association of american medical colleges

BACKGROUND PAPERS

FOR

SMALL GROUP DISCUSSIONS

AT THE

COUNCIL OF DEANS SPRING MEETING

MARCH 20 - 23, 1988

The Hotel Inter-Continental

Hilton Head, South Carolina

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

Small Group Discussion Format

The format for this year's Spring Meeting discussion groups will be as follows:

Monday, March 21st

Two topics will be presented. The declining applicant pool, with a concentration on minority students, will be the subject for the 8:30 session. Development of women & minority faculty members will be discussed at the 11:00 session. For each topic, everyone will meet together for a short presentation and then break into small groups for discussion.

Tuesday, March 22nd

Four different topics will be offered on this day **:

- Continuing medical education
- Graduate medical education
- International medical education
- The VA-medical school relationship

Each session will be offered in the morning at 8:30 and repeated at 11:00.

**** During registration, you must sign up for the two sessions you want to attend.**

BACKGROUND PAPERS

A Declining Applicant Pool: How Can We Preserve Affirmative Action?

Discussion Leader: Russell L. Miller, M.D.
Vice President for Health Affairs
Howard University College of Medicine

The Association of American Medical Colleges may wish to consider several different specific programs to increase the number of qualified black medical school applicants including: marketing of the profession; assisting in the development of local and national organizations that will help to develop educational opportunities for under represented students; providing academic enrichment for junior high school and high school students and expansion of scholarship and loan programs; and increasing lobbying efforts to expand existing federal programs which increase the opportunities for education in the health professions for under represented and disadvantaged students.

Marketing of the Profession:

Recent statistics indicate that black college students are diminishing in number. Those aspiring to and enrolling in higher education are being attracted to multiple career opportunities. Currently, every profession wants to have its fair share of talented black students. It must actively encourage them to want to be physicians.

As an important first step, medicine must market the profession to black youth. The issue of physician oversupply which might deter a general marketing approach is not applicable to the problem of the black physician supply. A joint effort by the AAMC, the AMA and/or the NMA in launching a major marketing campaign using radio, television, magazines, and school counselors and teachers as vehicles for the message that medicine wants and needs blacks would likely be successful. The message also should be aimed at convincing students that they can succeed as physicians, that they are needed in the profession, and that there are many opportunities for service, and many rewards, including financial. Another aspect of the message should be that while training is long, there are many phases, each with its own challenges and opportunities, which are not limited to the classroom. Finally emphasis should be placed on the fact that while a medical education is expensive, it is an investment with a good rate of return, and that financial aid is available.

Assisting in the Development of Local and National Organizations:

Not only must the Association strive to promote and market medicine, it also should promote education so that students do not foreclose educational and career opportunities before completing high school. Studies show that most individuals change jobs often during their life time, and need the learning skills and confidence that will enable them to adapt. A student who may not consider medicine as a career option in the eighth grade should have the academic background to begin premedical studies in college. The Association may wish to foster and support the efforts of groups such as the historical black colleges and universities, high school advisors, and junior high school advisors.

Medical schools are some of this nation's finest educational resources. Classrooms, laboratores, teachers, support staff, and equipment are in relative abundance. There are 127 medical schools in this country. Perhaps as many as 100 are in or near communities with large black populations. Undoubtedly, the AAMC could be a focal point for mobilizing just a few of these resources for supplemental training of black students, at an early stage, to prepare them for medical school.

High school programs are also important, but are limited because many talented students never go beyond the eighth grade. For example, according to the Department of Education, the drop-out rate of the District of Columbia is above 44%. Indeed, many black students do not advance beyond the junior high school level in our educational system.

If each medical school would commit itself to taking just 25 bright black students in the seventh or eighth grade under its wing each year for after school, during school and Saturday instruction, and for motivating experiences in medicine, at least 2500 students would be involved each year--10,000 over 4 years--in activities designed to: (1) prepare them for high school and college science courses and (2) instill in them the desire to become physicians. The schools could use volunteer faculty and staff supplemented by funds from grants. The AAMC would likely attract funds to support the program from foundations and government grant programs. Such a course of action would be an important and significant contribution toward addressing the problems.

Scholarship Program:

Attempts to increase the size of the black applicant pool is a long range goal which will require several years before even modest gains will be realized. If we wish to take steps which will have more immediate results, medicine must do something significant and dramatic if it is to compete for the best and the brightest black young minds. Currently, business and engineering, which I view as our chief competitors, promise high salaries with fewer years of training. One way of capturing the attention of students as they consider career options is to announce and publicize a major scholarship program on the order of $100,000,000. While in actuality, this money would not go very far when disbursed over let's say five years to other minorities and the economically disadvantaged as well as to blacks, it would send an important message. It would say to these students that medical schools

are truly committed to addressing the problem of the under represented in the profession, and that there is money to help them through medical school.

Also, efforts at enlarging the qualified black applicant pool should be accompanied by expanded scholarship and innovative financial aid opportunities. We want the message to applicants to be one of educational and professional opportunities and not one of the financial obstacles. I have not yet thought through how the money would be raised or administered; this will take careful consideration by individuals with expertise and experience in fund raising and the administration of financial aid. However, if we are to have a true impact on the problem, we must think in larger terms that we ever have before.

Preservation and Expansion of Federal Programs:

A part of the AAMC undertaking should be to lend political support to existing programs, specifically the Health Careers Opportunity Programs, the scholarship program of National Medical Fellowships, Inc., and the Office of Minority Health, Department of Health and Human Services.

The Division of Disadvantaged Assistance (DDA) of the Department of Health and Human Services administers several programs which have the goal of increasing the number of individuals from disadvantaged backgrounds who enter into and complete health or allied health professions education. The Division Administers Section 787- [295g-7] which was designed to assist individuals from disadvantaged backgrounds to enter a health profession. In the fiscal year ending 9/30/88, $30,000,000 was available for the HCOP program, but the Senate proposed an amendment that redirected 20% of the funds appropriated for the HCOP program to EFN scholarships. Although, both programs are important and useful, shifting funds from one program to expand another is not appropriate in this situation and may adversely effect efforts to develop innovative programs designed to recruit, admit, retain, and graduate more black students.

The AAMC should lobby for additional funds for DDA and the DDA must develop more flexible funding guidelines to encourage innovative programs which can be funded for a sufficient time to evaluate the long term results of the programs. Interagency agreements between the Department of Education and the Department of Human Services (DDA) should be developed, which can lead to the implementation of strategies and programs like the HCOP, which will begin in elementary and/or junior high school. These programs will have the additional benefit of increasing health promotion through education which is directed at disadvantaged youth.

Finally, another federal initiative that should be expanded is the Office of Minority Health, Department of Health and Human Services. The offices could be of great importance in assisting the AAMC in the development and support of all of these programs.

COMMITTEES:
EDUCATION AND LABOR
SMALL BUSINESS

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MAY 1, 1986

DEAR COLLEAGUE:

I thought you would be interested in knowing how your state ranks with respect to high school dropout rates. As you will note, the national average is 29.1%. This translates into thousands upon thousands of young people who for one reason or another, fail to graduate with their high school diploma.

Droping out of school is a non-partisian action. Each and every congressional district in this nation has residents who have dropped out of high school before receiving their diploma. Should we be content with the current national dropout rate of 29.1%? **I think the answer is obvious -- NO!** As we continue to formulate and implement policies geared toward excellence in education, I believe we must also devote some of our scarce resources toward those students who do not complete their education. Failure to address their needs ***now*** will only cause us to deal with them in the ***future*** through higher unemployment benefit costs, welfare costs, lost tax revenues, and a diminished industrial capacity.

Whether your state has a 10.7% rate or a 44.8% rate, the fact remains that those percentages represent your consitutients' sons and daughters -- constituents who could benefit by your cosponsoring **H.R. 3042 -- The Dropout Prevention and Reentry Act.**

• • • AVERAGE DROPOUT RATES IN THE U.S. • • •

(NATIONAL AVERAGE -- 29.1%)

	%	RANK
ALABAMA	37.9	3
ALASKA	25.3	26T
ARIZONA	35.4	10T
ARKANSAS	24.8	29T
CALIFORNIA	36.8	7
COLORADO	24.6	30
CONNECTICUT	20.9	40
DELAWARE	28.9	17
DIST. OF COLUMBIA	44.8	1
FLORIDA	37.8	4T
GEORGIA	36.9	6
HAWAII	26.8	21
IDAHO	24.2	31
ILLINOIS	25.5	24
INDIANA	23.0	34
IOWA	14.0	47
KANSAS	18.3	42
KENTUCKY	31.6	12
LOUISIANA	43.3	2
MAINE	22.8	36T
MARYLAND	22.2	38
MASSACHUSETTS	25.7	23
MICHIGAN	27.8	18
MINNESOTA	10.7	51
MISSISSIPPI	37.6	5
MISSOURI	23.8	33
MONTANA	17.9	43
NEBRASKA	13.7	49T
NEVADA	33.5	11
NEW HAMPSHIRE	24.8	29T
NEW JERSEY	12.3	37
NEW MEXICO	29.0	16
NEW YORK	37.8	4T
NORTH CAROLINA	30.7	14
NORTH DAKOTA	13.7	49T
OHIO	20.0	41
OKLAHOMA	26.9	20T
OREGON	26.1	22
PENNSYLVANIA	22.8	36T
RHODE ISLAND	31.3	13
SOUTH CAROLINA	35.5	8
SOUTH DAKOTA	14.5	46
TENNESSEE	29.5	15
TEXAS	35.4	10T
UTAH	21.3	39
VERMONT	16.9	44
VIRGINIA	25.3	26T
WASHINGTON	24.9	27
WEST VIRGINIA	26.9	20T
WISCONSIN	15.5	45
WYOMING	24.0	32

* T = Tie

SOURCE - U.S. DEPARTMENT OF EDUCATION
OFFICE OF PLANNING
BUDGET & EVALUATION PLANNING & EVALUATION SERVICE
FEBRUARY 1986

OVER

• • • SUMMARY • • •

•PURPOSE: To reduce the number of children who do not complete their elementary and secondary education.

•AUTHORIZATION: Authorizes $50 million in grants to a cross-section of school districts to demonstrate promising approaches to dropout identification and prevention, as well as methods for assisting dropouts to reenter school and complete their education.

•NATIONAL SCHOOL DROPOUT STUDY: Directs the Secretary of Education to conduct a national study during FY86 which will define the nature and extent of the nation's dropout problem, including factors contributing to children dropping out of school, as well as requires the development of a standard definition of a "dropout," and model management information system procedures which can be used at the local level to assist in focusing appropriate services upon dropouts and children at risk of dropping out of school.

•GRANT-MAKING PROCESS: School districts will be awarded demonstration grants through a procedure in which only school districts of similar size will compete. A priority will be extended to those school districts with the most significant dropout problems, which are proposing promising approaches for addressing such problems.

•DROPOUT PREVENTION PROJECTS: Projects will consist of school and community-based identification, prevention, outreach, and reentry activities designed by the school districts to address local school dropout problems, thus providing the foundation of effective dropout prevention strategies which school districts can build upon in overcoming this serious national problem.

• • • COSPONSORS • • •

(66 AS OF 4/30)

Gary L. Ackerman; Jim Bates; Helen Delich Bentley; Howard J. Berman; Mario Biaggi; William Hill Boner; Barbara Boxer; Sala Burton; William L. Clay; Cardiss Collins; John Conyers; William J. Coyne; Geroge Crockett; Ronald V. Dellums; Ron deLugo; Julian C. Dixon; Brian J. Donnelly; Thomas J. Downey; Mervyn Dymally; Bob Edgar; Don Edwards; Walter E. Fauntroy; James J. Florio; Harold E. Ford; William D. Ford; Barney Frank; Jaime B. Fuster; Benjamin A. Gilman; Henry B. Gonzalez; William H. Gray; Frank J. Guarini; Augustus F. Hawkins; Frank Horton; Marcy Kaptur; Dale E. Kildee; John J. LaFalce; William Lehman (FL); Mickey Leland; Sander Y. Levin; Thomas J. Manton; Edward J. Markey; Matthew G. Martinez; Robert T. Matsui; Norman Y. Mineta; Parren J. Mitchell; Joe Moakley; Bruce A. Morrison; Robert J. Mrazek; Major R. Owens; Claude Pepper; Carl C. Perkins; Nick Joe Rahall, II; Charles B. Rangel; Bill Richardson; Buddy Roemer; Gus Savage; James H. Scheuer; John F. Seiberling; Louis Stokes; Esteban E. Torres; Edolphus Towns; Ted Weiss; Alan Wheat; Pat Williams; Jim Valentine; Bruce Vento.

If you have any questions or wish to cosponsor H.R. 3042, please contact S. Howard Woodson of my staff at ext. 54372.

Cordially,

Charles A. Hayes

CHARLES A. HAYES
Member of Congress

Development of Women & Minority Faculty Members-- How Are We Doing?

Discussion Leader: Kenneth I. Shine, M.D.
Dean
UCLA School of Medicine

Women:

The number of women enrolled in American medical schools has risen progressively over the past twenty-five years from approximately 10 percent in 1961-1968 to over 34 percent in 1987. Moreover, the percentage of women graduates seeking academic careers has been consistently higher than the percentage of male graduates entering such positions (Table 1). The number of women on medical school faculties remains relatively low. In 1987, 10,840 women made up 18.7 percent of the total faculty. Of these, 50.4 percent held the M.D. degree; 31.3 percent were Ph.D.s; 2.4 percent were M.D./Ph.D.s, and the balance held other degrees. This phenomenon is likely to change as the impact of the increased number of women graduates affects the recruiting pool. However, some other trends with regard to the development of women faculty bear consideration. These trends include the relatively smaller percentage of women reaching professiorial rank in comparison to males beginning at the same time of graduation, and the tendency for having a relatively larger percentage of women in non-tenured track series. For example, AAMC data on distribution of M.D. faculty first appointed in 1976 reveals 11.6 percent of males at the professorial level compared to 3.3 percent of women (Table 2). Conversely, 12.1 percent of males were assistant professors while 22.5 percent of females were assistant professors. Additional AAMC data shows that 25.1 percent of males are either tenured or in a tenured track series, with only 19.4 percent of women in such series (Table 3). Of this group, 16.6 percent of males who graduated in 1976 had been tenured compared to 11.5 percent of females.

The frequency of promotion to full professor might suggest that child-bearing prolongs the time until women reach this level. However, no data is available to support this assumption. There may be additional factors which determine that women are less likely to be traditional tenured track physicians. It would be of interest for individual institutions to analyze the distribution and career advancement of women within the faculty. Within our institution, faculty members have identified a number of explicit problems which they face.

Most important has been the relative paucity of successful women role models to emulate. Moreover, they feel the absence of career mentors more keenly than male members of the faculty. This is particularly important in regard to advice about career advancement. As a consequence, the women in one of our clinical departments organized a series of Sunday afternoon meetings in which they discussed issues with the Vice Chancellor for Academic Affairs, Department Chairs, Division Chiefs and others, as well as exchanging information among themselves.

The women were concerned about their ability to accummulate a significantly convincing record of time for tenure review under circumstances when time for child bearing had to be taken. Recently, the University of California has indicated that an additional 12 months would be allowed before tenure reviews for a parent providing primary care for newborn children (whether the parent is male of female).

Recruiting of women for key leadership positions is difficult not only because of limited pool size but also because of the lack of adequate networking with regard to female candidates. As a matter of policy, we appoint at least one woman to every search committee for a position at the level of Division Chief or higher and to search committees for tenure track positions. Often, this means that women may not have expertise in the particular discipline for which the search is being conducted (for lack of women in that discipline). However, most of our women faculty members have felt the experience to be remarkably rewarding. It has allowed them to understand how search processes operate, and has led to greater networking to find women candidates. The presence of women on a search committee has had a salutory effect upon the male members before the candidacy of a particular woman is decided.

Questions the Deans may want to consider include:

- Is it worthwhile to do a survey of the status of women within your medical school?
- Are women primarily in non-tenure track positions because of job preference, schedule flexibility or systematic biases which could be addressed?
- Is the system for career development of women satisfactory, with special attention to mentoring, maternity leave, the tenure clock, participation in recruiting, day care, etc.?

Minorities:

The situation for minority faculty members is substantially different from that of women. The percentage of minorities within medical school classes remains low, although there are differences. For example: the percentage of blacks in medical school classes appears to have plateaued; whereas Mexican-Americans may be still increasing. While the numbers are small, the number of American Indian graduates may also be increasing. In contrast to women, AAMC data reveal that the percentage of blacks and Mexican-Americans obtaining faculty positions is substantially less than that of other graduates by as much as two to five to one (Table 4).

In comparison to white graduates of the class of 1976, the number of Asians, blacks, Mexican-Americans and other Hispanics who have reached professorial levels is significantly less (Table 5). The number of ethnic minorities in tenure track positions also varies among ethnic minorities. For the class of 1976, the percentage of blacks, Puerto Ricans, and whites are comparable although the percentage of Asians is somewhat less (Table 6). The data do not allow identification of the

proportion of black faculty members who are in black medical schools as opposed to schools which are not traditionally black.

The pool size for recruiting faculty from ethnic minorities depends critically on representation in medical school classes, which has been addressed in another session of this meeting. However, we may wish to address issues of faculty development for the precious few faculty who are involved:

- Of particular importance is the difficulty with mentoring and the possibility that economic pressures are particularly important in determining career choices. Certain ethnic minorities are under unusual pressure to produce maximum incomes in order to support the rest of their family. Should this be specifically addressed?

- Are current foundation programs of minority faculty development adequate?

- Are there additional initiatives which should be taken by government foundations or medical schools to foster their development?

Table 1

DISTRIBUTION OF MD FACULTY
BY SEX AND YEAR OF U.S. MEDICAL SCHOOL GRADUATION

Yr. of U.S. Med.School Graduation	MALE Number of Graduates	MALE Number of Faculty	MALE Percentage of Graduates	FEMALE Number of Graduates	FEMALE Number of Faculty	FEMALE Percentage of Graduates
1985	11414	6	.01	4904	3	.01
1984	11711	97	.08	4632	32	.07
1983	11570	249	2.15	4232	116	2.74
1982	11994	438	3.65	3991	193	4.84
1981	11775	713	6.06	3898	287	7.36
1980	11638	792	6.81	3497	332	9.49
1979	11521	1033	8.97	3445	384	11.15
1978	11306	1125	9.95	3085	373	12.09
1977	11001	1181	10.74	2613	354	13.55
1976	11422	1233	10.80	2212	298	13.47
1975	11010	1175	10.67	1706	246	14.42
1974	10101	1085	10.74	1264	195	15.43
1973	9462	1070	11.31	934	143	15.31
1972	8697	989	10.37	861	129	14.98
1971	8147	831	10.20	827	134	16.20
1970	7667	795	10.37	700	111	15.86
1969	7452	809	10.86	607	88	14.50
1968	7332	712	9.71	641	85	13.26
1967	7160	702	9.80	583	88	15.09
1966	7050	678	9.62	524	83	15.84
1965	6906	678	9.82	503	75	14.91
1964	6887	599	8.69	449	65	14.48
1963	6860	651	9.49	405	51	12.59
1962	6777	700	10.33	391	56	14.32
1961	6640	637	9.59	354	49	13.84

Source: AAMC Faculty Roster System

Table 2

CURRENT RANK DISTRIBUTION OF MD FACULTY
FIRST APPOINTED IN 1976 BY SEX

	MALE		FEMALE	
RANK	Number	Percent	Number	Percent
Professor	303	11.6	13	3.3
Assoc. Prof.	630	24.1	88	22.5
Asst. Prof.	316	12.1	88	22.5
Instructor	33	1.3	10	2.6
Other	9	.3	3	.8
No Longer on Faculty	1322	50.6	189	48.3
TOTAL	2613	100.0	391	100.0

Source: AAMC Faculty Roster System

Table 3

CURRENT TENURE DISTRIBUTION OF MD FACULTY
FIRST APPOINTED IN 1976 BY SEX

	MALE		FEMALE	
TENURE STATUS	Number	Percent	Number	Percent
Tenured	434	16.6	45	11.5
On Track	221	8.5	31	7.9
Not on Track	403	15.4	85	21.7
Not Available	94	3.6	9	2.3
Unknown	139	5.3	32	8.2
No Longer on Faculty	1322	50.6	189	48.3
TOTAL	2613	100.0	391	100.0

Source: AAMC Faculty Roster System

Table 4

ETHNICITY OF MD FACULTY
BY YEAR OF U.S. MEDICAL SCHOOL GRADUATION

Year of U.S. Medical School Graduation	BLACK			AMERICAN INDIAN			MEXICAN AMERICAN			PUERTO RICAN*			ALL OTHERS		
	# of Grds.	# of Fac.	% of Grds.	# of Grds.	# of Fac.	% of Grds.	# of Grds.	# of Fac.	% of Grds.	# of Grds.	# of Fac.	% of Grds.	# of Grds.	# of Fac.	% of Grds.
1985	828	-	-	65	-	-	242	-	-	89	-	-	15094	9	.01
1984	818	2	.02	59	-	-	220	4	1.82	94	1	1.06	15152	22	.08
1983	883	8	.09	45	-	-	228	4	1.75	75	2	2.67	14571	351	2.41
1982	763	18	2.36	45	-	-	225	4	1.78	74	2	2.70	14878	605	4.07
1981	766	30	3.92	43	1	2.33	201	6	2.99	76	6	7.89	14587	951	6.52
1980	768	41	5.34	33	-	-	192	5	2.60	73	9	12.33	14069	1054	7.49
1979	760	45	5.92	49	2	4.08	191	5	2.62	62	-	-	13094	1351	10.32
1978	791	34	4.30	46	2	4.35	166	3	1.81	62	5	8.06	13326	1444	10.84
1977	752	48	6.38	29	1	3.45	146	9	6.16	38	-	-	12649	1467	11.60
1976	743	44	5.92	31	-	-	130	2	1.54	29	1	3.45	12701	1473	11.60
1975	638	38	5.96	22	3	13.64	110	8	7.27	28	4	14.29	11918	1359	11.40
1974	511	42	8.22	3	-	-	80	5	6.25	17	-	-	10754	1228	11.42
1973	340	34	10.00	8	2	25.00	40	1	2.50	9	-	-	9999	1172	11.72
1972	229	29	12.66	2	-	-	19	-	-	14	-	-	9294	1091	11.73

* Student counts include only those who identified themselves as Mainland Puerto Ricans; faculty counts exclude individuals appointed to schools in Puerto Rico.

Source: AAMC Faculty Roster System

Table 5

CURRENT RANK DISTRIBUTION OF MD FACULTY
FIRST APPOINTED IN 1976 BY ETHNICITY

RANK	AMER. INDIAN		ASIAN		BLACK		MEXICAN AMER.		PUERTO RICAN		OTHER HISP.		WHITE		REFUSED/MISS.	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Professor	-	-	13	3.8	2	4.4	-	-	-	-	3	5.3	289	12.5	9	4.5
Assoc. Prof.	-	-	64	18.5	12	26.7	1	14.3	16	61.5	16	28.1	572	24.7	38	18.8
Asst. Prof.	-	-	62	17.9	8	17.8	3	42.9	4	15.4	10	17.5	304	13.1	13	6.4
Instructor	-	-	9	2.6	1	2.2	-	-	-	-	1	1.8	27	1.2	5	2.5
Other	-	-	1	.3	-	-	-	-	-	-	-	-	11	.5	-	-
No Longer on Faculty	2	100.0	197	56.9	22	48.9	3	42.9	6	23.1	27	47.4	1116	48.1	137	67.8
TOTAL	2	100.0	346	100.0	45	100.0	7	100.0	26	100.0	57	100.0	2319	100.0	202	100.0

Source: AAMC Faculty Roster System

Table 6

CURRENT TENURE DISTRIBUTION OF MD FACULTY
FIRST APPOINTED IN 1976 BY ETHNICITY

TENURE STATUS	AMER. INDIAN		ASIAN		BLACK		MEXICAN AMER.		PUERTO RICAN		OTHER HISP.		WHITE		REFUSED/MISS.	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Tenured	-	-	33	9.5	4	8.9	-	-	9	34.6	8	14.0	412	17.8	13	6.4
On Track	-	-	24	6.9	8	17.8	1	14.3	6	23.1	4	7.0	199	8.6	10	5.0
Not on Track	-	-	64	18.5	7	15.6	3	42.9	3	11.5	11	19.3	370	16.0	30	14.9
Not Available	-	-	7	2.0	1	2.2	-	-	1	3.9	3	5.3	90	3.9	1	.5
Unknown	-	-	21	6.1	3	6.7	-	-	1	3.9	3	5.3	132	5.7	11	5.5
No Longer on Faculty	2	100.0	197	56.9	22	48.9	3	42.9	6	23.1	27	47.4	1116	48.1	137	67.8
TOTAL	2	100.0	346	100.0	45	100.0	7	100.0	26	100.0	57	100.0	2319	100.0	202	100.0

Source: AAMC Faculty Roster System

Graduate Medical Education: How Should It Be Supported in the Future?

Discussion Leader: Jay P. Sanford, M.D.
President and Dean
Uniformed Services University
of the Health Sciences

In 1986, the AAMC published a committee report entitled Financing Graduate Medical Education. The committee recommendation's are set forth in the Executive Summary. Discussion will focus on whether these recommendations remain tenable in the face of changes occurring in the health care system and graduate medical education.

Within the past few years, there have been significant changes in the methods of paying for hospital care. Since graduate medical education takes place primarily in teaching hospitals and adds to the cost of operating the hospital, changes in the hospital payment methods have raised the concern that teaching hospitals may no longer be able to sustain their current support of graduate medical education. Additionally, there has been extensive growth in the proportion of care being delivered by health maintenance organizations and in ambulatory care settings, but there are no clear sources of funding that will enable educators to train physicians for practice in these settings. Concern over these changes and what they portend for the future of graduate medical education prompted the appointment of a Committee on Financing Graduate Medical Education.

The first major issue identified by the Committee was the advisibility of creating a separate societal fund for financing graduate medical education. This fund would eliminate the current reliance on teaching hospital payments from insurers and governmental programs to pay for residency and fellowship training; however, it would force graduate medical education to be totally dependent on the funding policies established by this single source of support. After considerable discussion of the benefits and inherent disadvantages of each of these potential positions, the Committee concluded that price competition and other changes in hospital payment are likely to reduce the amount of support teaching hospitals can provide for graduate medical education; however, the full effects of the current environment on teaching hospitals' ability to support graduate medical education are unknown, but do not appear to warrant acceptance of the disadvantages of a single national fund. Instead, the Committee recommends:

(1.) TEACHING HOSPITAL REVENUES FROM PATIENT CARE PAYERS SHOULD CONTINUE TO BE THE PRINCIPAL SOURCE OF SUPPORT FOR GRADUATE MEDICAL EDUCATION, BUT MODIFICATIONS SHOULD BE MADE IN WHAT THEY ARE EXPECTED TO FUND.

(2.) ALL HEALTH CARE PAYERS, INCLUDING MEDICARE, SHOULD CONTINUE TO PROVIDE THEIR APPROPRIATE SHARE OF SUPPORT FOR GRADUATE MEDICAL EDUCATION. MEDICARE MAY BE A KEYSTONE IN ASSURING THIS SUPPORT SINCE MEDICARE POLICIES ARE DETERMINED BY CONGRESS AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, BODIES WHICH ARE SUPPOSED TO GUARD THE PUBLIC INTEREST.

(3.) IN ADDITION TO PATIENT CARE PAYERS, OTHER SOURCES CURRENTLY PROVIDING FUNDS FOR HEALTH CARE TRAINING NEED TO CONTINUE TO PARTICIPATE IN FUNDING RESIDENCY TRAINING, OR, IN FACT, MAY BE CALLED UPON TO PROVIDE GREATER SUPPORT IN THE FUTURE. THESE OTHER SOURCES INCLUDE STATE AND LOCAL GOVERNMENTS, SPECIAL PURPOSE FEDERAL GOVERNMENT PROGRAMS, AND PRIVATE ORGANIZATIONS THAT PROVIDE SUPPORT TO MEET SPECIFIC NEEDS.

In return for continued broad-based societal support the Committee recommends that medical educators must recognize their responsibilities to fulfill society's expectations for the training of highly qualified and skilled practitioners. The Committee believes:

(4.) THE MEDICAL EDUCATION COMMUNITY SHOULD CONTINUE TO MONITOR THE QUALITY OF ITS RESIDENCY TRAINING AND PROVIDE ASSURANCES THAT GRADUATES OF ITS RESIDENCY PROGRAMS ARE ADEQUATELY PREPARED FOR PRACTICE.

(5.) THE INSTITUTIONS RECEIVING FUNDING SHOULD RECOGNIZE THEIR OBLIGATIONS TO TRAIN THE TYPES OF PHYSICIANS NEEDED BY SOCIETY.

(6.) THESE INSTITUTIONS ALSO MUST RECOGNIZE THEIR OBLIGATION TO OPERATE THE TRAINING PROGRAMS IN A COST-EFFECTIVE MANNER.

To elaborate on the changes envisioned in its first recommendation, the Committee deliberated on a variety of issues such as the length of training for which broad-based societal support might be expected, the types of trainees and programs to be funded primarily through teaching hospital revenues, and the appropriate means by which to influence the specialty choice of residents. The Committee recommends the following principles in determining the programs and residents to be supported:

(7.) FUNDING FOR GRADUATE MEDICAL EDUCATION SHOULD BE LIMITED TO GRADUATES OF MEDICAL SCHOOLS APPROVED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION OR THE AMERICAN OSTEOPATHIC ASSOCIATION.

(8.) ONLY RESIDENTS IN PROGRAMS APPROVED BY THE ACCREDITATION COUNCIL ON GRADUATE MEDICAL EDUCATION OR THE AMERICAN OSTEOPATHIC ASSOCIATION'S COMMITTEE ON POSTDOCTORAL TRAINING SHOULD BE FUNDED.

(9.) THE ACGME AND THE AOA SHOULD ACCREDIT PROGRAMS SOLELY ON THE BASIS OF WHETHER THE PROGRAMS MEET THE EDUCATIONAL CRITERIA ESTABLISHED.

(10.) FUNDED TRAINING OPPORTUNITIES IN RESIDENCY PROGRAMS SHOULD BE SUFFICIENT TO ENABLE ALL GRADUATES OF LCME OR AOA APPROVED SCHOOLS OF MEDICINE TO ENROLL IN AN ACGME OR AOA APPROVED RESIDENCY TRAINING PROGRAM.

The Committee believes limits should be placed on the length of training for which teaching hospitals are expected to provide a major source of support. However, it believes that in all instances, residents should be supported in their training at least until they are capable of the independent practice of medicine. The Committee believes that this level of competence is attained when the residents have completed sufficient training to be eligible to sit for their initial specialty board. Therefore, the Committee recommends:

(11.) RESIDENTS IN APPROVED TRAINING PROGRAMS SHOULD BE FUNDED LARGELY BY PAYMENTS TO TEACHING HOSPITALS BY PATIENT CARE PAYERS AT LEAST THROUGH THE NUMBER OF YEARS REQUIRED TO ACHIEVE INITIAL BOARD ELIGIBILITY IN THEIR CHOSEN DISCIPLINE.

(12.) ONE ADDITIONAL YEAR OF FUNDING BEYOND INITIAL BOARD ELIGIBILITY SHOULD BE PROVIDED FROM TEACHING HOSPITAL REVENUES FOR FELLOWS IN ACCREDITED TRAINING PROGRAMS TO THE EXTENT THAT THE HOSPITAL FUNDED SUCH TRAINING IN 1984.

(13.) AN INDIVIDUAL SHOULD BE SUPPORTED FROM PATIENT CARE PAYERS' PAYMENTS TO TEACHING HOSPITALS FOR A MAXIMUM OF SIX YEARS OF GRADUATE MEDICAL EDUCATION.

Other sources of funding must be found to support the advanced training of subspecialists and other trainees seeking advanced educational opportunities. The Committee recommends:

(14.) BEYOND THE FIRST YEAR OF FELLOWSHIP TRAINING, CLINICAL TRAINING FOR FELLOWS SHOULD INCREASINGLY BE SUPPORTED BY GOVERNMENT OR CORPORATE GRANTS, PHYSICIAN PRACTICE INCOME, PRIVATE PHILANTHROPY, AND OTHER SOURCES.

In adopting this series of recommendations, the Committee was aware that some specialty boards are considering, or in the future may consider, extensions of the length of training required to achieve board eligibility. The Committee believes that the training requirements set forth in the "Essentials of Accredited Residency Training" as published in the 1985-1986 *Directory of Residency Training Programs* should form a baseline. Any increase over this baseline deemed necessary by the special-

ty boards would be made only after full deliberation and public consideration of the educational needs and additional costs. In 1984, the president of the AAMC wrote to the executive vice president of the American Board of Medical Specialties (ABMS) stating in part:

> "The AAMC believes that the time has come when the ABMS must extend its role beyond simply coordinating the activities of its members and assume the power to approve or reject changes that are proposed in educational requirements. We believe that this is essential to avoid conflicts among member boards and between boards and the institutions and organizations that provide the resources for graduate medical education in the United States."

At the time the issue was raised by the AAMC, the ABMS discussed and tabled the AAMC's recommended change. The Committee believes it is time for the issue to be reconsidered.

The Committee believes that it is appropriate for students entering residency training and for the educators providing the training to be aware of the number of physicians practicing in each of the medical specialty areas. Such knowledge may influence students to pursue specialties in which there are shortages of physicians. The Committee was concerned that this data collection and dissemination should be performed by private organizations. Therefore, it recommends:

(15.) A COORDINATED, NATIONWIDE, PRIVATE SECTOR EFFORT SHOULD BE MADE TO COLLECT AND DISSEMINATE INFORMATION ON THE SUPPLY OF PHYSICIANS BY SPECIALTY.

The Committee was concerned that opportunities should be found to educate trainees in ambulatory care sites and other, non-hospital based settings. It recommends:

(16.) THE FUNDING FOR GRADUATE MEDICAL EDUCATION MUST SUPPORT THE RESIDENTS AND PROGRAMS IN THE AMBULATORY AND INPATIENT TRAINING SITES THAT ARE MOST APPROPRIATE FOR THE EDUCATIONAL NEEDS OF THE TRAINEES.

The Committee reviewed support received from the Veteran's Administration, the Department of Defense, and other health care service providers not typically receiving fees for services rendered. The Committee believes these other sources of support are vital to the current structure of medical education. In addition, the Veteran's Administration, the Department of Defense and some of the other providers care for an unusual group of patients who offer unique training opportunities which are needed for the training of a full spectrum of specialists. Thus, the Committee recommends:

(17.) THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF DEFENSE SHOULD CONTINUE THEIR SUPPORT OF RESIDENCY TRAINING, PARTICULARLY PROVIDING SUPPORT FOR THE EDUCATION OF PHYSICIANS TO MEET THE SPECIAL SERVICE NEEDS OF VETERANS AND ARMED FORCES PERSONNEL.

(18.) OTHER PROVIDERS OF SERVICE THAT ARE NOT TYPICALLY AMONG THOSE RECEIVING DIRECT PAYMENT FOR SERVICES RENDERED TO INDIVIDUAL PATIENTS SHOULD CONTINUE THEIR SUPPORT OF GRADUATE MEDICAL EDUCATION, PARTICULARLY FOR THOSE SPECIALTIES NEEDED FOR THEIR UNIQUE PATIENT POPULATIONS.

International Medical Education: What are the U.S. Roles and Responsibilities?

Discussion Leader: David S. Greer, M.D.
Dean
Brown University Program in Medicine

Despite remarkable progress in the medical sciences in recent decades, the burden of disease on the planet remains substantial. Although there are regional differences in health problems, many of the issues and challenges are global. Further, widening disparities in health and nutritional status between the developed and developing nations are among the most destablizing political influences in our latter twentieth century world.

Among the developed nations, the United States has been conspicuous in its meagre contribution to international medical education, especially when compared to the socialist-bloc nations. Recently, there has been increasing awareness in both the public and professional sectors of the U.S. that an important moral obligation is being neglected and a political opportunity as well. Interest in international health has been increasing once again among medical students and faculty, and a new organization has been spawned by the AAMC and five other national medical organizations, the International Medical Scholars Program.

"International medicine" encompasses a broad range of topics, disciplines and needs. Scientific and technological exchange between medical centers in developed nations is one aspect of the field. Tertiary level training and technology transfer from developed to developing nations is also important. But the most neglected area, and paradoxically the approach with the greatest potential impact on population health status, is collaboration on the primary care, public health and community medicine levels between developed and developing nations; it is here that we and our colleagues in the Third World have the most to learn from each other for the benefit of our patients and our populations.

In this session we will review current American activity in international medical education and seek opportunities for expansion of our national commitment to the field.

The International Medical Scholars Program

The development of the International Medical Scholars Program (IMSP) was stimulated by an Accreditation Council for Graduate Medical Education task force that was asked to examine how U.S. international educational obligations might be better fulfilled. There was concern

that too often foreign physicians are turning to specialist-bloc countries for education because of the increasingly vigorous barriers to reentry into the U.S.

The IMSP is sponsored by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the Educational Commission for Foreign Medical Graduates. There is a fifteen member board of directors for the program which is chartered as a not-for-profit corporation in the state of Illinois. The ECFMG will serve as the operating agency under a contractual agreement with the IMSP. The fundamental purpose of the program is to arrange opportunities in U.S. institutions for foreign physicians who are sponsored by public or private agencies in their countries. The concept is that the arrangements will fulfill the educational needs of the visitors as agreed to by their sponsors.

Funding for organizational and policy making purposes is being provided by the sponsoring organizations. Eventually, funding to support visitors and pay for their education will have to come from multiple sources. The first meeting of the board of directors was held in February 1988.

EDITORIAL

International Medical Scholars Program

The International Medical Scholars Program (IMSP), which is just getting underway, is the first nationally coordinated effort to provide planned educational opportunities in the United States for physicians from other countries. The program has been in the planning stage for over two years. It is sponsored by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. The Educational Commission for Foreign Medical Graduates (ECFMG) will serve as the secretariat, providing staff support to the program's 15-member board of directors.

The purpose of the IMSP (as stated in the bylaws) is to promote educational opportunities in the United States for foreign physicians to prepare them for positions of leadership in medicine in their home countries. The function of the program will be to place foreign physicians who are sponsored by an agency in their country in educational programs suited to their needs as defined by them and their sponsors. This is quite different from the function of the ECFMG certification program, which only certifies that a candidate has acceptable credentials and is deemed eligible to enter an accredited residency program in the United States.

The sponsors of the IMSP also intend that the program will raise funds for both operations and for the support of IMSP scholars. The ECFMG has already committed $100,000, and continuing support in the range of $20,000 per year is expected from each of the five sponsors. Funding will also be sought from multiple sources, including foundations, the government, and international corporations. The amount and the sources of funding will be critical if the program is to achieve its purpose. Simply placing foreign physicians in unfilled residency positions will not accomplish the program goals or fulfill the obligations of this country to provide medical education resources to the rest of the world.

The major challenge to the program's newly appointed board is to identify and nurture the development of educational opportunities for physicians who will provide health care to the general citizenry of third-world countries. Most of these countries need improved services in public health and primary care rather than high-technology medicine. Physicians from developed countries who are seeking special training in advanced high-technology areas will also be served by the program, but there must be a balanced opportunity for the education of physicians across the full spectrum of medicine and public health.

In the 1960s and early 1970s, the United States was criticized for recruiting foreign physicians to meet its manpower needs. More recently, we have been accused of throwing up barriers to entry into graduate medical education and preventing foreign physicians from immigrating. The IMSP provides an opportunity to establish a positive role for the United States in international medical education. Imaginative leadership and multilateral support will be needed if its purpose is to be achieved.

AUGUST G. SWANSON, M.D., *vice president for academic affairs, Association of American Medical Colleges, Washington, D.C.*

(From the Journal of Medical Education, Volume 63, No. 2, February, 1988)

Continuing Medical Education: Who is responsible for its quality and effectiveness?

Discussion Leader: Donald G. Kassebaum, M.D.
Executive Dean
The University of Oklahoma College of Medicine

Medical schools have tended to limit their role in continuing medical education (CME). It doesn't make money (in fact it is likely to lose money). The academic establishment values research and clinical practice as more important to departmental and personal goals. Community hospitals have assumed increasing roles, for quality assurance, risk management and marketing. And there has been reluctance to compete with initiatives of professional societies, medical associations and travel agencies.

In general, medical schools have not employed teaching methods much different from those of other purveyors of CME. Typically, CME is teacher- and lecture-dominated, measured for effectiveness in terms of attendance rather than behavioral outcomes, and based on an imperfect assessment of the needs of physician-learners.

The proportionate emphasis on continuing medical education is discordant with the need for it. Nationally, we devote most of our pedagogical energies to 56,000 medical students engaged in four years of undergraduate education and 75,000 residents in graduate training over three to seven years, while largely ignoring 522,000 physicians practicing over professional lifetimes of forty or more years. There can be little argument about the need for CME, to keep up with the pace of technological change, the acquisition of new knowledge, the need to relearn forgotten concepts, and the pending requirements for re-licensure and re-certification.

The role that individual medical schools desire or need to assume may vary with the local environment, the alternative agencies for CME, and the need to employ CME to build referral lines, service community practitioners, and enhance relationships between town and gown. Isn't it time for academic medical centers to assert a stronger role to increase the quality and effectiveness of CME? Should we foster more innovative and interesting formats, feature more group interaction and problem-solving instead of lectures, more closely target our presentations with the needs of practitioners, and establish and measure the behavioral outcomes?

Medical schools should be able to employ teaching technologies in CME that have proven successful in undergraduate education, such as computer-assisted instruction, interactive video, problem-solving, and teleconferencing via satellite. And as the academic campus evolves its biomedical information systems, it would seem logical to build in capabilities for electronic mail, information-brokering, and access to databases for the physician-learner.

Strengthening the VA--Medical School Relationship

Discussion Leader: John A. Gronvall, M.D.
Chief Medical Director
Veterans Administration

Since the reorganization of the Veterans Administration after World War II, the symbiotic relationship between the Veterans Administration and medical education in the United States has been a major factor in assuring both quality medical care for veterans and quality education for medical students and residents. To ensure that the VA-medical school partnership is maximumly effective requires consistent attention on the part of the leadership of both medical schools and Veterans Administration hospitals. Dr. Gronvall, who was Dean of the University of Michigan School of Medicine for over a decade, will explore how medical school relationships with the VA can be further strengthened.

DATE: March 29, 1988

TO: Executive Staff

FROM: Lou Kettel

SUBJECT: Recommendations and Actions of the COD and COD Admin Bd Spring Meeting, March 20-23, 1988

1. **Task Force on Physician Supply**
   - o Support of the proposed recommendations
   - o Particular support for voluntary class size reduction especially in relation to the quality of the applicant pool (a number of schools have announced reductions for incoming 1988 e.g. Georgetown).
   - o There was no particular objection to opening the NBME Part I and II to FMGs in lieu of FMGEMS.
   - o Questions were asked concerning the status of enrollment in off-shore schools; the output of osteopaths; and the recommedations concerning the residency programs especially the idea of requiring four or more programs in an institution (because of the effect on family practice programs).

2. **Dues increase**
   - o Support, but some `hallway' preference to a.)phasing in the increase and b.)scaling the increase to school size/budget e.g from the Dakatos.

3. **Resident hours and supervision** there was little comment.

4. **November 1 deans' letter**
   - o The majority seemed comfortable with holding to this date.
   - o The COD asked that
     - a. Unembellished transcripts be sent whenever requested
     - b. Copies of all letters to Program directors be sent to deans.
     - c. Beran send a letter to Program Directors explaining what the COD position is.

5. **Minority recruiting**
   - o The recent successes of the lawyers and engineers were noted. The NSF program reaching into grade schools was highlighted. Liz Martin was asked to bring that program to our attention for possible implementation.
   - o A joint meeting with the Minority Affairs Officers and the COD at the Annual Meeting was suggested.
   - o The AAMC new initiatives were applauded.

6. **Faculty development for minorities and women**
   - o Schools should look into the problem of `topping out' of the promotion and tenure system at the associate professor level.
   - o Salary equity should be assured.
   - o Women and minorities should be more involved in P&T and search committees.

7. **VA relationships**
   - o Interest in field consultations by VACO people on local problems.
   - o An AAMC/VA workshop on affiliations, problems and understanding of the system was suggested. Referral to the AAMC/VA Liaison Group was recommended.
   - o There was support for a meeting of VA Directors and COD at the Annual Meeting.
   - o Deans were encouraged to work closely with Service Organizations.

8. **CME**
   - o Support for a Task Force similar to the past GME task force.
   - o Concern about the role of CME in relicensure and recertification.

9. **Funding for GME**
   - o Interest in a scenario of funding loss, but a sanguine approach to keeping the status quo as long as possible.
   - o Jay Sanford's ideas were generally opposed.
   - o There is a mood to make residents students for purposes of deferring loan repayment.

10. **International medical education**
    - o Support for present AAMC efforts.
    - o AAMC was asked to survey schools on what is being done. This has been done, but not tabulated and distributed. It will be finished soon according to Gus.

11. **Other action:**

    A. Joe Keyes was asked to prepare a position paper on the various tax laws affecting students and residents--- their loans, salaries, etc.

    B. Interest in an Annual Meeting presentation on retirement and the `aging of the faculty.'

    C. The value of the Curriculum Directory was questioned. DAA is studying this.

    D. The variation in perks for non-tenure faculty versus tenure-eligible faculty was noted at the new deans' orientation. Is there data on this variation? Should such data be collected?

12. **Future meetings**
    - o Interest in Puerto Rico for a Spring meeting to avoid the `cold weather'.

13. **Nominating Committee** action was reported by Dr. Petersdorf March 24, 1988.

14. A more detailed report of the working group recommendations will be prepared and distributed with the COD business meeting minutes.

HOTEL
INTER•CONTINENTAL
HILTON HEAD

135 SOUTH PORT ROYAL DRIVE • HILTON HEAD ISLAND, SOUTH CAROLINA 29928 • TEL. 681-4000 • TELEX: 805030

June 23, 1986

Ms. Debora Day
Meeting Planner
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES
Suite 200, #1 Dupont Circle N.W.
Washington, DC 20036

Dear Ms. Day:

It was my pleasure speaking with you recently and we, of the Hotel Inter-Continental Hilton Head, look forward to the opportunity of hosting the ASSOCIATION OF AMERICAN MEDICAL COLLEGES.

Enclosed please find our Group Reservation Agreement outlining the arrangements we are presently holding on a tentative basis with regard to your meeting. Should these specifications meet with your approval, please sign and return the enclosed to my attention as soon as possible so that we may block this space on a definite basis.

I await your favorable reply.

Sincerely,

Raymond Nowak
Sales Manager

RN/cit
Enclosure: GRA, FBF

HOTEL
INTER•CONTINENTAL
HILTON HEAD

DEFINITE ☐ TENTATIVE ☒

TODAY'S DATE 6/23/86

FILE NUMBER N

SALES PERSON 6/23/86

FUNCTION BOOKING FORM

ORGANIZATION NAME ASSOCIATION OF AMERICAN MEDICAL COLLEGES
POST AS
CONTACT Ms. Debora Day, Meeting Planner
ADDRESS Suite 200, #1 Dupont Circle N.W CITY Washington
STATE DC ZIP 20036 TELEPHONE 202/828-0400 EXT.
PERSON IN CHARGE

TUESDAY, APRIL 12, 1988

	Reception	60 pax	

WEDNESDAY, APRIL 13, 1988

8:00a - 1:00p	General Session	175 pax	Theater/S
3:00p - 4:00p	Spouse Hosp.	50 pax	
PM	Reception	250 pax	

THURSDAY, APRIL 14, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00P	General Session	175 pax	Theater/S
8:00A - 10:00A	Spouse	50 pax	
11:00A - 1:00P	(12) B/O 15 pp each		

FRIDAY, APRIL 15, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00A	General Session	175 pax	Theater/S
	Lunch	30 pax	
	Luau - Dinner	160 pax	

SATURDAY, APRIL 16, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00P	General Session	175 pax	Theater/S
8:00A - 10:00A	Spouse	50 pax	

ENTERED BY _____ SIGNATURE _____ DATE _____
PLEASE PRINT NAME

INTER•CONTINENTAL HOTELS
GROUP RESERVATION AGREEMENT

FORUM HOTELS

File # N

Date 6/23/86

Thank you for your recent request. We are pleased to reserve the following accommodations at the:

Hotel: HOTEL INTER-CONTINENTAL HILTON HEAD

Address: 135 So. Port Royal Drive at Port Royal Plantation

Hilton Head Island, SC 29928

Name of Group: ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Division: _____ Telephone: 202/828-0400 Telex: _____

Name of Contact: Ms. Debora Day Title: Meeting Planner

Address: Suite 200, #1 Dupont Circle N.W., Washington D.C. 20036

TYPE OF MEETING ☐ ANNUAL ☐ MID-YEAR ☐ BOARD ☒ OTHER (Specify) Council of Dean's Mtg.

GUEST ROOM REQUIREMENTS

Major Arrival Date: Tue - 4/12/88 (day/date/year) **Major Departure Date:** Sun. 4/17/88 (day/date/year)

Maximum Rooms Blocked: 150/ 0 (rooms/suites) **Room Nights:** 550 **Number of People** 300

Day of Week	TUE	WED	THU	FRI	SAT	SUN				
Date	4/12	4/13	4/14	4/15	4/16	4/17				
Single										
Double	50	150	150	150	50	0				
Twin										
Triple										
Suite—1 Bedroom (equals 2 rooms)										
Suite—2 Bedrooms (equals 3 rooms)										
Other										
Total	50	150	150	150	50					

Room Rates: Single: $118 One-Bedroom Suite: _____

Double: $118 Two-Bedroom Suite: _____

Twin: _____ Other: _____

Triple: _____ Other: _____

Complimentary Rooms: 1 comp room per 50 revenue producing rooms utilized

☒ Above rates are confirmed.

☐ Above rates are 19__ rates. Confirmed rates will be available ____ months prior to the major arrival date.

☒ Rates subject to 7% tax 17% service 5.00 porterage.

☐ Other charges: _____

RESERVATION PROCEDURES

☒ Rooming List required by 3/12/88 (date) ☐ Reservation Cards. Number required _____ by _____ (date)

☐ Other _____ ☒ Reservation Cut-Off Date 3/12/88

CATERING/CONFERENCE REQUIREMENTS

☒ Catering/Conference facilities are required.
Details are outlined on the attached Catering/Conference Booking Form.

☐ Catering/Conference facilities not required.

BILLING PROCEDURES

	Master Account	Individual Account		Master Account	Individual Account
Room	X		Service Charge	X	
Tax	X		Incidental Charges		X
Porterage	X		Other		

Comments: _____

Deposit Information: first and last night's deposit required by 1/12/88

Billing Instructions: In the unlikely event of cancellation of your program within a year of the standard commencement date, the Hotel Inter-Continental Hilton Head will assess a one night penalty for each room held. If, however, we are able to replace your program or resell a similar or partial number of rooms, we will refund the one night's penalty or a prorated portion thereof.

ACCEPTANCE

Contained in this agreement are detailed commitments and arrangements to be provided. To enable us to provide maximum service, any requirements beyond these commitments should be indicated by you upon return of the signed copy of this agreement. The conditions shall be considered confirmed upon hotel's receipt of signed copy of this agreement, which is to be received no later than June 30, 1986.

For Organization:

Name: _____

Signature: _____

Title: _____ Date: _____

For Hotel:

Name: RAymond Nowak

Signature: Raymond Nowak

Title: Sales Manager Date: 6/23/86

SUBJECT TO CONDITIONS ON REVERSE SIDE

ORIGINAL-CLIENT SIGN AND RETURN

1. Guest rooms not confirmed by the reservations cut-off date shall revert back to the hotel for general sale. Reservations will continue to be confirmed, subject to space availability.

2. Reservations for groups must be guaranteed in writing on organization's letterhead. Individual reservations may be guaranteed by an approved credit card or one night's deposit. Guaranteed reservations are held for one night only (without occupancy) and not for the entire stay.

3. Rooms may not be available on the day of arrival prior to the hotel's stated check-out time. However, every effort will be made to accommodate early arrivals.

4. Stated deposit requirements shall be paid as outlined on the reverse side.

5. Full payment is due on check-out; or, with approved credit, within 30 days of presentation of invoices.

6. Changes to this agreement must have the written approval of the hotel.

7. Signature by the hotel and client on the reverse side shall constitute acceptance by both parties of the stated arrangements. Inter-Continental Hotels reserve the right to charge a cancellation fee in the event of cancellation by the client.

aamc association of american medical colleges

July 24, 1986

Mr. Raymond Nowak
Sales Manager
Hotel Inter-Continental
Hilton Head
135 South Port Royal Drive
Hilton Head Island, SC 29928

Dear Ray:

Enclosed please find the signed contract for the Association of American Medical Colleges' Council of Deans Meeting, March 19-23, 1988. I have amended the contract in several instances, therefore, please review and let me know if there are any questions. I also have attached an outlay of the 1987 meeting requirements which will be basically identical for 1988 in assisting you in meeting room requirements, catering, etc.

While this is a signed contract the Council of Deans' Administrative Board must approve the choice at its September 10th meeting. I do not anticipate a problem. I will give you a call after the Board meeting to verify the status.

I hope you are enjoying your summer as I know the fall will be an extra busy one with the wedding and all. I look forward to working with you and the staff at Hotel Inter-Continental.

Warm regards.

Sincerely,

Debra B. Day
Department of Institutional
Development

Enclosure

cc: Ron Puglisi, Sales Manager
Mid-Atlantic

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

INTER•CONTINENTAL HOTELS
GROUP RESERVATION REVISION

FORUM HOTELS
WASHS-03

File # N
Date 6/24/86

TENTATIVE REVISION

Hotel: HOTEL INTER-CONTINENTAL HILTON HEAD

Address: 135 So. Port Royal Drive at Port Royal Plantation
Hilton Head Island, SC 29928

Name of Group: ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Division: _____ Telephone: 202/828-0400 Telex: _____

Name of Contact: Ms. Debora Day Title: Meeting Planner

Address: Suite 200, #1 Dupont Circle, N.W., Washington, D.C. 20036

TYPE OF MEETING ☐ ANNUAL ☐ MID-YEAR ☐ BOARD ☒ OTHER (Specify) Council of Dean's Mtg.

GUEST ROOM REQUIREMENTS Sun. 3/19/88

Major Arrival Date: ~~Wed. 3/09/88~~ day/date/year

Wed. 3/23/88

Major Departure Date: ~~Mon. 3/14/88~~ day/date/year

Maximum Rooms Blocked: ~~150~~ / 220* rooms/suites

Room Nights: 500 **Number of People** 300

NEW ROOM BLOCK Tues 3/8

Day of Week	WED	THU	FRI	SAT	SUN	MON				
Date	3/9	3/10	~~3/11~~	3/12	3/13	3/14				
Single										
Double	50	150	150	100	50	0				
Twin										
Triple										
Suite—1 Bedroom (equals 2 rooms)						See below				
Suite—2 Bedrooms (equals 3 rooms)										
Other										
Total	50	150	150	100	50	0				

PREVIOUS ROOM BLOCK Sat. Sun. Mon. Tues. Wed.

Day of Week	~~TUE~~	~~WED~~	~~THU~~	~~FRI~~	~~SAT~~	~~SUN~~				
Date	~~4/12~~	~~4/13~~	~~4/14~~	~~4/15~~	~~4/16~~	~~4/17~~				
Single	3/19	3/20	3/21	3/22	3/23					
Double	50	150	150	150	~~50~~ 25	0				
Twin										
Triple										
Suite—1 Bedroom (equals 2 rooms)										
Suite—2 Bedrooms (equals 3 rooms)										
Other					25					
Total	50	150	150	150	~~50~~	0				

REASON FOR CHANGE

☐ Tentative, now definite
☐ Increase in room block
☒ Decrease in room block
☐ Confirmed Rates (See Comments)
☐ Change in rates (See Comments)
☐ Change in billing instructions (See Comments)
☒ Change in dates
☐ Cancellation (Provide details below)
☐ Other _____
☐ Other _____

COMMENTS

RATES: $118 single or double - confirmed
COMP: 1 per 50 revenue producing rooms utilized
RESERV: Rooming list required by 2/9/88
DEPOSIT: ~~first and last night's deposit required by 1/12/88~~ By 1/12/88: 10% of 1st nights' revenue. Based on 150 rooms @ $118-/night = $1,700.00.
CXL: 1 year cxl clause
BILLING: Master account established for Room, tax, porterage and service charge, Individual account for incidentals
DECISION DATE: June 30, 1986
AGENDA: Attached (Revised dates)
COMMENT: ~~Original dates were misquoted by sales manager~~
* 20 - jr. executives @ $190 - confirmed
5 - exec. suites @ $250 - confirmed } per R. Nowak 7/11/86

Accepted: 1) Joan Mory
ACCEPTANCE 2) Debora B. Day

CANCELLATION
Reason for Cancellation: sent 7/24/86 / D. Day

Date of Lost Business Report _____

Sales Executive: ~~Raymond Nowak~~ Raymond Nowak

Original—Client Sign and Return

HOTEL
INTER•CONTINENTAL
HILTON HEAD

DEFINITE ☐ TENTATIVE ☒

TODAY'S DATE 6/23/86

FILE NUMBER N

SALES PERSON 6/23/86

FUNCTION BOOKING FORM

ORGANIZATION NAME ASSOCIATION OF AMERICAN MEDICAL COLLEGES

POST AS

CONTACT Ms. Debora Day, Meeting Planner

ADDRESS Suite 200, #1 Dupont Circle N.W CITY Washington

STATE DC ZIP 20036 TELEPHONE 202/828-0400 EXT.

PERSON IN CHARGE

WEDNESDAY, MARCH 9, 1988

	Reception	60 pax	

THURSDAY, MARCH 10, 1988

8:00a - 1:00p	General Session	175 pax	Theater/S
3:00p - 4:00p	Spouse Hosp.	50 pax	
PM	Reception	250 pax	

FRIDAY, MARCH 11, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00P	General Session	175 pax	Theater/S
8:00A - 10:00A	Spouse	50 pax	
11:00A - 1:00P	(12) B/O 15 pp each		

SATURDAY, MARCH 12, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00A	General Session	175 pax	Theater/S
	Lunch	30 pax	
	Luau - Dinner	160 pax	

SUNDAY, MARCH 13, 1988

7:30A - 8:00A	Breakfast	30 pax	
8:00A - 1:00P	General Session	175 pax	Theater/S
8:00A - 10:00A	Spouse	50 pax	

See attached tentative 1988 Agenda Program

ENTERED BY _____ SIGNATURE _____ DATE _____
PLEASE PRINT NAME

aamc association of american medical colleges

May 10, 1988

MEMORANDUM

TO: Dr. Kettel

FROM: Amy

SUBJECT: COD Spring Meeting Billings

When Dr. Butler and I discussed the budget for his two chairman's receptions, we agreed that the AAMC would contribute a total of $2,000 towards the functions (which is actually $500 greater than we have ever contributed in the past). Since Dr. Butler wanted to entertain the entire group of deans **plus** hold the traditional small chairman's reception, he agreed that Baylor would pick up anything over $2,000. We talked about this on several occasions, so he shouldn't be surprised when the bill arrives. His total bill for the receptions was $4,347.24. Subtracting our $2,000 contribution, Baylor owes the AAMC $2,347.24. I think your idea of showing the amount as a balance due is a good one.

I think it is worthwhile to note that the bill for his smaller reception was only $888.10. If you can convince Will Deal to go back to holding a reception for only 25 or 30 people, we can go back to the AAMC gladly picking up the tab!

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400