AGENDA

for the

Council of Deans Business Meeting

November 3, 1972
2:00 pm-5:30 pm, French Room
Fontainebleau Hotel, Miami, Florida

*ACTION ITEMS

PAGE

XIII. New Business

XIV. Adjournment

INFORMATION ITEMS

Association of American Medical Colleges

Minutes
Council of Deans

Friday, February 4, 1972

1:30 pm - 5:00 pm
Palmer House
Chicago, Illinois

I. Call to Order

The Council of Deans Business Meeting was called to order by its Chairman, Dr. Carleton B. Chapman. Attendance was taken by registration at the door; a quorum was determined to be present.

II. Minutes of the Previous Meeting

Minutes of the October 29, 1971 meeting were accepted without change.

III. Chairman's Report

A. COD Spring Meeting - The Spring Meeting will be held at the Arizona Biltmore, Phoenix, Arizona, commencing with a reception and dinner on April 19th and concluding at noon on April 22. The unifying theme selected by the Steering Committee is to be: "The Demands of Our Dual Responsibility: Institutional Freedom and Public Accountability." Business items were deliberately omitted from the session in order to provide a cordial and uncluttered climate for Deans to deal among themselves with Deans' problems.

Dr. Chapman indicated that the dean or the official chief executive officer of the school would be invited to attend and that this invitation was not extended to a substitute. A question was raised from the floor challenging the no substitute rule. The Chairman indicated that it was a rule of the Chair which could by vote be overturned.

After discussion the following motion was made and seconded:

"That either the Dean or his representative be permitted to attend the Phoenix Meeting."

ACTION: The motion was defeated by a roll call vote. No - 55, Yes - 13, Abstain - 2.

B. Business Officers Section - Dr. Chapman reported that the BOS had sought and received COD Administrative Board approval to conduct a series of seminars for the professional development of the BOS members over a two day period prior to the 1972 AAMC Annual Meeting. The Board counselled the BOS to strive to provide a quality program and admonished them to handle the financial arrangements for the program in a manner consistent with AAMC policy. Costs of the program were to be met by charging a registration fee of the participants.

C. The Administrative Boards of the COD-OSR held a joint meeting the previous evening. A number of topics of interest to the students were discussed particularly with a view toward clarifying or developing an AAMC position. These included the selective service regulations, and the effect of foreign house staff on undergraduate medical education programs.

IV. Faculty Representation in the AAMC

Dr. Chapman introduced this topic by referencing the material in the agenda book which provided a history of the debate on the matter of faculty representation. In particular he noted that of the number of options under discussion, the retreat participants had suggested an Organization of Faculty Representatives similar in structure to the Organization of Student Representatives. The Executive Council upon consideration of the matter favorably recommended the proposed "Guidelines for the Organization of Faculty Representatives" to the constituent Councils for consideration.

The discussion which followed addressed the merits of both the general concept of additional faculty participation in the governance of the AAMC on an institutional basis and of the specific proposal forwarded by the Executive Council. After the discussion had proceeded for a while it became apparent that a significant number of the membership were insufficiently familiar with the OFR proposal to take a position on the issue. The following motion was offered, seconded and adopted:

> "That discussion and action on this issue be delayed until such time as all regions have had an opportunity for full discussion of the specific proposal; and further that the delay be no longer than the November meeting of the Council." (The full text of the motion, including the introductory clauses appears as Attachment I to these minutes.)

V. The "Fifth Pathway" for Americans Studying Medicine Abroad

The Council discussed a June 23, 1971 policy statement of the AMA Council on Medical Education which would permit certain U.S. citizens who have studied medicine abroad to enter AMA-approved residencies although not having completed the full requirements for graduation and licensure, if in the alternative, they completed a year of supervised clinical experience in the U.S. under the auspices of an accredited U.S. medical school.

The matter had previously been considered at two regional meetings of the deans. The motions adopted by the Midwest-Great Plains Region and the Southern Region, included in the agenda book, emphasized that the participation by a medical school in such a program is and ought to be a matter within the sole discretion of that school. The Midwest motion, in addition, urged that schools look with "disfavor on involvement in a program where their responsibility for quality education is diluted." The "Fifth Pathway" was viewed as involving such a dilution of responsibility. The AAMC COTRANS mechanism was indicated as a preferable approach to matriculation of students at advanced levels.

The staff recommendation for a COD policy statement with respect to

an appropriate approach to dealing with the increasing numbers of students at foreign schools seeking entry into the mainstream of American medicine was as follows:

> "All U.S. medical schools are urged to pay increased attention to American students in foreign medical schools by being receptive to applications to transfer on advanced standing via COTRANS, which uses Part I of the National Boards as a qualifying screen."

An amended motion reading as follows was made, seconded and adopted.

> "Each U.S. medical school may independently consider applications of students in foreign medical schools to transfer on advance standing via COTRANs which uses Part I of the National Boards as a qualifying screen."

The Council then tabled further consideration of the "Fifth Pathway" issue.*

VI. Policy Statement on Eliminating the Freestanding Internship

After consideration of the background material provided in the agenda book the Council approved the following policy statement referred to it by the Executive Council.

> "The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training."

The statement was referred back to the Executive Council with the recommendation that it be adopted by that body.

VII. The Faculty Roster Survey

Dr. Chapman noted the status report on the Faculty Roster Project appearing in the agenda book at the request of the Council at its previous meeting. He indicated that there remained considerable

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*Attachment II to these minutes summarizes subsequent Executive Council consideration of this issue.

work to do to transform the project into an effort with substantial utility but that this was being vigorously pursued.

VIII. Election of Provisional Institutional Members

Noting that the following schools were eligible for membership in the Association, the Council voted to recommend to the Executive Council their election to Provisional Institutional Membership in the Association of American Medical Colleges:

Southern Illinois University School of Medicine
Mayo Medical School
Texas Tech University School of Medicine
Eastern Virginia Medical School

IX. Admissions Process

Dr. Chapman explained that the morning's joint session with the Council of Academic Societies on Admissions was held in response to the motion passed at the Council's previous meeting urging the establishment of a mechanism to assist the schools in dealing with admissions problems. The session devoted to an airing of some of the issues was viewed as an appropriate first step.

Discussion by the Council disclosed a consensus that the matter should be further pursued. Dr. Chapman pledged to appoint a committee to consider the matter and prepare recommendations for the Council's consideration at the AAMC Annual Meeting in November 1972.

X. New Business

Dr. Tupper reported to COD on meeting of a small group of deans from around the country with Dr. Marston and his top staff. He noted that the meeting was informal and set up by Dr. Crispell. He said that he was encouraged that NIH wanted to talk directly with the Deans. Discussion was mainly focused around the capitation grant system and how it seems to be working.

XI. The meeting was adjourned at 4:00 pm

After a short intermission, the Council reconvened to meet with the Organization of Student Representatives for a discussion of matters of mutual interest.

In that the Assembly of the AAMC has instructed the President and the Executive Council to develop recommendations for changes in the bylaws of the Association in order to make possible the incorporation of faculty representation in the affairs of the Association

In that the retreat of the officers and other selected members of the Association held at Airlie House on December 2-4, 1971, recommended that an Organization of Faculty Representatives structurally equivalent to the Organization of Student Representatives

In that the Executive Council of the AAMC at their meeting on December 17 favorably recommended the proposed "Guidelines for the Organization of Faculty Representatives" to the constituent Councils for consideration

In that since this recommendation only one of the four AAMC regions has been able to discuss the specific proposal

MOVE THAT: Discussion and action on this issue be delayed until such time as all regions have had an opportunity for full discussion of the specific proposal and further that that delay be no longer than the November meeting of the Council.

Motion approved by COD at its February 4, 1972 business meeting.

ATTACHMENT II

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #72-13 March 3, 1972

TO: Council of Deans
FROM: Marjorie P. Wilson, M.D., Director, Department of Institutional Development

SUBJECT: THE "FIFTH PATHWAY" or SPECIAL JUNIOR CLINICAL CLERKSHIPS FOR U.S. CITIZENS STUDYING AT FOREIGN MEDICAL SCHOOLS

Because of its importance, and the attention currently being given to the matter of U.S. citizens studying medicine in foreign medical schools, I thought it would be valuable for each of you to have a description of AAMC Executive Council consideration of the subject.

The Council on Medical Education of the American Medical Association adopted a policy statement on June 23, 1971, which would permit U.S. citizens who have studied medicine abroad to enter AMA-approved internships and residencies even though they have not fulfilled all the requirements for graduation of the institution they are attending and requirements for licensure in the country of their education (ECFMG prerequisite). The stated purpose of this policy is to allow U.S. citizens to escape the necessity of meeting requirements for assigned internship and/or social service in the foreign country.

The political pressure generated by this enlarging group of American citizens who desire ultimately to practice medicine in the U.S.A. is increasing rapidly. At present we know of three states which have made medical licensure available to American foreign medical school graduates without regard to ECFMG procedures. (California, New Jersey, and Connecticut - other states are now considering the matter.)

The Executive Council has considered this matter at two previous meetings, December 16, 1970, and December 17, 1971, and it was considered by the three Councils, COD, CAS, and COTH, February 4, 1972, which duly reported back to the Executive Council. At its February 5, 1972 meeting, the Executive Council reached a consensus on the following points:

1. The provision of such special supervised clinical training for U.S. citizens studying in foreign schools as the suggested special junior clinical clerkship or any other type of training is a matter for individual consideration by the individual school, however,

2. The Executive Council wishes to call attention to the Coordinated Transfer Application System (COTRANS) which is available to assist the medical schools and U.S. students desiring to arrange for transfer with advanced standing in American Medical schools. COTRANS screens the credentials of the student and sponsors him to take Part I, NBME. Last year COTRANS sponsored 580 eligibles, 437 of which actually took Part I, NBME. 115 were accepted for advanced standing transfers through this service in 1971. In 1970, 34 U.S. medical schools participated in COTRANS; this number increased to 46 in 1971. The Executive Council believes this is a valuable service and endorses it as a mechanism the schools may wish to consider utilizing more fully.

3. The "5th pathway" or special junior clinical clerkship does not result in the granting of the M.D. by either the foreign medical school or the U.S. medical school; the Executive Council believes member institutions should look with disfavor on any such approach where their responsibility for quality education may be compromised in any way and should seek mechanisms which provide adequate opportunity for all students to earn an unqualified degree in medicine, and

4. Finally, because of the pressure of the growing number of applicants for the expanding but still limited number of places in medical schools will continue and become more severe and because of a large number of adequately qualified applicants are being left over each year many of whom will enroll in foreign medical schools, the Executive Council requests that the Council of Deans continue to study the matter of U.S. citizens studying medicine in foreign medical schools.

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Association of American Medical Colleges

Minutes

Council of Deans
Spring Meeting

April 19-22, 1972
Arizona Biltmore, Phoenix

"The Demands of Our Dual Responsibility: Institutional Freedom and Public Accountability"

This meeting of the Council involved a change in pace and format from those of the recent past. It consisted of a program devoted to the elaboration of the single theme appearing above in seven sessions during the course of an evening and three mornings. The program was developed by a steering committee chaired by Carleton Chapman, M.D. and consisting of J. Robert Buchanan, M.D., Dean, Cornell Medical School; M. Kenton King, M.D., Dean, Washington University School of Medicine; Clifton Meador, M.D., Dean University of Alabama School of Medicine; Donald N. Medearis, Jr., M.D., Dean, University of Pittsburgh School of Medicine; Sherman M. Mellinkoff, M.D., Dean, The UCLA School of Medicine. The speakers and their topics appear in the program appearing as an attachment to these minutes.

At the concluding sessions of the meeting, the Council passed two motions, the wording of which was subsequently formalized by the Council of Deans Administrative Board at its May 18, 1972 meeting as follows:

1. The Council of Deans recommends that the AAMC undertake a major study of undergraduate and graduate medical education programs, a study which has at its focus the definition of the quality of their product in quantifiable terms. This should include: (A) The development of standards and priorities by which the quality of educational programs may be assessed; and (B) The identification of the relationship between the performance of the physician and his educational experience.

2. The Council of Deans recommends that the AAMC assume a leadership role in bringing together appropriate organizations for the purpose of developing standards and priorities by which the quality of health care services may be assessed, and for the purpose of assessing the appropriate role of academic medical centers in the delivery of health care, especially in relation to any future national health insurance program.

In lieu of an attempt to develop an additional summation of the meeting, the following pages contain an excerpt of the remarks of the speakers at the concluding session which led to the adoption of the motions.

Association of American Medical Colleges
Council of Deans Meeting
Phoenix, Arizona

REMARKS OF JOHN R. EVANS, M.D., D.PHIL.

The Measure of the Response

"How Things Look as of April 22, 1972"

Three priorities stand out in 1972 as matters for urgent action by medical schools individually and collectively.

The number one scientific priority for academic medicine at this time is the development of broadly acceptable, quantitative measures and indicators of the quality of health care. Measures such as death, disability and days off work are too insensitive and perceptions of process of the delivery of health care will not be convincing except to those who are already converted. *It is equally important that similar measures and indicators be developed for the quality of medical education.* The numbers of students graduating from a program is too crude an index; we require quantitative measures which relate to the quality of the graduate, to justify the difference in cost between mediocre and high quality educational programs. Since the outcome of high medical education should be a higher standard of health services delivered by the graduates, it follows that the approach to assessment of the quality of medical education will be dependent at least in part on the development of more sensitive quantitative measures of the quality of health care.

Why are these quantitative measures of the quality of health care and quality of medical education required? Both are vital services in our society but extremely costly and supported primarily by public funds. We require, therefore, a basis for external accountability -- that is justification to public, to government, to the university, and to the other health professions -- of the costs which relate to the quality as well as the quantity of medical educational programs. Our speaker last night put it succinctly, "How do we know they are excellent? Don't ask me to take your word." We also require a form of internal accountability as we respond to change within the constraint of limited resources. If we are to make changes without sacrificing quality, we must have a better base of information about what determines quality of medical education in order to know what we can afford to let go and what we must retain. We need persuasive facts, not persuasive voices if we are to achieve both quality and relevance to changing needs.

The number one administrative priority for academic medicine at this time is the development of administrative approaches and mechanisms which foster the following goals individually for each school and collectively for the system of medical schools:

1. Focus attention on and gain commitment for corporate objectives and overcome the current fragmentation of

loyalties and goals.

2. Facilitate a more rapid and more selective response to the panorama of possibilities for change.

3. Encourage a more rigorous approach to decision-making with effective analysis of alternatives.

4. Provide greater flexibility and capacity for medical schools to interact in relation to specific tasks and for limited periods with various segments of health services in the community, other elements of the community, other educational programs for health personnel and other university disciplines.

The Management Seminars to be sponsored by AAMC may be an important first step in meeting this priority.

The number one health service priority to which academic medicine should contribute is the development of an organizational base for total health services in the community with the following characteristics:

1. It should relate to the full spectrum of health services including primary care and extended care, and should not be confined to active treatment hospitals.

2. It must be visible and accountable to the community and to government for operation of the health services.

3. It should not be directly controlled by but should be contractually articulated with the academic medical centre in order to provide suitable opportunities for education and research.

4. Responsibility for quality control and evaluation of the health service system and for innovations should be assumed by the academic medical centre.

Can the academic health centre afford to become involved with the full spectrum of health services? This should only be a financial problem for the centre if it insists on controlling these services as has been the case with university hospitals. But control by the academic health centre carries with it several perils. First, the services controlled and operated by the centre may become sufficiently different from those of the community system to be irrelevant; experience to date with university hospitals does not allay this fear. Secondly, with the major responsibility for operating health services, the academic health centre could lose

its objectivity, become defensive about criticism and resist change, thereby jeopardizing its innovative role in education and health care research. Finally, the substantial commitment of resources required to control and operate its own health services would limit the scope of involvement of the academic health centre with health care delivery and seriously curtail its capacity to respond to changing needs. Although a strong case can be made for a separately controlled university hospital or a community clinic in special circumstances, there is an equally pressing responsibility for the academic health centre to interact with the broader spectrum of health services without control of these services in order to further the evolution of a balanced system of services and adapt its educational programs to the changing needs predicted for these services.

Basically there needs to be an alternative to the academic medical centre as an organization identified with responsibility for the operation of health services for a community. A Regional or District Health Council might be a suitable agency for this purpose. If education and health services are financed through a single organization, education will probably be the loser in a budget squeeze because the returns are less immediate; communities and governments are more likely to mortgage the future than compromise the present. Furthermore, when the financial basis of programs of health services and education are not separately identified, there is always the temptation that one agency or bureau of government will assume that a shortfall in its appropriations can be met from the other source. The cost of programs of education and health services must be identified separately with convincing clarity to the consumer and paymaster. On the other hand, functional separation of medical education and the system of health services must be avoided or we risk the danger of the academic medical centre becoming sterile and irrelevant.

The economic, political, and social climate make these three priorities for academic medicine matters of real urgency.

CONFERENCE SUMMARY AND CONCLUSION

REMARKS OF
CHARLES SPRAGUE, M.D.
and
SHERMAN MELLINKOFF, M.D.

The Role of the Academic Medical Centers in Health Care Delivery

Charles Sprague, M.D.

We have been told that a national health insurance program will probably be enacted in the Fall of 1973. I think this prospect and the other points made during this meeting make it incumbent to address ourselves to issues larger than our individual institutions.

Now the health care system must change and will continue to change dynamically in the situation from now on and I think medical schools should be involved in the development of the proposed changes and continue to be involved in terms of monitoring, experimenting and making recommendations regarding the qualitative aspects of that system. And I would like to make two particular points: First, that we should be involved and second, that medical schools through the AAMC should assume a leadership role, bringing together this organization and agencies which should play a role in the development of a plan for the national health care delivery system.

Although I have in a sense a clear consensus and particularly listening to John Evans this morning and Merlin DuVal last night, the medical school itself should not assume the primary responsibility for the operational aspects of delivering health care to the large segment of the region it serves. And I submit the following reasons for this impression:

1. The medical school itself is ill equipped for the very large managerial effort required;

2. Every attempt should be made in the future to separate the funding for educational programs and health care delivery services. If both programs are funded through a single entity, for example the medical school, you can be sure that in times of austerity when the dollar shrink comes, then the educational program is going to come out second best. And I think you heard testimony that that in fact has occurred in our neighboring country to the north.

3. The objectives of large scale health services delivery program and the objectives of patient care programs in medical schools are not the same. They complement one another, but it is better that the two types of programs remain separate than combined into a single operation.

4. We enjoy, according to the conversation with Dr. DuVal last night, an excellent image and reputation on the Washington scene but as academic institutions, no credibility as potential leaders in overseeing health services to large segments of our population.

Dr. DuVal likens the medical school to the research and development in industry. We should begin to think more and more of the medical profession as a single profession.

As to the degree in participation of the university schools, clearly no single form will apply. It is dependent on local circumstances, almost certainly there will be a wide variety of specialized health care programs. Although in response, for overseeing the program, the medical school would be committed to a sustained high level of interest and involvement in the quality aspects of the health care delivery system of its region.

In conclusion, it would seem exceedingly important for the Council of Deans today to come to a conclusion at least in principle, then instruct your Administrative Board and the Executive Council to undertake definitive action.

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Sherman Mellinkoff, M.D.

One central idea to this whole meeting is that an educational institution is not the same as the health care delivery system. The fundamental problem of all education is how to interface with society, with social needs. An educational institution is not a factory, it does not have a measurable product in that sense. In that sense I agree that we ought to try to set standards so that we can convey what we are doing to others more readily.

We are victims of a nonsequitur which we ourselves, I think, perpetuate sometimes. It's like this. The health care delivery system or medical delivery system in the United States has very serious shortcomings in it. Therefore, the medical schools ought to do something about that. The dean is caught right in the middle of this. He must be about the job of teaching bright people who are prepared for the future and are prepared to think. If a dean of a medical school is going to be doing that, he cannot at the same time be organizing a health care delivery system as Kaiser has done or the Mayo Clinic has done, and other groups organized for different purposes.

So deans, all of us, are caught between ...at this interface. I don't say that we should not contribute to the development of a better health care delivery system. But we should do it by the creation of new systems, new institutions with which the medical school articulates. In some places that may mean Kaiser, in some places it may be the Mayo Clinic. In some places it may be a separate, new form of organization and it must have a relationship with the medical school, but I do not believe that it should be the medical school. If the medical school becomes the Kaiser organization or something else, it will cease to be a medical school. This, I think, is what Ivan Bennett was driving at when he said that the dean's task

is that of differentiating between needs and demands. I believe it is what Clifford Grobstein meant when he said our problem is not whether we should do something about societal needs, but how.

It does not do any good to belabor the deans for the difficulties and the massive health care problems in the United States.

We ought to address ourselves more constructively to this problem. Dr. Medearis said that we should try more effectively to measure our results. I agree with that; however, I think that is an extremely difficult task. And if we do not do it or have it done by some private enterprise - and I would hope it would be some private enterprise - I am afraid that the government will do it by default. I think they will do it badly. So that is the important thing that we should address outselves to. How do we measure and convey these things.

In summary, I want to emphasize that we should address ourselves to the problems of health care delivery as sort of friends of the court, but we should not let clinical science disappear from the medical school. We should not let research and attention to things which are not of immediate economic importance disappear from medical schools, but rather we should cooperate with new institutions in order to solve those problems.

ATTACHMENT TO
MINUTES FOR THE COUNCIL
OF DEANS SPRING MEETING

Program for:

Spring Meeting of the
Association of American Medical Colleges
Council of Deans

"The Demands of Our Dual Responsibility: Institutional Freedom and Public Accountability"

April 19, 1972 - 6:30 to 9:30 pm

Reception - 6:30 pm - Aztec Patio
Dinner - 7:00 pm - Aztec Patio

SESSION I

The Nature of the Problem - 8:00 pm

Keynote: "The University and Social Purpose"
Professor Walter A. Rosenblith
Provost, MIT

The Objectives of the Meeting:

Carleton Chapman, M.D.
Dean and Vice President
Dartmouth Medical School

April 20, 1972 - 8:30 am to 1:00 pm

Moderator: Alfred Gellhorn, M.D.
Dean and Director of the Medical Center, University of Pennsylvania School of Medicine

SESSION II

An Analysis of Appropriate Responses

"How Vigorous An Accommodation to Societal Needs?"

Ivan Bennett, Jr., M.D.
Vice President and Dean
New York University School of Medicine

"The Freedom and the Obligation of the University to Pursue Excellence"

Irving London, M.D.
Director, Harvard MIT Program in Health Sciences and Technology

Discussant: Clifford Grobstein, Ph.D.
Vice Chancellor and Dean
University of California San Diego School of Medicine

Floor Discussion - 9:30-10:30

Program (continued)

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Coffee Break - 10:30-11:00

SESSION III

The Institutional Framework

"Medical School-Hospital Relationships Organization for Medical Care and Medical Education"

Ray E. Brown
Executive Vice President
Northwestern University McGaw Medical Center

Discussant: Donald N. Medearis, M.D.
Dean, University of Pittsburgh School of Medicine

Floor Discussion - 12:00-1:00

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Afternoon and Dinner Hour Free

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Reconvene - 8:00 pm

Discussion with John A. D. Cooper, M.D.
President, Association of American Medical Colleges

April 21, 1972 - 8:30 am to 1:10 pm
Aztec Room

Moderator: Emanuel Suter, M.D.
Dean, University of Florida College of Medicine

SESSION IV

The Academic Medical Center and Health Care Delivery

"Who's in Charge?"

John Danielson
Director, North Carolina Memorial Hospital, University of North Carolina

"Education for the Health Professions and Community Service"

Robert Stone, M.D.
Dean and Vice President for Health Sciences, University of New Mexico School of Medicine

Discussant: William D. Mayer, M.D.
Dean and Director of the Medical Center
University of Missouri-Columbia School of Medicine

Program (continued)

Floor Discussion - 9:30-10:30

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Coffee Break - 10:30-11:00

SESSION V

Increasing Federal Support for Medical Education and Health Services: Moral and Fiscal Implications

"The Problems of Stewardship from 1970-80"

Kenneth Crispell, M.D.
Vice President for Health Sciences
University of Virginia School of Medicine

"Political Priorities and Controls: Implications for Medical Schools"

Irving Lewis, Professor
Department of Community Health
Albert Einstein College of Medicine

Discussant: John Gronvall, M.D.
Dean, University of
Michigan Medical School

Floor Discussion - 12:10-1:10 pm

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1:10 pm - 6:00 pm Free

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Reception - 6:00 pm - Poolside
Dinner - 7:00 pm - Poolside

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After Dinner: 9:00 pm, Aztec Room

Discussion with: Merlin K. DuVal, M.D.
Assistant Secretary for Health and Scientific Affairs
Health Education and Welfare

April 22, 1972 - 8:30 - 1:00 pm, Aztec Room

Moderator: Carleton Chapman, M.D.

SESSION VI

The Measure of the Response

"How Things Look as of 8:30 am, April 22, 1972 ---"

Fletcher L. Byrom
President, Koppers Company, Inc.
Pittsburgh, Pennsylvania

Discussant: John Evans, M.D., D.Phil.
Dean and Vice President
Health Sciences McMaster University

Floor Discussion - 9:35-10:05

Coffee Break - 10:05-10:30

SESSION VII

Conference Summary and Conclusion 10:30-12:00 noon

Summary: Sherman Mellinkoff, M.D.
Dean, UCLA School of Medicine

and

Charles Sprague, M.D.
Dean, University of Texas Southwestern Medical School
at Dallas

V. REPORT OF THE COMMITTEE TO CONSIDER MEDICAL SCHOOL ADMISSIONS PROBLEMS

The attached report summarizes the conclusions and recommendations of the Committee convened on July 11, 1972 in response to the mandate of the COD resolution adopted at the Council's February meeting. The COD Administrative Board received the report at its September 14 meeting and commended the Committee for its work. The report is forwarded to the COD for its information and endorsement with the following recommendations of the Administrative Board for specific Council action:

1. The Council of Deans recommends that the Association President and appropriate staff explore all aspects of the feasibility of a medical school admissions matching program and prepare a plan for the phased implementation of such a program for the review and approval of the COD.

2. The Council of Deans commends the efforts of the Association staff and the Group on Student Affairs in working with premedical advisors. The Council recommends that this work continue with increased emphasis on developing background information on and advising students of the range of potential careers available to those interested in working in the health field.

In addition to these recommended action items the Administrative Board calls particular attention to the Committee's observations with respect to the American Medical College Application Service. The Board anticipates that the coming year will provide substantial evidence that the service has overcome its start-up problems and wishes to advise each nonparticipating institution to carefully evaluate this progress and to assess the potential utility of AMCAS in assisting in its own admissions process.

Finally, the Administrative Board has requested that the AAMC staff, with appropriate consultation, prepare the background material referred to in the third recommendation in the report for the review of the Board prior to general distribution.

RECOMMENDATION:
1. That the Council of Deans receive and endorse the Committee's report.
2. That the Council adopt the specific recommendations referred to it by its Administrative Board appearing above.

Report of the Committee Convened by the Chairman of the Council of Deans to Consider Medical School Admissions Problems

July 11, 1972

Martin S. Begun
Associate Dean (Administrative)
New York University School of Medicine

Carleton Chapman, M.D.
Chairman, Council of Deans
Dean and Vice President
Dartmouth Medical School

John E. Chapman, M.D.
Associate Dean for Education
Vanderbilt University School of Medicine

Sam L. Clark, Jr., M.D.
Chairman, Council of Academic Societies
Chairman of Anatomy
University of Massachusetts Medical School

Clifford Grulee, Jr., M.D.
Dean, University of Cincinnati College of Medicine

Frederick Hofmann Ph.D.
Associate Dean for Admissions
Columbia University
College of Physicians and Surgeons

Cheves McC. Smythe, M.D.
Dean, University of Texas at Houston, Medical School

Robert L. Tuttle, M.D.
Chairman, Group on Student Affairs
Associate Dean for Academic Affairs
University of Texas at Houston, Medical School

Harold Wiggers, Ph.D.
Dean, Albany Medical College of Union University

James Erdmann, Ph.D.
Director, Division of Educational Research and Measurement
AAMC

Waltraut F. Dubé, Assistant Director, for Special Programs, Division of Student Affairs
AAMC

Roy K. Jarecky, Ed.D.
Associate Director, Division of Student Affairs
AAMC

James R. Schofield, M.D.
Deputy Director
Department of Institutional Development
AAMC

August G. Swanson, M.D.
Director
Department of Academic Affairs
AAMC

Robert Thompson, Ed.D.
Director, Division of Academic Information
AAMC

Marjorie P. Wilson, M.D.
Director
Department of Institutional Development
AAMC

Report prepared by:

Joseph A. Keyes, J.D.
Assistant Director
Department of Institutional Development
AAMC

The meeting was convened in response to the mandate of the Council of Deans expressed in a resolution passed at the 1971 AAMC Annual Meeting and reaffirmed at the mid-year meeting in Chicago on February 5, 1972:

> Resolved: That there be established an ad hoc committee, a task force or other appropriate mechanism to examine the nature and extent of admissions problems and to recommend to the COD ways to ameliorate these problems.

The resolution was stimulated by the recognition that the rapidly increasing number of applications to be processed by each medical school has reached proportions that are placing serious burdens on schools and applicants alike and that serious attention must be devoted to the concomitant problems to ensure that the admissions process is as efficient and equitable as possible.

While the number of first year places has been enlarged substantially since 1960-1961 (from 8,298 to 13,000 presently, an increase of 57%), the number of individuals seeking admission has risen at a much more rapid rate (from 14,397 to 36,302 during the same period, an increase of 153%). At the same time, as the relative difficulty of gaining admission has increased, applicants have sought to improve their chances by increasing the number of schools to which they apply. A total of 245,000 applications are expected to be filed for the entering year 1973-74. As a consequence, schools are frequently called upon to process a volume of applications that exceeds their projected enrollment by 20 to 40 times. The sheer administrative burden of processing these applications and supporting documents is substantial. New files, storage and personnel have been required. Moreover, the task of processing countless papers is merely the beginning. Remaining is the primary function of selecting perspective students with characteristics germane to the educational program of the particular school from an oversized applicant pool.

The current situation presents a series of challenges to the medical schools:

1. To process applications efficiently so that this function is not an undue drain on the institution's resources.

2. To process applications in a fair and equitable manner which ensures each applicant a full opportunity to have his credentials reviewed.

3. To select from the qualified applicants, those who are most likely to contribute to the fulfillment of the objectives of the educational program of the institution.

4. To minimize the financial, academic and emotional cost to the applicant.

5. To assist potential applicants with a realistic assessment of their potential for success in gaining admission to medical school.

The committee has developed a series of recommendations designed to

assist the schools in meeting these challenges.

Recommendations

DEFINE OBJECTIVES

Careful attention should be devoted to defining the mission and objectives of the medical school and specifying the role of the admissions process as it relates to institutional objectives.

ARTICULATE AND PUBLISH SELECTION FACTORS

Factors influencing applicant selection, including minimum cut-off scores and GPA's, should be articulated as explicitly as possible. They should be widely published, consistently expressed wherever they appear and adhered to faithfully in the selection process. Catalogues, Medical College Admission Requirements Handbook entries and AMCAS materials should portray the schools' policies consistently and accurately.

CAREFULLY SELECT AND EDUCATE THE COMMITTEE

Admissions committee members should be carefully selected according to their ability, their commitment to the institution's policies and their willingness to devote the substantial time and energy requisite to the task. This task is of such importance that the decisions require the full participation and consistent attention of each committee member.

Admissions committee members should undertake their assignment only after carefully informing themselves of institutional policies and objectives, the mechanics of the process, and the current state of the art represented by the literature on the subject. Locally organized seminars or briefing sessions might contribute significantly to this objective. The AAMC staff should assist in this by providing appropriate educational material including an annotated bibliography on the subject, and by standing ready to provide consultative assistance on problems within the areas of their expertise.

PROVIDE FULL-TIME SUPPORT

There should be a full-time admissions staff appropriately trained and under the direction of a responsible official of the administration whose sole or primary function consists of providing appropriate assistance to the dean, the admissions committee, and students who apply.

DESIGN PROCESS WITH COSTS IN MIND

Every aspect of the admissions process should be designed with full cognizance of the substantial financial, emotional and academic cost of the process to each applicant. Each step in the process should be designed to minimize these costs and to maximize the return to both the applicant and the institution.

Interviews should be recognized as the most expensive element in the process to the applicant and should be arranged in order

to minimize this expense. All reasonably competitive applicants should be afforded an opportunity to visit the school and be interviewed at their option, but no interview should be required which will not substantially contribute to the selection decision. Where interviews are deemed desirable in cases involving applicants geographically distant from the school, consideration should be given to sending the interviewer to the applicant's locale, rather than requiring each to travel to the school.

A TRAVEL LOAN SUPPLEMENT FEASIBLE?

The cost of travel to interviews is a heavy financial burden on the applicants, particularly on those with limited means. The committee considered this problem and a suggested approach to solving it. To ensure that this burden does not operate to preclude the admission of worthy but financially strained candidates, some mechanism might be developed whereby students would be able to apply for supplementary financial assistance to cover the special costs involved in such travel. A student who has already demonstrated financial need and is receiving student aid should be able to receive further assistance through the regular undergraduate college financial aid office for this purpose. A successful medical school applicant should be able to defray some of these extraordinary costs through a similar process. His medical school student aid officer could take into consideration the accumulated financial obligations which were in part derived from his quest to enter medical school.

The AAMC staff, in conjunction with the GSA, might profitably pursue this suggestion and explore its feasibility.

UNIFORM ACCEPTANCE DATES

The establishment of uniform acceptance dates is a worthy objective. It would facilitate a more consistent review of applications, provide for a more orderly process and minimize the anxiety of applicants associated with the continuing uncertainty of their status. Further efforts should be devoted to surmounting the remaining obstacles to the establishment of uniform acceptance dates.

DECISIONS SHOULD BE TIMELY MADE AND COMMUNICATED

Selection decisions should be announced in accordance with a predetermined schedule and applicants should be promptly informed of their status. Applicants who are clearly not qualified for the work of the school should be indentified early and so informed. Only those who clearly have a reasonable opportunity should be placed on "hold" and their status should be continually re-examined.

POLICIES MUST ACCORD WITH THE PUBLIC TRUST

Admissions policies should be designed with full cognizance of substantial public trust placed in the medical school. This involves recognition of the role of admissions decisions in governing access to the medical profession and the needs of society and particular socio-economic groups for medical services.

AMCAS USEFUL SUPPORT

The Committee was pleased to note the Association's efforts directed toward improving the usefulness to the schools of the American Medical College Application Service (AMCAS). The service, now under the direction of Dr. Robert Thompson, was viewed as having the potential to be of great assistance in the effort to simplify and expedite the applications process. 70 schools will be participating in the program during the academic year 1972-73, as they choose their September 1973 entering class. Those schools which are not yet participating are urged to carefully evaluate the progress of AMCAS as they assess its potential for meeting their future needs.

ADVISORS DESERVE SUPPORT

Pre-medical advisors are in a position to assist potential applicants in assessing their suitability for medical education and to assist medical schools in their assessment of the applicants. The AAMC should continue to devote substantial attention to enhancing the effectiveness of these advisors. Individual medical schools should work closely with these advisors to ensure that they have an accurate understanding of the admissions process, of the demands of medical education, and the nature of the medical profession.

HUMAN BIOLOGY AND HEALTH CAREERS

In view of the increasing interest in health careers among college students, medical educators should cooperate fully in the development of courses in the undergraduate curriculum designed to provide a fundamental understanding of human biology and the full spectrum of health careers available. Such courses would provide substantial assistance to students in making early and appropriate career choices.

GSA IMPORTANT FORUM

The Group on Student Affairs has proved to be an important forum for the exchange of views and information regarding the admissions process and for reaching agreement among the schools on matters requiring a common approach. Deans should be cognizant of this resource and should utilize it to the fullest.

A MATCHING PLAN FEASIBLE?

A matching plan similar in concept to the NIRMP is a possible next step in organized efforts to expedite the application and admissions process. The COD should recommend that the Group on Student Affairs and the AAMC staff begin immediately to explore all aspects of the feasibility of undertaking such a program.

FURTHER STUDIES NECESSARY

The AAMC should continue its studies to determine those characteristics of an applicant which influence not only his ability to successfully complete the medical curriculum, but also those which influence his effectiveness as a physician.

In addition to the matters set out above, the committee considered a number of policy related issues which it found difficult to reduce to specific recommendations. Basic to this aspect of the discussion was the underlying desire to achieve greater confidence that the procedures, policies, standards and decisions could be designed to ensure that admissions determinations produced an optimal match between students selected and the needs of society and the medical profession. No formula was discovered for assuring beyond dispute this kind of result.

The legal challenges being brought against admissions committee decisions were discussed. It was agreed that while legal considerations were important, they should not be viewed with alarm. Mr. Begun has recently surveyed a number of New York State judges regarding their views on a series of issues related to the admissions process. This survey is expected to be published shortly and is commended to your attention. (Attachment I)

The committee recognizes that it has not taken a startling new approach in its recommendations. Many may appear obvious and most are undoubtedly implemented in some fashion at schools around the country. Nevertheless, it is believed that if each school evaluates its procedures against these suggestions, much room for improvement will be found. Consequently, the committee is forwarding its report to the Council of Deans and urges the Council's endorsement. The report is also submitted to the Group on Student Affairs and the Council of Academic Societies for their information and consideration.

8-14-72

Legal Considerations Related to Minority Group Recruitment and Admissions*

For too long there has been unusual and understandable concern for the legal and ethical problems relating to the admission of students to professional and graduate schools from minority and underprivileged communities. The purpose of this memorandum is to explore in as concise a fashion as possible prevailing legal attitudes and how several distinguished jurists view this irksome problem.

The Northeast Group on Student Affairs appointed a select committee to explore this issue and generally determine if existing mechanisms within the admissions process were tenable and consistent with the best interests of the school and the students affected. What about the "legality" of special committees on minority admission, recruitment and incentive programs, tutorial and academic support courses?

Any and all of these approaches have been tried and tested. Medical schools have used these and other techniques with some measurement of success but rarely with satisfaction. The message has been clear for some

*Reported to the Northeast GSA of the AAMC on June 22, 1972 by Martin S. Begun, Associate Dean, New York University School of Medicine.

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time - special efforts are to be made to equalize opportunities, to increase the numbers of physicians from minority groups, to enlarge the pool of doctors who will serve in depressed and physician-shortage areas and to generally broaden the realities of professional education for all who wish and are able to seek it.

There are questions of equity involved and serious doubts as to the appropriateness of all these good intentions in view of the long-established belief that the equal protection clause of the fourteenth amendment may restrict or inhibit this activity. Equally significant is the reality of legal challenge. Hardly a day goes by and certainly rarely a meeting of more than two medical school administrators that does not hear the refrains and whispered tones of self-doubt as to whether the "special efforts" are appropriate, legal and moral. Deans, school and university administrators, admissions officers, faculty, students, pre-medical advisors, parents, grandparents, politicians and the scores of friends and allies of prospective medical applicants have views which conveniently suit their needs or prejudices - but there is hardly anyone who does not hold a firm and resolute attitude on this most contentious subject except for those of us who may have the ultimate responsibility for developing and executing admissions policies. Ours is a world of paradox and uncertainty.

To the admissions office staff and Dean, it's the challenge of walking a tight rope. The angry, rejected applicant, the threatened and less often executed law suit, the countless inquiries and the awesome truth that urgent national need and historical deprivation necessitates a special response. With this as a backdrop, I viewed the problem from a legal standpoint. Self-doubt has always been endemic to the admissions process. Even when confronted by riches of academically talented youngsters there remains the element of choice and the inevitable query - why not me? Recognizing that choice and selection are constant admissions variables and what remains is the probability of a successful legal challenge. The heart of the matter is how the courts will treat the problem if and when presented with it, and their response which may not be consistent is the only tangible and dependable support available.

Five justices of the New York State Supreme Court were identified for consultation. Three judges spent a considerable amount of their time discussing their own and what they thought the courts ultimate response would be to a law suit similar to the one now before the Supreme Court of the State of Washington. The now recognized deFunis case which is a challenge to the University of

Washington Law School on the question of the constitutionality of its admissions committee decision to deny a place to an applicant while granting admission to thirty students who are members of racial minorities with inferior academic qualifications. The plaintiff, Mr. deFunis, prevailed in the lower court and the law school was ordered to admit him. This case has now achieved national status and has conveniently found a niche in the sub-conscious of every admissions officer. Each of the judges selected for interview were given in advance the brief of amici curiae submitted to the appellate court in Washington as an introduction to the general problem.

Parenthetically, the justices were all mindful of the issues involved and anxious to discuss their philosophy in anticipation of having to rule on such a challenge. The approach and criteria used in choosing the judges were based on their availability, previous personal friendship, their political and social philosophies and care to ensure some divergance in viewpoint if possible. One judge is considered liberal, another moderate and the third conservative. Two additional judges were interviewed as a modified control but less intensively and ultimately substantiated the views and opinions which follow. All justices are from the First Department of the New York State Supreme Court which covers a jurisdiction of Manhattan

and the Bronx. Within the jurisdiction reside some four million inhabitants and several colleges and universities including five law schools, two dental and six medical schools, e.g. Einstein, Columbia, New York Medical College, Mount Sinai, Cornell and New York University.

The quid for the quo was that each jurist was to have his anonomity protected and a pledge was accordingly given. This is an understandable restraint which governs their conduct on matters which may ultimately come before them for adjudication. Therefore, the reader of this memo must rely on my notes, interpretive abilities and genuine concern for the issue at hand. This memorandum, therefore, by necessity lacks footnotes and other qualifying academic appurtenances. Nevertheless, the material and thoughts expressed are worthy of consideration and tend to cast a wholesome and positive light on the subject.

As a result of these interviews, the entire matter was reviewed not long ago at a conference of supreme court judges in the same judicial department and illustrates the concern of the bench for this particular issue.

The following sentiments have been marshalled as "items" for consideration and are put forth in a positive light to encourage medical schools to increase minority enrollment and to undertake appropriate support mechanisms.

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No priority or special significance is accorded to any one item and they are listed at random for equal consideration.

Item: The United States Supreme Court through various interpretations of the Constitution has not forbidden programs designed to increase access of minority groups to higher education. Further measures instituted to correct racial imbalance have been upheld as constitutional.

Item: Remedial and tutorial support programs in graduate and professional education is justified necessary and compelling.

Item: Preferential treatment of certain members of minority groups does not indicate exclusive reliance on race. Certain minority applicants are admitted with records of lower rank than some excluded non-minority candidates - the significance here can be too easily exaggerated. Race is not and should not be the sole and determinant factor. As a matter of fact, not all minority applicants are admitted - only those who after careful review of their records were deemed likely to succeed.

Item: Admissions Committees should consider many factors in making a decision - and factors which go beyond statistical and mathematical determinants are allowable and important. A committee which goes beyond consideration of scores, grades and rank order in aptitude tests seems eminently rational, since it seeks to "humanize" the process of selecting prospective members of the profession.

Item: Courts have generally shied away from upholding challenges to administrative rulings and tend not to override faculties of colleges and universities unless the act is obviously arbitrary and capricious. There is a long and continuing tradition to rely on the judgments of a faculty, especially when it concerns qualifications and standards of admission to a graduate or professional school.

Item: The best approach (and here there was absolute unanimity among all judges queried) is to spell out criteria and to broaden the number of factors which are involved in making a decision to admit or reject. Incidentally, medical schools are at a distinct advantage over other professional schools because of the general policy of requiring a personal interview

before acceptance. This factor alone extends the judgment area beyond the mere consideration of scores and grade points as the sole criteria for admission.

Item: Experimentation in selecting a class is both desirable and permitted. The tendency to get away from rigid categories is also healthy so long as experimental and special programs are published and clearly defined as different from the normal or traditional practices.

Item: Admissions Committees clearly have the obligation and right to expand or restrict admissions criteria - although expansion of criteria is preferred and desirable. New and reasonable criteria may be included when considering applicants, i.e. the nature of societal and community needs viewed from a national as well as a local perspective; the school's surrounding neighborhood and its special requirements; a clear preferance on the part of the candidate to pursue a specific community oriented experience upon completion of the course of study and the applicant's extra-curricular activities when examined against the immediate societal need and his long-range plan. No commitments by the student are necessary, just an expression of future interest and an honest belief that the applicant will most probably fulfill the commitment which

made his selection so compelling.

All of these factors and others make a rational basis for making a judgment other than on a score or grade comparison. Grades cannot in and of themselves accurately predict performance. Furthermore, grades as an exclusive determinant are being legitimately questioned.

Item: Establishing given percentages or quotas of minority students to be accepted in a class represents predictable problems. This should be avoided at all costs. It is possible to achieve the same results without giving the appearance of restricting portions of the class for designated groups.

Item: Medical schools may stimulate interest by creating mechanisms for recruitment, tutorial support and special preparatory courses so as to qualify and ultimately enroll minority students.

Item: Special committees or sub-committees of admissions entrusted with the unique problems of minority applicants are in fact legitimate and permissible.

Item: It is also appropriate to identify some students as career models or examples and to

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reassure other disadvantaged youths that emulation is possible and the "system" is penetrable.

Twelve items have been identified, all representing a consensus of judicial thought on the subject of minority recruitment and admissions. It would be foolhardy to rely on this memorandum as definitive law or as a cover for a multiplicity of actions not entirely consistent with local traditions, laws and judicial temperaments.

The purpose here is to convince the cautious, encourage the timid and fortify those who have engaged in useful and productive exploration. This memorandum and its information was not designed to be an admission office legal primer and should your institution be served with a subpoena, don't call the undersigned - call your lawyer.

Martin S. Begun
Associate Dean
New York University School of Medicine

August 11, 1972

VI. FACULTY PARTICIPATION IN THE AAMC

The attached History of the Faculty Participation Debate provides a summary of the developments to date on the issue of faculty participation in the AAMC. In brief, an Assembly resolution in February 1971 set in motion a series of deliberations culminating in a proposal recommended to the constituent Councils by the Executive Council in December 1971. This proposal was that the Councils favorably consider the proposed "Guidelines for the Organization of Faculty Representatives" as a mechanism to accomplish the mandate of the Assembly. The CAS rejected the proposal and supported instead the establishment of the Council of Faculty. The Council of Deans moved to delay action until there had been adequate regional consideration of the Executive Council proposal.

In order to stimulate local deliberation of the issue at the institutional level, and to give the COD Administrative Board an understanding of how these deliberations were progressing, Dr. Chapman, COD Chairman, by letter dated June 1, 1972, invited each Dean to query his executive faculty and his general faculty on the matter of the OFR proposal and to communicate the reactions of these two groups as well as his own assessment to the COD Chairman.

The Administrative Board considered these responses at its September 14 meeting. At that time, the Board judged that the responses were inconclusive in that they gave no clear mandate for any particular resolution of the faculty question. Consequently, the Board has asked that the issues be fully deliberated at the regional meetings of the deans.

The following specific questions were to be considered:

1. Are the existing mechanisms for faculty involvement on the basis of issues, projects, programs and functions insufficient to provide adequate faculty input?

2. Should faculty members be provided with a mechanism for participation in the governance of the AAMC on an institutional basis?

3. What should the mechanism for faculty participation in the governance of the AAMC be?

   A. An Organization of Faculty Representatives as proposed by the Executive Council
   B. A Council of Faculty as proposed by the CAS
   C. Some alternative structure

Each of the regions will have met to consider these questions and the chairman will be prepared to report the results of these deliberations.

RECOMMENDATION: That the Council of Deans resolve its position on the matter of faculty representation in the governance of the AAMC on an institutional basis. As the first order of business in this regard, consideration should be given to the Executive Council proposal that an Organization of Faculty Representatives, structured according to the Guidelines appearing on page 40 be established.

History of Faculty Participation Debate

1965 - Coggeshall Committee recommended a broadened constituency in order to provide greater opportunity for the academic medical community to participate in the governance of the Association.

1966 - June-Executive Council Meeting approved the establishment of a Council of Faculty and a Council of Academic Societies.

1966 - July-At the meeting of the Institutional Membership, it was decided that the faculty could make its most meaningful contributions at the regional level or through the various academic societies and so the motion to establish a Council of Faculties was defeated. It was at this meeting that the decision was made to establish the Council of Academic Socieites.

1967 - January-Council of Academic Societies held its first organizational meeting.

1968 - Discussion on Organization of Faculties but no action taken.

1970 - October/November-Annual Meeting of the AAMC. It was recommended that an Organization of Faculty ('institutional') Representatives related to the Council of Deans be developed. No action was taken.

1971 - February-At the Assembly meeting there was a resolution passed that there be an organization of the faculties of the member institutions represented in the governance of the Association. Following this resolution recommendations were solicited. Much discussion followed but no decisions were reached.

May-COD meeting approved a statement urging no further mechanisms of representation of the faculties in the national association.

June-Executive Council received remmendations from the CAS on possible mechanisms to give faculty broader representation in CAS. It was decided that no organizational or bylaw changes were necessary.

September-CAS Administrative Board passed a resolution to expand the CAS to include 2 representatives from the faculty of each institutional member. In agreement with this, CAS votes in the Assembly and on the Administrative Board were to be increased by elected faculty representatives. This resolution was then presented to a full meeting of the CAS.

At the September meeting of the Executive Council, a motion was adopted to recommend a retreat to further study the issue of faculty representation. Each Council was to be represented at the Retreat.

October-The CAS tabled the resolution adopted by its Administrative Board in view of the upcoming December Retreat.

December-The Executive Council heard a report on the consideration of the question at the Retreat. The conclusion of the Retreat was that the Executive Council should forward to each of the Councils a proposal for the establishment of an Organization of Faculty Representatives. A set of Guidelines was prepared by the Staff in pursuance of this determination. The Executive Council unanimously voted to "favorably

recommend the proposed 'Guidelines for the Organization of Faculty Representatives' to the constituent Councils for consideration."

1972-February-The CAS adopted a motion proposing the development of a Council of Faculty within the AAMC and defeated amotion to establish an Organization of Faculty Representatives.

February-The COD voted to delay action pending regional consideration of the OFR proposal. The final resolution on this matter was set to be made in the November meeting.

March-Dr. Carleton Chapman, Chairman of the Council of Deans, requested that there be no further discussion on this question until he had communicated with the individual deans to ascertain each school's sentiments on the issue.

The following are the results from Dr. Chapman's letter of request to individual schools for interest in this issue:

In response to Dr. Chapman's request for some data from the individual schools on the question of faculty organization, the following information was obtained:

52 Responding Schools

	Favor	Oppose	Ambivalent	No Answer
Deans	17	24	3	8
Executive Faculty	13	19	9	11
General Faculty	15	11	5	21
	45	54	17	40

Of the total favorable responses given:

37.7% were Deans
29.0% were Executive Faculty
33.3% were General Faculty

Of the voting schools, 36% voted as a block (Deans, Executive Faculty, and General Faculty all voting in the same manner).

Regional Breakdown

Western Region -- 9 schools voting -- responses here based on yes-no answers only. Percentages are those favorable to OFR.

Deans	25%
Executive Faculty	0%
General Faculty	0%

Southern Region -- 13 schools voting -- responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	27.3%
Executive Faculty	28.6%
General Faculty	75.0%

Mid-west-Great Plains Region -- 11 schools voting-responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	70.0%
Executive Faculty	66.7%
General Faculty	66.7%

Northeastern Region -- 19 schools voting -- responses are based on yes-no answers only. Percentages are those favorable to OFR.

Deans	41.7%
Executive Faculty	50.0%
General Faculty	55.5%

Less than 47% of the schools responded. Therefore the statistical information must be viewed as incomplete. Since a high percentage of those who responded were ambivalent or could give no final response, even the results obtained are statistically inconclusive.

GUIDELINES FOR THE ORGANIZATION OF FACULTY REPRESENTATIVES

ORGANIZATION

There shall be an Organization of Faculty Representatives which shall be related to the Council of Deans and which shall operate in a manner consistent with Rules and Regulations approved by the Council of Deans.

COMPOSITION

The OFR shall be comprised of one representative form each Institutional Member and Provisional Member of the COD, chosen from the full-time faculty of each such member.

SELECTION

A faculty representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will insure representative faculty input and be appropriate to the governance of the institution. The dean of each participating institution shall file a description of the process of selection with the Chairman of the COD and shall certify to him annually the name of the faculty member so selected.

MEETINGS

Annual Meeting. The OFR shall meet at least once a year at the time and place of the COD Annual Meeting in conjunction with said meeting.

To facilitate the smooth working of the organizational interrelationships, the above shall be interpreted to require that the Annual Meeting of the OFR be held during the period of the Association's Annual Meeting, not simultaneously with the COD meeting. This meeting will be scheduled in advance of the COD meeting at a time which will permit the attendance of interested or designated deans.

ACTIVITIES

The OFR will:

- Elect a Chairman and a Chairman-Elect.
- Recommend to the COD the Organization's representatives to the Assembly. (10% of OFR Membership)
- Consider other matters of particular interest to the faculty of Institutional Members.
- Report all actions taken and recommendations made to the Chairman of the COD.

18.

RELATIONSHIP TO COD

The Chairman and Chairman-Elect of the OFR are invited to attend the COD meetings to make such reports as requested of them by the COD Chairman, to act as resource persons to express the concerns of faculty when invited, and to inform themselves of the concerns of the deans.

RELATIONSHIP TO THE EXECUTIVE COUNCIL

The Chairman of the OFR shall be an ex officio member of the Executive Council with voting rights.

RELATIONSHIP TO THE ASSEMBLY

The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the COD and a number of the OFR equivalent to 10 percent of the members of the Association having representatives in the OFR.

Each such representative (to the Assembly) shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings.

The Chairman of the Assembly may accept the written statement of the Chairman of the COD reporting the names of individuals who will vote in the Assembly as representatives chosen by the OFR.

COMMITTEES

One representative of the OFR to the Assembly shall be appointed by the Chairman of the Assembly to sit on the Resolutions Committee.

RULES AND REGULATIONS

The OFR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

FINANCES

- The Association will meet the cost of the travel required for authorized faculty participation in Association committee activities, i.e., Executive Council, Administrative Board, and designated committee meetings.

- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with faculty participation will have to be individually arranged at the institutional level.
- Association funds required to support this organization must be reallocated from currently budgeted funds reducing activities in other areas.

VII. REPORT OF THE NOMINATING COMMITTEE AND ELECTION OF OFFICERS

At the time of the Annual Meeting, the terms of office of the Chairman and of Member-at-Large of the Council of Deans Administrative Board expire. The Chairman-Elect assumes the office of Chairman and a new Chairman-Elect is elected.

Dr. Chapman has appointed a nominating committee to propose a slate of candidates for these offices. The committee, chaired by John Rose, M.D., and consisting of Franz K. Bauer. M.D.; Andrew J. Hunt, Jr., M.D.; F. C. Pannill, M.D.; and Winston K. Shorey, M.D., met in Phoenix, Arizona on April 21, 1972. Dr. Rose will report on the slate proposed by that committee.

Additional nominations may be made from the floor.

RECOMMENDATION: That the Council of Deans elect from its membership persons to fill the offices of Chairman-Elect and Member-at-Large of the COD Administrative Board.

Four additional vacancies on the COD Administrative Board will be filled by vote of the Assembly as it elects COD Members to the AAMC Executive Council. The nominating committee chaired by Dr. Rose has suggested a slate to the Association-wide nominating committee to fill these vacancies. Dr. Rose will report on the slate of that committee of which he was a member.

VIII. ELECTION OF INSTITUTIONAL MEMBERS

The AAMC bylaw provisions relating to election of institutional members and the procedures for such elections specified by the Executive Council require the following sequence of actions:

1. COD recommendation to the Executive Council;
2. Executive Council recommendation to the Assembly;
3. Assembly election to membership.

Since the Executive Council is not scheduled to convene in the interval between the COD Business Meeting, November 3, and the Assembly Meeting on November 4, it will not be possible to follow this sequence precisely if the Assembly is to act upon membership applications this year. Furthermore, with the abolition of the mid-year Assembly meeting, the consequence of the failure of the Assembly to act in November is a full year interval between COD action and final election to membership. To preclude this undesirable result, the following procedural modification was adopted by the COD Administrative Board and the Executive Council:

1. COD Administrative Board recommendation regarding membership to the Executive Council subject to ratification by the full Council of Deans;
2. Executive Council recommendation to the Assembly contingent upon COD ratification;
3. Council of Deans action;
4. Assembly action.

Pursuant to this procedure the Administrative Board recommended to the Executive Council the following actions:

A. The election to Provisional Institutional Membership of the University of South Alabama College of Medicine.
B. The election to full Institutional Membership of the following schools:

    University of California-Davis, School of Medicine
    University of California-San Diego, School of Medicine
    University of Connecticut School of Medicine

C. The election to Affiliate Institutional Membership of the Faculty of Medicine, McMaster University

RECOMMENDATION: That the Council of Deans ratify these actions of the COD Administrative Board and the Executive Council and clear the item for Assembly action.

The Medical College of Ohio at Toledo, having graduated a class of students and having been accredited by the Liaison Committee on Medical Education is, under traditional criteria eligible for Institutional Membership in the AAMC. The COD Administrative Board, however, judged that in view of the LCME action granting the institution only probationary

accreditation it would be inappropriate to elect it to full Institutional Membership at this time. In the Board's view the status of Provisional Institutional Member, the current status of the school, is the more appropriate status. The Executive Council, seven members abstaining, did not concur in this view, and voted to recommend to the Assembly the election of the Medical College of Ohio at Toledo to full Institutional Membership.

In view of this discrepancy, the action of the Council of Deans on this matter will determine whether the election of the Medical College of Ohio at Toledo to full Institutional Membership is considered by the Assembly.

RECOMMENDATION: That the Council of Deans resolve the question. No action on the issue or a recommendation that the status of this school not be changed will preclude consideration of the election of the Medical College of Ohio at Toledo to full Institutional Membership at the Assembly.

X. A FOLLOW-UP TO THE COD PHOENIX MEETING RESOLUTION ON THE QUALITY OF HEALTH CARE AND THE ROLE OF THE ACADEMIC MEDICAL CENTER IN THE DELIVERY OF HEALTH CARE

The memorandum appearing on the following pages describes the disposition of the resolution and actions within the Association stimulated by it.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

DATE October 6, 1972

TO: Council of Deans

FROM: Marjorie P. Wilson, M.D.

SUBJECT: Health Services Advisory Committee, Subcommittee on the Quality of Medical Care: A follow-up to the COD Phoenix Meeting Resolution on the Quality of Health Care

Following the Phoenix Meeting the Administrative Board of the Council of Deans formalized the two resolutions which resulted from the discussions on the final day of the Spring Meeting of the Council of Deans. The Chairman of the COD in due course reported these to the Executive Council. Following the Executive Council's receipt of the resolutions, the President of the Association assigned the resolution relative to the quality of health care to the Health Services Advisory Committee for its consideration. The resolution is as follows:

> "The Council of Deans recommends that the AAMC assume a leadership role in bringing together appropriate organizations for the purpose of developing standards and priorities by which the quality of health care services may be assessed, and for the purpose of assessing the appropriate role of the academic medical centers in the delivery of health care, especially in relation to any future national health insurance program."

I attended the meeting of the Health Services Advisory Committee in order to hear the Committee deliberations, explain the resolution, and respond insofar as possible to questions the Committee had about the nature of the COD interest in this area. The Advisory Committee took note of the extensive work which had been done in the field, but at the same time acknowledged the relatively modest progress which had been made in the development of criteria for the evaluation of quality of health care. The Committee pointed out that the AAMC would not be in a position to undertake any extensive investigation of this area either from

the standpoint of resources available within the organization or perhaps the appropriateness to the Association. However, the Committee was impressed with the importance which the Council of Deans attached to the subject and also felt that it was beginning to develop the operational program to implement the second half of the resolution and decided that a subcommittee should be appointed to review with other leaders in the health field existing studies and assessments on the quality of care. The Subcommittee was appointed under the Chairmanship of Dr. Robert Weiss.

I attended the meeting of the Subcommittee on September 28 and 29 and it was an exceedingly interesting and valuable session. The Chairman of the Council of Deans had requested a written report from the Committee for this November COD agenda, and the Committee is conscientiously responding to that request. The tenor of the discussion and the nature of the contents of the presentation at the meeting from the invited speakers, however, appears to be so important and to hold such potentially profound implications for the future that it seems in order that we ask in addition for a verbal comment from the Chairman of the Committee. Chris Fordham is on the subcommittee from the COD membership. The work of this Subcommittee has generated sufficient attention and interest that actually it will be placed on the agenda of all of the Councils in November. The Barro report, prepared as a background paper for another project, is considered by the Subcommittee to be an excellent review article and they urged wide distribution of it. It will be published some time in the near future, but in the meantime a copy is enclosed with the agenda for your information.

The Subcommittee met so recently that its report is not finalized at the time we must print the agenda. Therefore, it will be mailed to you under separate cover in advance of the meeting if at all possible. Otherwise, please obtain your copy at the door of the COD business meeting on November 3.

XI. FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

The document appearing on the following pages is a revision of the basic policy statement of the Liaison Committee on Medical Education governing accreditation of M.D. degree-granting medical schools. The current document which it will replace was approved by the AMA and the AAMC in 1957.

No action by the Council of Deans is required. The document appears in this agenda book to call it to the attention of the COD prior to anticipated Assembly action on November 3. 1972.

Dr. Thomas Kinney, Chairman of the Liaison Committee will report briefly to the COD on the development of the document.

Approved by LCME 4-26-72
Approved by Exec. Council AAMC 5-19-72
Approved by CME of AMA 6-16-72
Sent to the AAMC Assembly 8-18-72

FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL

I. Introduction

This is a statement of the Liaison Committee on Medical Education, of the Association of American Medical Colleges, and of the Council on Medical Education of the American Medical Association.* It is intended that this material be used to assist in attainment of standards of education that can provide assurance to society and to the medical profession that graduates are competent to meet society's expectations; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated.

The concepts expressed here will serve as general but not specific criteria in the medical school accreditation process. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education.

For two-year schools, see Functions and Structure of a School of Basic Medical Sciences.

*Adopted by the House of Delegates of the American Medical Association on _____, and the Assembly of the Association of American Medical Colleges on _____.

II. Definition and Mission

A medical school is an aggregation of resources that have been organized as a definable academic unit to provide the full spectrum of education in the art and science of medicine in not less than 32 months, culminating with the award of the M.D. degree. The educational program must be sponsored by an academic institution that is appropriately charged within the public trust to offer the M.D. degree.

As an institution of higher education, a medical school has four inherent responsibilities which embody the concept of a continuum of education throughout professional life. These are:

I. A principal responsibility of the school is to provide its undergraduate medical students with the opportunity to acquire a sound basic education in medicine and also to foster the development of lifelong habits of scholarship.

II. A medical school is responsible for the advancement of knowledge through research. In addition to biologically oriented studies, the research carried on in a medical school will ordinarily include studies related to cultural and behavioral aspects of medicine, and methods for the delivery of health care, and in the medical education process.

III. Each school is responsible for development of graduate education, both to provide models for better care of patients through clinical residency programs and to contribute to the development of teachers and investigators through advanced degree programs in the basic medical sciences.

IV. Continuing education is another important role for the medical school because it improves the competence of physicians engaged in caring for patients in the years following completion of formal graduate education.

In addition, the resources that characterize the modern academic medical center constitute a unique instrument for meeting selected community health

needs. As a central intellectual force within its community, the medical school should identify those of its community needs that it might meet and create programs to meet those needs. These efforts can serve as models for students.

Participation by medical schools may contribute to the educational programs of other professions in the health field, such as dentistry, nursing, pharmacy, and the allied health professions.

A medical school should develop a clear definition of its total objectives, appropriate to the needs of the community it is designed to serve and the resources at its disposal. When objectives are clearly defined, they should be made familiar to faculty and students alike, so that efforts of all will be directed toward their achievement. Schools should be cautious about overextending themselves in the field of research or service to the detriment of their primary educational mission.

III. Educational Program

The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects. Further, there is no single curriculum that can be prescribed for the undergraduate period of medical education. Each student should acquire a foundation of knowledge in the basic sciences that will permit the pursuit of any of the several careers that medicine offers. The student should be comfortably familiar with the methods and skills utilized in the practice of clinical medicine. Instruction should be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as ambulatory. At the same time, it should foster and encourage the development of the specific and unique interests of each student by tailoring the program in accordance with the student's preparation, competence, and

interests by providing elective time whenever it can be included in the curriculum for this purpose.

Attention should also be given to preventive medicine and public health, and to the social and economic aspects of the systems for delivering medical services. Instruction should stress the physician's concern with the total health and circumstance of patients and not just their diseases. Throughout, the student should be encouraged to develop those basic intellectual attitudes, ethical and moral principles that are essential if the physician is to gain and maintain the trust of patients and colleagues, and the support of the community in which the physician lives.

IV. Administration and Governance

A medical school should be incorporated as a nonprofit institution. Whenever possible it should be a part of a university since a university can so well provide the milieu and support required by a medical school. If not a component of a university, a medical school should have a board of trustees composed of public spirited men and women having no financial interest in the operation of the school or its associated hospitals. Trustees should serve for sufficiently long and overlapping terms to permit them to gain an adequate understanding of the programs of the institution and to function in the development of policy in the interest of the institution and the public with continuity and as free of personal and political predilections as possible.

Officers and members of the medical school faculty should be appointed by, or on the authority of, the Board of Trustees of the medical school or its parent university. The chief official of the medical school, who is ordinarily the dean, should have ready access to the university president and such other university officials as are pertinent to the responsibilities of his office. He should have the assistance of a capable

business officer and such associate or assistant deans as may be necessary for such areas as student affairs, academic affairs, graduate education, continuing education, hospital matters and research affairs.

In universities with multiple responsibilities in the health fields in addition to the school of medicine as, for example, schools of dentistry, pharmacy or nursing, it may be useful to have a vice-president for health affairs, or a similarly designated official who is responsible for the entire program of health-related education at the university. Ordinarily, the deans of the individual health-related schools would report to this individual.

The medical school should be organized so as to facilitate its ability to accomplish its objectives. Ordinarily, this is best effected through the development of a committee structure that is representative of such concerns as admissions, promotions, curriculum, library, and animal care. Names and functions of the committees established should be subject to local determination and needs. Consideration of student representation on all committees is both desirable and useful.

The manner in which the institution is organized, including the responsibilities and privileges of administrative officers, faculty and students, should be clearly set out in either medical school or university bylaws.

V. Faculty

The faculty must consist of a sufficient number of identifiable representatives from the biological, behavioral and clinical sciences to implement the objectives that each medical school adopts for itself. The specific fields represented do not have to be reflected in any set pattern of departmental or divisional organization although the faculty should have an interest in research and teaching in the fields in which

instruction is to be provided. Inasmuch as individual faculty members will vary in the degree of competence and interest they bring to the primary functions of the medical school, assignment of responsibility should be made with regard to these variations.

The extent to which the school's educational program may depend on the contributions of physicians who are practicing in the community will vary with many factors, including the size of the community and the availability of qualified teachers in the several medical specialties. The advantage to the student of instruction by such physicians, as well as by those in full-time academic service, should be kept in mind.

Nominations for faculty appointment ordinarily involve participation of both the faculty and the dean, the role of each customarily varying somewhat with the rank of the appointee and the degree to which administrative responsibilities may be involved. Reasonable security and possibility for advancement in salary and rank should be provided.

A small committee of the faculty should work with the dean in setting medical school policy. While such committees have typically consisted of the heads of the major departments, they may be organized in any way that would bring reasonable and appropriate faculty and student influence into the governance of the school. The faculty should meet often enough to provide an opportunity for all to discuss, establish, or otherwise become acquainted with medical school policies and practices.

VI. Students

The number of students that can be supported by the education program of the medical school and its resources, as well as the determination of the qualifications that a student should have to study medicine, are proper responsibilities of the institution. Inasmuch as all medical schools constitute a national resource, and all operate in the public interest, it is desirable for the student body to reflect a wide spectrum of social and

economic backgrounds. Decisions regarding admission to medical school should be based not only on satisfactory prior scholastic accomplishments but also on such factors as personal and emotional characteristics, motivation, industry, resourcefulness, and personal health. Information about these factors can be developed through personal interviews, college records of academic and nonacademic activities, admission tests and letters of recommendation. There should be no discrimination on the basis of sex, creed, race, or national origin.

Ordinarily, at least three years of undergraduate education are required for entrance into medical school although a number of medical schools have developed programs in which the time spent in college prior to entering medical school has been reduced even further. The medical school should restrict its specified premedical course requirements to courses that are considered essential to enable the student to cope with the medical school curriculum. A student preparing for the study of medicine should have the opportunity to acquire either a broad, liberal education, or if he chooses, study a specific field in depth, according to his personal interest and ability.

Advanced standing may be granted to students for work done prior to admission. The increasing diversity in medical school curricula and the greater integration of the total curriculum, require that transfers between medical schools be individually considered so that both school and student will be assured that the course previously pursued by the student is compatible with the program he will enter. Otherwise, supplementation of the student's program may be necessary after he has transferred.

There should be a system for keeping student records that summarizes admissions, credentials, grades, and other records of performance in medical school and where possible, information regarding the performance

of the student during the first year of graduate training. These records should reflect accurately each student's work and qualifications by including a qualitative evaluation of each student by his instructors.

It is very important that there be available an adequate system of student counselling. Such counselling is especially critical for those students who may require remedial work. Academic programs allowing students to progress at their own pace are desirable.

There should be a program for student health care that provides for periodic medical examination and adequate clinical care for the students.

VII. Finances

The school of medicine should seek basic operating support from diverse sources. The support should be sufficient for the school to conduct its programs in a satisfactory manner and it should reflect, as accurately as possible, the educational, research, and service programs of the school.

Special attention must be paid to providing financial aid for students since it is desirable that economic hardship not hinder the acquisition of an education in medicine.

Arrangements whereby professional fees earned by the faculty are used to support salaries or other medical school activities should be clearly understood and agreed to by all concerned.

VIII. Facilities

A medical school should have, or enjoy the assured use of buildings and equipment that are quantitatively and qualitatively adequate to provide an environment that will be conducive to maximum productivity of faculty and students in fulfilling the objectives of the school. Geographic proximity between the preclinical and clinical facilities is desirable, whenever possible. The facilities should include faculty offices and research laboratories, student classrooms and laboratories, a hospital of

sufficient capacity for the educational programs, ambulatory care facilities and a library.

The relationship of the medical school to its primary or affiliated hospitals should be such that the medical school has the unquestioned right to appoint, as faculty, that portion of the hospital's attending staff that will participate in the school's teaching program. Hospitals with which the school's association is less intimate may be utilized in the teaching program in a subsidiary way but all arrangements should insure that instruction is conducted under the supervision of the medical school faculty.

A well-maintained and catalogued library, sufficient in size and breadth to support the educational programs that are operated by the institution, is essential to a medical school. The library should receive the leading medical periodicals. the current numbers of which should be readily accessible. The library or other learning resource should also be equipped to allow students to gain experience with newer methods of receiving information as well as with self-instructional devices. A professional library staff should supervise the development and operation of the library.

IX. Accreditation

The American Medical Association through its Council on Medical Education and the Association of American Medical Colleges serve as the recognized accrediting agencies for medical schools. Though retaining their individual identities, both groups work very closely in this activity through the Liaison Committee on Medical Education. To be accredited, a medical school must be approved by the Liaison Committee on Medical Education, by the Council on Medical Education and be offered membership in the Association of American Medical Colleges. This is granted on the finding of a sound educational program as a result of a survey conducted by the Liaison Committee on

Medical Education. The Liaison Committee representing the voluntary professional sector includes a representative from the government and the public, and is recognized by the National Commission on Accrediting, the United States Commissioner of Education, the NIH Bureau of Health Manpower Education and various state licensure boards as providing the official accreditation for medical education.

It is the intent that newly developing medical schools should be surveyed several times during the initial years of active existence. Provisional accreditation is granted, when the program warrants, for the first two years of the curriculum and definitive action is taken during the implementation of the last year of the curriculum.

Existing medical schools are surveyed at regular intervals. Decisions regarding accreditation require assessment of the school's constellation of resources in relation to the total student enrollment. Any significant change in either should be brought to the attention of the Liaison Committee and may occasion review of the accreditation. Every attempt is made to fulfill requests for interim surveys as a service to the medical schools.

Further information about accreditation can be obtained from the Secretary, Council on Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, or from the Director, Department of Institutional Development, Association of American Medical Colleges, One Dupont Circle, NW, Washington, D. C. 20036.

Approved by LCME 4-26-72
Approved by Exec.Council AAMC 5-19-72
Approved by CME of AMA 6-16-72

XII. LIAISON OFFICERS FOR INTERNATIONAL ACTIVITIES

The Committee on International Relations in Medical Education (CIRME) has recommended that there be devised a better definition for the appointment of the Liaison Officer for International Activities. The description of the Liaison Officer for International Activities functions on the following page has been prepared by the Division of International Medical Education and will be discussed at the COD Meeting by Dr. Robbins, Chairman of CIRME.

Association of American Medical Colleges
Division of International Medical Education

LIAISON OFFICER FOR INTERNATIONAL ACTIVITIES*

The Liaison Officer for International Activities at each AAMC member institution should perform the following functions:

1. Assist DIME in the formulation, implementation, and evaluation of programs regarding international medical education.

2. Disseminate information about international education and research programs sponsored by the Division of International Medical Education of the AAMC and other organizations and coordinate those programs with the needs of medical school faculty and students.

3. Serve as a national faculty resource for investigative programs of an international scope.

4. Provide DIME with input as to the types of cross-national opportunities needed for the development of programs within a particular AAMC institution.

5. Provide information regarding international programs of an educational and research nature which are offered by a U.S. medical school and which could be of assistance to, or be utilized by, other institutions of the AAMC.

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* It is proposed that this title be changed to "Coordinator of International Programs"

INFORMATION ITEM I

FACULTY UNIONIZATION

Collective bargaining as a means of coordinating faculty action has continued to gain momentum over the past year. The American Association of University Professors (AAUP), at its annual meeting in the Spring, voted overwhelmingly (373 to 54) to endorse a recommendation of the AAUP policy-making council to "pursue collective bargaining as a major additional way of realizing the Association's goals." The National Education Association (NEA), traditionally dominated by elementary and secondary school teachers, voted at its annual convention in July to make union organizing on college campuses an "NEA priority." The Chronicle of Higher Education reported on May 15, 1972, that a total of 254 institutions of higher education have faculties which are now represented by collective bargaining agents. (List attached)

The process of collective bargaining in the academic setting is governed by the same legal standards and procedures as govern labor-management relations generally: Federal law administered by the National Labor Relations Board (NLRB) in the case of private institutions (with gross annual revenues in excess of one million dollars), and in the case of public institutions, state law administered by state labor relations boards where these exist. In the absence of state legislation governing collective bargaining by public employees, unionization at public institutions is unregulated and the status of bargaining agents is dependent upon the willingness of the governing boards of the institution (the employer) to grant them recognition (i.e. to negotiate with them).

In general the steps in the process of collective bargaining are as follows:

A. Organizing Activity. Organizations seeking to represent the employees of a particular group or category (a "unit") conduct a campaign to elicit the interest and commitment of the employees. Authorization or designation cards are distributed and collected.

B. Request for Recognition. If the employer and the employee organization agree as to the configuration of the bargaining unit, and the organization can demonstrate that it has more than majority support from the employees in the unit, the employer is free to recognize the organization as the employees' agent for collective bargaining purposes.

Unit determination requires the resolution of such questions as: Should the unit include all professional employees or only the teaching faculty? ...all colleges of the university or only specified schools? Should it include or exclude department chairmen? The general principle is that the unit should include all of the employees who share in a common community of interests.

The operation of this principle in a particular situation depends on the facts of the case. The factors considered by the NLRB in determining the appropriateness of the bargaining unit in the Fordham University case, where the issue was the inclusion or exclusion of the faculty of the law school, were:

1. The separate building in which educational programs are conducted;
2. The exclusivity of use of that facility;
3. The lack of interdisciplinary involvement among the other schools of the university by the faculty of that professional school;
4. The percentage of faculty members holding full professor ranks in the professional schools as compared with the rest of the university;
5. The more rapid rate of acquiring tenure in the professional school as compared with the university;
6. The average salary scale employed in the professional school as compared to the university;
7. The market place which is used for comparison and competition for determining prevailing faculty salary rates in the professional schools;
8. The prerequisite of degree requirements for faculty status at that professional school;
9. The regulation of the course of curriculum and class scheduling in the professional school by outside agencies;
10. Teacher work load as compared with the rest of the university;
11. Unique operation within the context of the professional school;
12. Unique calendar and examination date;
13. Prior bargaining history;
14. Preferences of the faculty within the proposed unit.

The designation cards are used for the purpose of demonstrating the organization's support. The employer and the organization may agree upon a procedure for proving majority status such as submitting employee lists and the preference cards to some neutral third party for counting and comparison. Again, no public institution in a state without enabling legislation is under any compulsion to recognize any employee representative for collective bargaining purposes.

C. Filing for Certification. If the employer refuses to recognize the organization as the employees' agent, or the parties cannot agree on a unit determination, the organization may file a petition for certification with the NLRB or the state labor relations board. Generally, this requires approximately a 30% showing of interest from the employees of the potential unit. The board will hold hearings and resolve the issues between the parties. It may find it appropriate to certify the organization as the employees' agent or it may order an election.

D. Election of the Agent. Once the unit has been determined, if the parties agree to an election or one is ordered by the board, this becomes the next step in the process. Requirements for competing organizations to gain a place on the ballot vary. Some states require a showing of interest of 30%, some 10%, of the employees. In some, one designation card is sufficient. The NLRB will allow an organization on the ballot without any additional showing if it already represents a similar segment of employees in the same industry. In the election the choice is between any agent appearing on the ballot and "no agent." Victory in the election requires majority support from those voting; runoff elections may be required.

E. Certification. The organization receiving a majority vote is certified as the bargaining agent for the unit, normally the exclusive bargaining agent. This means that the employer is precluded from negotiating with any other agent and is required to negotiate in good faith with the certified agent. Failure to comply with these restrictions constitutes an "unfair labor practice."

F. Negotiation of a Contract. The agent and the employer may now negotiate a contract governing the terms and conditions of employment of all employees within the bargaining unit (whether or not they are members of the agent's organization). Both must bargain in good faith, neither may discriminate in favor or against a member or non-member of the union. They need not reach agreement, but neither may they refuse to bargain.

G. The Contract once signed governs the terms and conditions of employment of all employees in the unit. It also governs relations between the employer and the agent for the duration of the contract, to the extent the agreement is not inconsistent with the applicable law governing their relations generally.

The chart which follows indicates the status of collective bargaining activity at universities with medical colleges.

Prepared by
Joseph A. Keyes, J.D.
Assistant Director
Department of Institutional Development
AAMC
September 1, 1972

STATUS OF COLLECTIVE BARGAINING ACTIVITY AT UNIVERSITIES WITH MEDICAL COLLEGES

School	Organizing Activity	Unit Determination	Agent Elected	Contract Negotiated
State University of New York		All academic and non-academic professional employees; all campuses; includes medical faculty; includes dept. chairmen.	Senate Profession Association, affiliate of NEA	For Period July 1, 1971 to June 30, 1974
Wayne State University, Michigan		All teaching faculty; includes medical faculty; excludes dept. chairmen in five colleges including medical college.	AAUP	Negotiations underway
College of Medicine and Dentistry of New Jersey		Rutgers Medical School and New Jersey Medical School have separate bargaining units	AAUP local chapters represent each unit.	Negotiations in the Fall of 1973
University of Hawaii		Single state-wide bargaining unit set by legislation includes medical faculty.	Scheduled for Fall 1972; on ballot: AAUP, AFT NEA & Hawaii Govt. Employees Assn	
Michigan State University	X	Includes Medical Faculty	Election in the Fall of 1972; choice is NEA affiliate or no agent.	No Contract
University of Wisconsin	50% show of interest; includes medical faculty; enabling legislation anticipated; AAUP expects to be the agent			
University of Nebraska	Enabling legislation recently enacted.	Not determined; AFT seeking to represent Omaha campus; AAUP seeking to represent Lincoln campus. Univ. seeking single bargaining unit.		

STATUS OF COLLECTIVE BARGAINING ACTIVITY AT UNIVERSITIES WITH MEDICAL COLLEGES

School	Organizing Activity	Unit Determination	Agent Elected	Contract Negotiated
University of Illinois	Organizing activity in anticipation of enabling legislation; Board of Regents has not recognized previously elected agents.			
Mt. Sinai		Medical faculty paid by City U. of New York are members of CUNY bargaining unit; this is small fraction of Mt. Sinai faculty.	Agent affiliated with both NEA and AFT.	Yes
Univ. of California	No enabling legislation; legislative study commission is expected to report this at next session with recommendation favoring such a statute.			
University of Minnesota	Legislation has been enacted; no organizing activity to date.			
Temple University	X	Medical faculty was excluded from bargaining unit by Pa. Labor Relations Board.		
New York University		Before the NLRB		

Colleges and Universities Where Faculties Have Chosen Collective Bargaining Agents

Following are 254 institutions of higher education where faculty members have named agents to represent them in collective bargaining. Numbers in parentheses following the names of multi-campus systems indicate the number of institutions in those systems.

NATIONAL EDUCATION ASSOCIATION

Four-Year Institutions

Central Michigan U
City U of New York (19) (with AFT)
Detroit C of Business, Mich.
Fitchburg St C, Mass.
Monmouth C, N.J.
Nebraska St C System (4)
New Jersey St C System (6)
Pennsylvania St C and U System (14)
Saginaw Valley C, Mich.
Salem St C, Mass.
State U of New York (26)

Two-Year Institutions

Adirondack C C, N.Y.
Alpena C C, Mich.
Arapahoe C C, Colo.
Atlantic C C, N.J.
Auburn C C, N.Y.
Bergen C C, N.J.
Big Bend C C, Wash.
Broome C C, N.Y.
Burlington Cnty C, N.J.
Camden Cnty C, N.J.
Centralia C, Wash.
Clinton C C, N.Y.
Cloud Cnty C J C, Kan.
Columbia Basin C C, Wash.
College of Lake Cnty, Ill.
Cumberland Cnty C, N.J.
Dutchess C C, N.Y. (with AFT)
Edmonds C C, Wash.
Erie C C, N.Y.
Essex Cnty C, N.J.
Ft. Steilacoom C C, Wash.
Fox Valley Tech Inst, Wis.
Fulton-Montgomery C C, N.Y.
Garden City C J C, Kan.
Genesee C C, Mich.
Genesee C C, N.Y.
Glen Oaks C C, Mich.
Gloucester Cnty C, N.J.
Gogebic C C, Mich.
Grays Harbor C, Wash.
Green River C C, Wash.
Highline C C, Wash.
Hudson Valley C C, N.Y.
Hutchinson C J C, Kan.
Independence C J C, Kan.
Jackson C C, Mich.
Jamestown C C, N.Y.
Jefferson C C, N.Y.
Kalamazoo Valley C C, Mich.
Kansas City C J C, Kan.
Kellogg C C, Mich.
Kenosha-Racine Tech Inst, Wis.
Labette C J C, Kan.
Lake Land, Ill.
Lake Shore Tech Inst, Wis.
Lansing C C, Mich.
Lehigh Cnty C C, Pa.
Lowe Columbia C, Wash.
Luzerne Cnty C C, Pa.
Massasoit C C, Mass.
Mercer Cnty C C, N.J.
Mid-Michigan C C, Mich.
Mid-State Tech Inst, Wis.
Minnesota St J C System (18)
Mohawk Valley C C, N.Y.
Moraine Park Tech Inst, Wis.
Monroe C C, N.Y.
Monroe Cnty C C, Mich.
Montcalm C C, Mich.
Mt. Wachusett C C, Mass.
Muskegon C C, Mich.
North Country C C, N.Y.
North Central Tech Inst, Wis.
Oakland C C, Mich.
Ocean Cnty C, N.J.
Olympic C, Wash.
Orange Cnty C C, N.Y.
Peninsula C, Wash.
Rhode Island J C
St. Clair Cty C C, Mich.
Sauk Valley C, Ill.
Schenectady Cnty C C, N.Y.
Schoolcraft C, Mich.
Shoreline C C, Wash.
Skagit Valley C, Wash.
Somerset Cnty C, N.J.
Southwestern Michigan C
Spokane C C, Wash.
Suffolk Cnty C C, N.Y.
Ulster Cnty C C, N.Y.
Walla Walla C C, Wash.
Washtenaw C C, Mich.
Waukeshaw Cnty Tech Inst. Wis.
Wenatchee Valley C, Wash.
Williamsport Area C C, Pa.
Yakima Valley C, Wash.

AMERICAN FEDERATION OF TEACHERS (AFL-CIO)

Four-Year Institutions

Boston St C,, Mass.
Bryant C, R.I.
City U of N Y (19) (with NEA)
Layton Sch of Art and Des, Wis.
Long Island U, Brooklyn Center, N.Y.
Long Island U, C.W. Post Center, N.Y.
Lowell St C, Mass.
Massachusetts C of Art
Moore C of Art, Pa.
Pratt Inst, N.Y.
Rhode Island C
Southeastern Massachusetts U
U.S. Merchant Marine Academy, N.Y.
University of Guam
Westfield State College, Mass.
Worcester State College, Mass.

Two-Year Institutions

C C of Allegheny Cnty, Pa.
C C of Baltimore, Md.
C C of Philadelphia, Pa.
Bristol C C, Mass.
Bucks Cnty C C, Pa.
Chicago City Colleges, Ill. (7)
Columbia-Greene C C, N.Y.
Dutchess C C, N.Y. (with NEA)
Eau Claire Tech Inst, Wis.
Fashion Inst of Tech, N.Y.
Henry Ford C C, Mich.
Highland C C, Ill.
Highland Park C, Mich.
Illinois Valley C C
Joliet J C, Ill.
Lincoln Land C C, Ill.
Lake Michigan C, Mich.
Madison Area Tech C, Wis.
Milwaukee Area Tech C, Wis.
Middlesex Cnty C, N.J.
Montclair St C, N.J.
Moraine Valley C C, Ill.
Morton C, Ill.
Nassau C C, N.Y.
Northeast Wisconsin Tech Inst, Wis.
Olympia Vocational Tech Inst, Wash.
Onondaga C C, N.Y.
Prairie St C, Ill.
Rockland C C, N.Y.
Seattle C C, Wash.
Tacoma C C, Wash.
Thornton C C, Ill.
Waubonsee C C, Ill.
Wayne Cnty C C, Mich.
Westchester C C, N.Y.
Washington Tech Inst, D.C.

AMERICAN ASSOCIATION OF UNIVERSITY PROFESSORS

Four-Year Institutions

Ashland College, Ohio
Bard C, N.Y.
Dowling C, N.Y.
New York Inst of Tech
Oakland U, Mich.
Polytech Inst of Brooklyn, N.Y.
U of Rhode Island
Rutgers U, N.J.
St. John's U, N.Y.

Two-Year Institutions

Belleville Area C, Ill.

INDEPENDENT AGENTS

Four-Year Institutions

Fordham U Law School, N.Y.
U of Scranton, Pa.
U of Wisconsin-Madison (teach. assts.)

Two-Year Institutions

Bay De Noc C C, Mich.
Grand Rapids J C, Mich.
Kirtland C C, Mich.
Macomb Cnty C C, Mich.
Niagara Cnty C C, N.Y.
Western Wisconsin Tech Inst
West Shore C C, Mich.

SOURCES: NEA, AFT, AAUP

INFORMATION ITEM II

FOLLOW-UP TO THE COD PHOENIX MEETING RESOLUTION ON THE QUALITY OF MEDICAL EDUCATION

On May 18, 1972 the Chairman of the COD reported to the Executive Council the action of the Council of Deans at its Spring Meeting in Phoenix in adopting two resolutions relating to the assessment of the quality of medical education and of health services. Subsequently, the Association's Executive Staff reviewed the resolutions with the President with the following disposition:

1. It was the expressed view of the Executive Staff that the first resolution relating to the quality of medical education expressed the general mission of the AAMC and that a number of ongoing programs covered the range of considerations contained in the resolution. Dr. August Swanson, Director of the AAMC Department of Academic Affairs prepared the attached statement outlining the relevant programs.

2. The Executive Staff referred the second resolution to the Association's Health Services Advisory Committee for appropriate action. (See Agenda Item X)

Comments on the Council of Dean's resolution passed at the Phoenix meeting.

> The Council of Deans recommends that the AAMC undertake a major study of undergraduate and graduate medical education programs, a study which has at its focus the definition of the quality of their product in quantifiable terms. This should include: (A) The development of standards and priorities by which the quality of educational programs may be assessed; and (B) The identification of the relationship between the performance of the physician and his educational experience.

Assessing the outcomes of medical education is of continuous concern to the AAMC and its constituent members. In the past, the medical schools and the Association chiefly limited their interests and responsibilities to selecting students and providing the education necessary for them to attain the M.D. degree. Little concern or responsibility was directed toward students' graduate education or their ultimate performance in medical practice. The spirit of this resolution makes obsolete the old, narrowly-defined mission of the academic medical community and the AAMC and acknowledges that medical educators must become engaged with every level of professional activity in medicine.

In determining how the Association should facilitate the effective expansion of responsibility for its constituency, the elements of the resolution must be analyzed and the current and planned activities of the Association must be inventoried and evaluated regarding their contributions to the goals of the resolution.

There are two major elements in the resolution: 1) Developing standards and priorities for assessing the quality of both undergraduate and graduate programs; 2) Identifying the relationship between the educational process and the ultimate performance of physicians in practice. Interrelating these elements implies that standards of educational quality should be dependent upon the assessment of ultimate performance in practice.

The quality of an educational program is determined by:

1. The quality of the students;
2. The quality of the faculty;
3. The nature of the curriculum;
4. The nature of the instructional experiences provided to students by faculty within the constraints of the curriculum;
5. The nature of the evaluation of the effectiveness of institutional instructional programs;
6. The nature of the evaluation of student achievement.

Assessing these determinants of the educational programs of medical schools has largely been limited to academic standards set by institutions for institutions and the yard stick of ultimate professional performance has never been applied. Presently there are many programs and projects under way at the Association which will significantly modify these old standards and improve the procedures for establishing new standards and priorities.

A. The revision of the Medical College Admissions Test.

A three-year program for revision of the MCAT is under way. This is directed toward improving the MCAT as an instrument for detecting those qualities in applicants which are deemed desirable which are not now measured. Biographical and other noncognitive indicators will be explored and the feasibility of including data which are predictors of problem-solving ability and personal patient care proclivities versus interests in technical skills will be studied. In carrying out this task, those responsible will have to pay particular attention to the performance outcomes desired by the public, the academic faculties and the practicing profession.

B. The Longitudinal Study.

This study involves 2,200 M.D.s who graduated from 28 medical schools in 1960. During their four undergraduate years, intensive studies were made of this cohort. These data are being transferred to computer tapes and will be available for studying outcomes. In conjunction with the AMA--which has the follow-up data needed to locate and make first descriptions of these physicians--and the NCHSRD--which has interests in relating educational experience with ultimate performance--several studies are planned. A workshop was held June 6, 7 and 8 bringing together the principal investigators working on performance measures for physicians. Although a firm protocol was not adopted, it is believed that a

study plan can be evolved which will allow investigations into questions relating to educational experience and ultimate performance. It is expected that these studies will be directed toward both selection factors and the educational process and thus will be relevant to the MCAT revision program and the Curriculum Survey described below.

C. Curriculum Survey.

In April 1972, all U.S. and Canadian medical schools were asked to provide a detailed description of their undergraduate curricula. The purpose is to provide current information on what is happening in undergraduate medical education and to distribute a book which shows precisely the courses taught, the hours devoted to each course, the amount of free time students are provided, elective programs, pathways for early tracking, special clinical and scientific experiences and other data. It is expected that these data will enable the academic medical community to assess what is perceived as the educational mission of the undergraduate program in each medical school. While formal queries regarding standards and priorities were not made, these should be inferrable from the data.

D. New educational technologies.

An outcome of the AAMC report on New Roles for the Lister Hill Center in Promoting New Educational Technology was the generation of a second report, now in progress, on

the responsibilities of the institutions and faculties for making full use of new technologies. A significant recommendation of the committee preparing this report is that the AAMC should establish a resource to assist the schools in developing and reviewing multimedia instructional programs. Inherent in this thrust is the need for faculties to articulate standards and priorities, for unless the objectives of creating or purchasing multimedia instructional packages are determined in advance, very costly mistakes will be made. Negotiations are under way with the NLM to establish such a resource through cooperative interaction between the NLM and the AAMC.

E. Continuing Medical Education Study Committee

This committee will have its report ready by the fall. The thrust of committee discussions indicate that the faculties should work with practicing physicians in establishing criteria of performance, measure performance against these criteria and then direct educational efforts toward narrowing the gap between accepted criteria and actual performance. Thus, this committee is also emphasizing the need for setting standards and priorities and relating them to the objectives of the educational process.

F. The National Board of Medical Examiners' Committee on Goals and Priorities

The committee is preparing a report regarding the future needs for a national evaluation system for both undergraduate

and graduate medical students. Although it is an NBME committee, it is chaired by Bill Mayer and the makeup of the committee (shown below) assures strong input from the Association and its constituents. The committee has discussed extensively the need to tailor future exams to the expected performance of students in practice.

Members of NBME Committee on Goals and Priorities:

Dr. William D. Mayer, Chairman
Missouri

Dr. Stephen Abrahamson
USC

Dr. John R. Evans
McMaster

Dr. Robert L. Hill
Duke

Miss Margaret Mahoney
Robert Wood Johnson Found.

Dr. C. Barber Mueller
McMaster

Dr. Thomas E. Piemme
George Washington

Dr. Melvin Sabshin
Illinois

Dr. August G. Swanson
AAMC

Dr. D. Dax Taylor
Southern Illinois

Dr. James V. Warren
Ohio State

The activities listed in A through F directly relate to the spirit of the Council of Deans' resolution in the area of student quality, curricular design, instructional design and the assessment of student achievement. The net effect of these activities will be to focus attention on setting standards and priorities which relate to performance outcomes. Of the 6 quality determinants on page 2, only two are not directly covered by the activities discussed in A through F. These are determining faculty quality and investigating the nature of institutional procedures for evaluating educational program

effectiveness. Both of these will indirectly be affected as the various activities evolve.

The activities listed above are, or course, in addition to the Association's heavy involvement in the accreditation of medical education programs. The AAMC is represented on the Liaison Committee on Medical Education; six of the fourteen LCME members are appointed by the AAMC Executive Council. The Association staff provides the Secretariat in alternating years and is continually involved in the process of revising LCME standards, policies and procedures. The document "Structure and Function of a Medical School," which serves as the statement of basic LCME policy and the standards on which accreditation decisions are based, has recently been revised and will be presented for Assembly approval at its next meeting. The document "Programs in the Basic Medical Sciences" setting forth LCME policy with respect to medical education programs not culminating in the M.D. degree has also been revised and is in the early stages of the approval process. Other relevant LCME activities include the exploration of means by which the accreditation process may serve as a more useful stimulus to productive self-examination by the institutions.

In the near future the activities of the Graduate Medical Education Committee, charged with the implementation of the corporate responsibility concept, and the input of the AAMC to the Liaison Committee on Graduate Medical Education and the Coordinating Council for Medical Education will have major effects upon the development of standards and priorities which relate to the linkage of the graduate educational process to ultimate physician performance.

Because so many of the activities of the Association are directed toward the spirit of the resolution, a separate study seems inappro-

priate. Rather, this resolution might be considered a mandate requiring that educational standards and priorities must be directed toward improving the performance of practicing physicians and that the AAMC and its constituents must assume leadership on all related fronts including graduate medical education and the evolution of this Nation's health service system. Such a mandate would provide strong impetus to both at once broaden the horizons and focus the attention of the Association and its constituent members.

August G. Swanson, M.D.
Director of Academic Affairs

6-14-72