40 schools suggested moving the date earlier than May 15 with March 15 being the clear preference.
- B. By April 15, an applicant who has received offers of admission from more than one school should choose the one school he or she prefers and withdraw from all other schools to which he or she has been accepted.

Coupled with the observance of March 15, the acceptance of the practice of requiring students holding multiple acceptances to decide by April 15 will reduce considerably the problems that now exist during the summer prior to the beginning of classes.

- C. Recommended Amount of Acceptance Deposit Remains at \$100.00
  - 1) Survey of admissions officers indicated that 52 of the 83 respondents require a deposit, most at \$100.00.
  - 2) Forty-six of the schools responding wanted the deposit amount stated in the current traffic rules (\$100.00) to remain the same and 20 schools wanted it to be increased.
  - 3) Twenty-eight schools wanted the deposit to remain refundable until June 15, with 10 schools preferring dates prior to April 15, 11 schools preferring dates from April 16 - May 15, and 7 schools preferring dates from May 16 - June 14.

**AAMC Recommendations Concerning  
Medical School Acceptance Procedures for  
First Year Entering Students**

For the information of prospective medical students and their advisors, the recommended procedures for offering acceptance to medical school and for student responses to those offers are as follows:

1. Each school of medicine should prepare and distribute to applicants and college advisors a detailed schedule of its application and acceptance procedures and should adhere to this schedule unless it is publicly amended.
2. Each school of medicine should agree not to notify its applicants (except for those applying via Early Decision Program (EDP)) of acceptance prior to October 15 of each admission cycle.
3. By March 15 of the year of matriculation, each school of medicine should have issued a number of acceptances at least equal to the size of its first year entering class.
4. By April 15 of the year of matriculation, an applicant who has received offers of admission from more than one school should choose the one school that he or she prefers and withdraw from all other schools to which he or she has been accepted.
5. Only after April 15 are schools free to make appropriate rules for dealing with accepted applicants who, without adequate explanation, hold one or more places in other schools. These rules should recognize the problems of the applicant who has multiple offers and also of those applicants who have not yet been accepted.
6. Prior to April 15 of the year of matriculation, an applicant should be given at least two weeks to reply to an offer of admission. After April 15, schools may require applicants to respond to acceptance offers in less than two weeks. An applicant may be required to file a statement of intent, or a deposit or both. The statement of intent should provide freedom to withdraw if the applicant is later accepted by a school that he or she prefers.
7. It is recommended that the acceptance deposit not exceed \$100 and be refundable until May 15. After that date, a school may retain the deposit as a late withdrawal fee. If the applicant matriculates at the school, the school is encouraged to credit the deposit toward tuition.
8. Subsequent to June 1, a school of medicine seeking to admit an applicant already known to be accepted by another school for that entering class should advise that school of its intent. Because of the administrative problems involved in filling a place vacated just prior to the commencement of the academic year, schools should communicate fully with each other with respect to anticipated late roster changes in order to keep misunderstandings at a minimum.
9. After an applicant has enrolled in a U.S. school of medicine or begun a brief orientation program contiguous to enrollment, no further acceptances should be offered to that individual. Once enrolled in a school, students have an obligation to withdraw their applications promptly from all other schools. Enrollment is defined as being officially registered as a member of the first year entering class at a school.



# association of american medical colleges

## SCHEDULE OF SMALL GROUP MEETINGS

Being held in conjunction with the COD Spring Meeting

### Saturday, March 19

6:30 pm 7:30 pm  
*Pool Terrace*

NEW DEANS & SPOUSES RECEPTION

### Sunday, March 20

8:00 am - 9:00 am  
*Archer West*

NEW DEANS & SPOUSES BREAKFAST

9:00 am - 12:00 pm  
*Archer East*

NEW DEANS MEETING

9:00 am - 12:00 pm  
*Archer West*

NEW DEANS' SPOUSES MEETING

10:00 am - 3:00 pm  
*Camellia Boardroom*

DEANS OF PRIVATE-FREESTANDING SCHOOLS MEETING

### Monday, March 21

7:15 am - 8:30 am  
*Elliot Room*

SOUTHERN DEANS BREAKFAST

1:15 pm - 2:30 pm  
*Danner West*

COMMUNITY-BASED DEANS LUNCHEON

4:00 pm - 5:00 pm  
*Camellia Boardroom*

NOMINATING COMMITTEE MEETING

### Tuesday, March 22

7:15 am - 8:30 am  
*Elliot Room*

MIDWEST-GREAT PLAINS DEANS BREAKFAST

7:15 am - 8:30 am  
*Camellia Boardroom*

WESTERN DEANS BREAKFAST

1:15 pm - 2:30 pm  
*Camellia Boardroom*

COD ADMINISTRATIVE BOARD LUNCHEON



**Association of American Medical Colleges**

**Council of Deans**

**1988 Spring Meeting**

**The Hotel Inter-Continental**

**Hilton Head Island, South Carolina**

**March 19-23, 1988**

**List of Participants**

## Deans

*Karl P. Adler*  
Joan Adler  
New York Medical College

*George M. Bernier*  
University of Pittsburgh  
School of Medicine

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

*Samuel H. Black*  
Elisabeth Zandveld Black  
Texas A&M University  
College of Medicine

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

*Stuart Bondurant*  
Peg Bondurant  
University of North Carolina  
School of Medicine

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

*L. Thompson Bowles*  
Judy Bowles  
George Washington University  
School of Medicine

*Charles M. Baugh*  
Ebby Baugh  
University of South Alabama  
College of Medicine

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

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

*David M. Brown*  
Sandra Brown  
University of Minnesota  
Medical School - Minneapolis

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

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

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

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

*Louis J. Bernard*  
Lois Bernard  
Meharry Medical College  
School of Medicine

*Michel A. Bureau*  
Universite de Sherbrooke  
Faculty of Medicine

*Gerard N. Burrow*  
UC - San Diego  
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*  
University of Virginia  
School of Medicine

*John E. Chapman*  
Judy Chapman  
Vanderbilt University  
School of Medicine

*D. Kay Clawson*  
Janet S. Clawson  
University of Kansas  
School of Medicine

*Jordan Cohen*  
SUNY at Stony Brook Health  
Sciences Ctr Sch of Medicine

*Stuart D. Cook*  
Josepha Cook  
Univ of Medicine & Dentistry  
New Jersey Medical School

*Richard A. Cooper*  
Medical College of Wisconsin

*Thomas S. Cottrell*  
Jane Cottrell  
SUNY at Stony Brook Health  
Sciences Ctr Sch of Medicine

*Richard L. Cruess*  
McGill University  
Faculty of Medicine

*Robert W.P. Cutler*  
Marjorie Cutler  
Stanford University  
School of Medicine

*Walter J. Daly*  
Joan B. Daly  
Indiana University  
School of Medicine

*Robert S. Daniels*  
Vikki Daniels  
Louisiana State University  
Sch of Medicine in New Orleans

*Robert M. Daugherty*  
Sandra Daugherty  
University of Nevada  
School of Medicine

*Nydia R. de Jesus*  
University of Puerto Rico  
School of Medicine

*William B. Deal*  
Elizabeth W. Deal  
University of Florida  
College of Medicine

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

*Richard A. DeVaul*  
Mary DeVaul  
West Virginia University  
School of Medicine

*John W. Eckstein*  
University of Iowa  
College of Medicine

*Norman H. Edelman*  
Ida Nadel Edelman  
UMDNJ-Robert Wood Johnson  
Medical School

*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

*Bernard J. Fogel*  
Judy Fogel  
University of Miami  
School of Medicine

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

*Robert L. Friedlander*  
Mary Lou Friedlander  
Albany Medical College

*Vincent Fulginiti*  
Shirley Fulginiti  
University of Arizona  
College of Medicine

*Martin Goldberg*  
Marion Lindblad-Goldberg  
Temple University  
School of Medicine

*Doyle G. Graham*  
Lea O'Quinn, M.D.  
Duke University  
School of Medicine

*David S. Greer*  
Marion Greer  
Brown University  
Program in Medicine

*James T. Hamlin*  
Mary Hamlin  
Tulane University  
School of Medicine

*J. Barry Hanshaw*  
Chris Hanshaw  
University of Massachusetts  
Medical School

*J. Ted Hartman*  
Texas Tech University  
School of Medicine

*Jane Henney*  
University of Kansas  
School of Medicine

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

*John J. Hutton*  
University of Cincinnati  
College of Medicine

*Eugene D. Jacobson*  
Laura Jacobson  
University of Colorado  
School of Medicine

*Edwin C. James*  
University of North Dakota  
School of Medicine

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

*Joseph E. Johnson*  
Judy Johnson  
University of Michigan  
Medical School

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

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

*Donald G. Kassebaum*  
University of Oklahoma  
College of Medicine

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

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

*Donald R. Kmetz*  
Joan Kmetz  
University of Louisville  
School of Medicine

*Franklyn G. Knox*  
Anne Knox  
Mayo Medical School

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

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

*Richard G. Lester*  
Louise Lester  
Eastern VA Medical School

*John O. Lindower*  
Doris Lindower  
Wright State University  
School of Medicine

*William H. Luginbuhl*  
University of Vermont  
School of Medicine

*Russell L. Miller*  
Daryl Miller  
Howard University  
College of Medicine

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

*Jock Murray*  
Dalhousie Medical School

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

*John Naughton*  
Margaret Naughton  
SUNY-Buffalo School of  
Medicine & Biomedical Sciences

*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

*Edward J. Quilligan*  
Betty Quilligan  
UC - Irvine  
California College of Medicine

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

*Stanford A. Roman*  
Ngina Lythcott, Ph.D.  
Morehouse School of Medicine

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

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

*Henry P. Russe*  
Pastora Cafferty, Ph.D.  
Rush Medical College  
of Rush University

*Luis F. Sala*  
Judith Sala  
Ponce School of Medicine

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

*Jay P. Sanford*  
Lorrie Sanford  
Unif Serv Univ of Hlth Sci  
F. Edward Hebert Sch of Med

*Rudi Schmid*  
Sonja Schmid  
UC - San Francisco  
School of Medicine

*Richard H. Schwarz*  
Patricia Schwarz  
SUNY Health Science Center at  
Brooklyn, College of Medicine

*Charlie W. Scott*  
Jeanette Scott  
University of Alabama  
School of Medicine

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

*Eugene M. Sigman*  
June Sigman  
University of Connecticut  
School of Medicine

*W. Douglas Skelton*  
Jane Skelton  
Mercer University  
School of Medicine

*Frank G. Standaert*  
Joan Standaert  
Medical College of Ohio

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

*Hugh Stephenson*  
Sally Stephenson  
Univ of Missouri - Columbia  
School of Medicine

*William Stoneman*  
Bette Stoneman  
Saint Louis University  
School of Medicine

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

*Alton I. Sutnick*  
Mona Sutnick  
Medical Coll of Pennsylvania

*Robert C. Talley*  
Katherine Talley  
University of South Dakota  
School of Medicine

*Francis J. Tedesco*  
Luann Tedesco  
Medical College of Georgia  
School of Medicine

*Daniel C. Tosteson*  
Harvard Medical School

*Robert E. Tranquada*  
Janet Tranquada  
Univ of Southern California  
School of Medicine

*Manuel Tzagournis*  
Madeline Tzagournis  
Ohio State University  
College of Medicine

*John G. Wade*  
Marilyn Wade  
University of Manitoba  
Faculty of Medicine

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

*Irwin M. Weiner*  
SUNY Health Science Center at  
Syracuse, College of Medicine

*W. Donald Weston*  
Ms. Patricia Butch  
Michigan State University  
College of Human Medicine

*Darryl M. Williams*  
Susan Williams  
LSU - Shreveport  
School of Medicine

*Emery A. Wilson*  
Clara Wilson  
University of Kentucky  
College of Medicine

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

*Harry Wollman*  
Carol Wollman  
Hahnemann University  
School of Medicine

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Jacki Challoner

*William D. Mayer*  
Donna Dashiell

*Carleton B. Chapman*  
Ruth Chapman

*Stanley W. Olson*  
Lorraine Olson

*William J. Grove*  
Betty Grove

*Robert L. Van Citters*  
Mary Van Citters



## Guests

*John W. Colloton*  
University of Iowa  
Hospitals and Clinics

*Douglas E. Kelly*  
Univ of Southern California  
School of Medicine

*Harry S. Jonas*  
American Medical Association  
LCME Secretary

**Speakers**

*John A. Gronvall*  
Veterans Administration

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Div of Clinical Services

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Assistant Vice President

**A SPECIAL PROGRAM**

**FOR**

**SPOUSES AND GUESTS**

**At the Council of Deans Spring Meeting**

**March 19-23, 1988**

**THE HOTEL INTER-CONTINENTAL**

**Hilton Head Island, South Carolina**

PROGRAM

FOR

SPOUSES & GUESTS

At the Council of Deans' Meeting  
March 20-23, 1988

The Hotel Inter-Continental  
Hilton Head, South Carolina

DATE: Monday, March 21, 1988  
TIME: 8:30 - 11:00 a.m., including Continental Breakfast  
PLACE: Danner West

- I. Introduction & Comments Carol Butler
- II. The Hotel Inter-Continental Guest Relations Rep will discuss the facilities
- III. COLOR ME BEAUTIFUL\* (beginning at 9:30 am)

Ms. Phyllis Busch, a certified *Color Me Beautiful* consultant, will give a ninety minute presentation that demonstrates the effects of wearing the right and wrong colors of clothing and makeup. Ms. Busch has given over 150 programs and lectures regularly on cruise ships. Ladies from the audience will be selected as models, and everyone will instantly be able to see the positive results!

Ms. Busch will conclude her program by packing 23 outfits into a small briefcase, demonstrating the art of being able to coordinate a complete wardrobe. This class will be both entertaining and informative.

**PLEASE NOTE:** Enrollment for this class is limited.  
Please sign up early at the AAMC registration table if you wish to participate.

\* Cost for this exciting program will be just \$10.00 per person.

Spouse and Guest Program -continued-

DATE: Tuesday, March 21st  
TIME: 8:30 - 12:30 (including continental breakfast)  
PLACE: DRAYTON ROOM

TOUR OF HILTON HEAD ISLAND

I. Continental Breakfast

II. Tour of Hilton Head Island

Hilton Head is one of the most beautiful of the "Sea Islands," which stretch along 250 miles of coastline, from the Carolinas to northern Florida.

This tour is your chance to really see the beauty of Hilton Head. Low Country Adventures will take you on a island visit that will be interesting, informative and fun. Their guides are island experts, proud of the rich cultural heritage and charm of the Low Country.

The tour will begin with a drive through the present day plantation developments, each a showplace of beautiful homes and gardens. You will also visit numerous sites of historical significance, and finally wind up in charming Harbour Town. Harbour Town, with its unique complex of shops and marina is a picturesque island "village." The landmark lighthouse overlooks the Calibogue Sound. Reminiscent of a Mediterranean seaside village, Harbour Town is both memorable and delightful. The tour will allow ample time for shopping and refreshments before departing back to the Inter-Continental.

\*Cost for this enjoyable island tour is just \$15.00. Please sign up at the AAMC registration table.