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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS

Washington Hilton Hotel
Washington, DC

ANNUAL PROGRAM

Sunday, October 27, 1985

1:00 pm - 4:30 pm

Jefferson East

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I. *Proposed Comprehensive Examination of National Board of Medical Examiners* 1

Moderator:

L. Thompson Bowles, M.D.
Dean for Academic Affairs
George Washington University
Medical Center

Panel Members:

Robert Volle, M.D.
Assoc. Dean for Basic Science
and Research
University of Kentucky
College of Medicine

David Citron
President
Federation of State
Medical Boards

Richard Peters
Chairman-Elect, OSR
Univ of California - San Diego
School of Medicine

Richard H. Moy, M.D.
Dean
Southern Illinois
University

2:30 pm - 3:00 pm

BREAK

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II. *Transition to Graduate Medical Education* 8

Moderator:

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

Presentor:

Norma E. Wagoner, Ph.D.
Chairman, GSA
Assoc. Dean for Student Affairs & Educational Resources
University of Cincinnati
College of Medicine

Commentators:

Jack C. Gardner, M.D.
Assoc. Dean for Student Affairs
UMDNJ-Rutgers Medical School

Jon H. Levine, M.D.
Asst. Dean, Curriculum
Medical University of South Carolina
College of Medicine

Paula L. Stillman, M.D.
Assoc. Dean for Curriculum
University of Massachusetts
Medical School

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COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

Monday, October 28, 1985

2:00 pm - 5:00 pm

Georgetown East & West

AGENDA

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University of North Carolina School of Medicine

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UCLA School of Medicine

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--Henry L. Nadler, M.D., Dean
Wayne State University School of Medicine

G. Ad Hoc Committee on the Financing of Graduate Medical Education
--W. Donald Weston, M.D., Dean
Michigan State University College of Human Medicine

H. Legislative Report
--Thomas J. Kennedy, Jr., M.D., Director
AAMC, Dept. of Planning & Policy Development

--Richard M. Knapp, Ph.D., Director
AAMC, Dept. of Teaching Hospitals

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XII. New Business

XIII. OSR Report

XIV. Installation of Chairman

XV. Adjournment

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PROPOSED COMPREHENSIVE EXAMINATION OF NATIONAL BOARD OF MEDICAL EXAMINERS

As background for the discussion of the report and recommendations of the NBME Study Committee to Review Part I and Part II, as endorsed by the National Board at its Annual Meeting in March 1985, the following materials are attached:

(1) Summary overview of the committee's recommendations;

(2) Members of the Study Committee to Review Part I and Part II;

(3) Actions Taken at the National Board Annual Meeting;

(4) Charge to and Membership of Ad Hoc Planning Group for the Comprehensive Examinations.

At the time of the meeting, Dr. Robert Volle, who chaired the Study Committee and who is the current Chairman of the Ad Hoc Planning Group, will present a summary of the Study Committee's recommendations and rationale as well as a preliminary report on the deliberations of the Ad Hoc Planning Group.

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NATIONAL BOARD ENDORSES RECOMMENDATIONS OF THE STUDY COMMITTEE TO REVIEW PART I AND PART II *

The National Board of Medical Examiners at its Annual Meeting on March 28-29, 1985, took formal action to endorse recommendations of its Study Committee to Review Part I and Part II. The study committee had been appointed in the fall of 1983 under the chairmanship of Dr. Robert L. Volle, Vice Chairman of the Board. The study committee was charged to evaluate and make recommendations regarding the content and organization of the Part I and Part II examinations. In developing its recommendations, the study committee reviewed the Part I and Part II examinations, the use of these examinations over time by licensing bodies and the schools of medicine, the final draft and subsequently the Final Report of the AAMC-GPEP Study, as well as concerns expressed about specific content, and the overall quality of the exams during the past several years.

The committee's recommendations were presented in detail by its chairman to the members of the Board. The major focus of the recommendations relate to the design and development of Part I and Part II as comprehensive certifying examinations, and the development of subject examinations that would be directly focused on assessing academic achievement in specific content areas. As presented by the committee, content specifications for the comprehensive Part I and Part II examinations would reflect the scientific principles, basic medical knowledge, and problem-solving skills students should have acquired for subsequent educational experiences in the continuum of medical education and further learning as a physician. These comprehensive Part I and Part II examinations, together with Part III, will continue to be developed as high quality examinations for National Board certification leading to licensure. For each comprehensive part, detailed multidimensional content specifications (including new content domains) would be developed and these content specifications would not be simply the sum of current subject outlines. Additionally, in order to allow time for more items that test reasoning skills, the total number of times in the comprehensive parts would be reduced from that which is currently administered.

In order to accomplish this design and development, a comprehensive committee would be established for each part. This comprehensive committee would have responsibility for defining the content specifications for the respective part. In addition to test material developed by the subject test committees, test material in new content areas and multidisciplinary subjects will be developed by special task forces designated by the comprehensive committee. The total number of test items, total testing time, and the relative weights for current subjects would be developed for each comprehensive part.

The study committee included recommendations related to reporting and feedback systems for the new comprehensive examinations. Schools of medicine would receive the comprehensive part scores for individual students, group mean scores for current subjects and other content areas and, if requested, item analysis data with keyword phrases for each item. Students would also receive the comprehensive part total score including a designation of pass or fail. No subject scores, however,

would be available for the individual examinees. To assist students in identifying areas of academic deficiency, keyword phrase feedback for test items answered incorrectly would be provided to students on request. It was further suggested that mechanisms be developed to provide these keyword reports to failing students automatically.

Recognizing the importance of National Board subject examinations as academic achievement tests, and recognizing further that the implementation of comprehensive Part I and Part II examinations would preclude subject exams derived wholly from the Part exams, the study committee proposed a new plan for subject examinations. These new subject exams would be developed specifically to focus upon the needs of schools of medicine for assessing academic achievement. Therefore, the test committee for each subject would have more flexibility in defining content specifications related to the depth and breadth of the medical curriculum. There would be fewer constraints on the number of items and, in addition, these examinations would provide additional feedback benefits, while maintaining national standards for comparison.

The Board members discussed in depth the recommendations of the study committee in taking its action to endorse the recommendations. Recognizing that there are many issues which need to be addressed in relation to implementation, the Board delegated to the Executive Board responsibility for moving ahead with implementation planning. The plans and studies requisite for implementation require several years and progress reports will be provided to the Board in the interim and at the next annual meeting in 1986.

*Excerpt from The National Board Examiner, Spring, 1985: "Highlights of 1985 Annual Meeting"

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STUDY COMMITTEE TO REVIEW PART I AND PART II

* Robert L. Volle, Ph.D. (Chairman)
Vice President for
Academic Affairs and Research
West Virginia University

Robert M. Berne, M.D.
Chairman and Charles Slaughter
Professor of Physiology
University of Virginia
School of Medicine

B. R. Brinkley, Ph.D.
Professor of Cell Biology
and Head, Division of Cell
Structure and Function
Baylor College of Medicine

John A. DeMoss, Ph.D.
Professor and Chairman
Department of Biochemistry
and Molecular Biology
University of Texas
Medical School
at Houston

William R. Drucker, M.D.
Chairman
Department of Surgery
University of Rochester School
of Medicine and Dentistry

Laurence Finberg, M.D.
Professor and Chairman
Department of Pediatrics
State University of New York
Downstate Medical Center
College of Medicine

Joseph S. Gonnella, M.D.
Dean and Vice President
Jefferson Medical College
of Thomas Jefferson University

Karen R. Hitchcock, Ph.D.
George A. Bates Professor
and Chairman
Department of Anatomy
and Cellular Biology
Tufts University
School of Medicine

James A. Knight, M.D.
Professor of Psychiatry
Louisiana State University
School of Medicine
in New Orleans

Charles E. Lewis, M.D.
Professor of Medicine
University of California
Los Angeles
UCLA School of Medicine

George E. Miller, M.D.
Director of the Health Center
Hamilton College
and Emeritus Professor
of Medical Education
University of Illinois

Robin D. Powell, M.D.
Dean
College of Medicine
University of Kentucky

Truman G. Schnabel, Jr., M.D.
C. Mahlon Kline Professor
of Medicine
University of Pennsylvania
School of Medicine

* As of 8/85 - Associate Dean of Research
and Basic Sciences
University of Kentucky
College of Medicine

STUDY COMMITTEE TO REVIEW PART I AND PART II

(Continued)

Parker A. Small, M.D.
Professor of Immunology,
Medical Microbiology,
and Pediatrics
University of Florida
College of Medicine

Marian C. Craighill, M.D.
(Resource Consultant)
Resident and Clinical Fellow
in Obstetrics and Gynecology
Brigham and Women's Hospital
Harvard Medical School

Ex Officio

Kenneth I. Berns, M.D., Ph.D.
Chairman
National Board of Medical Examiners
Test Committee Chairmen (7/84-7/85)

John R. Marshall, M.D.
Immediate Past Chairman
National Board of Medical Examiners
Test Committee Chairman (7/83-7/84)

C. William Daeschner, Jr., M.D.
Chairman of the Board
National Board of Medical Examiners

Edithe J. Levit, M.D.
President
National Board of Medical Examiners

3/13/85

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Formal action taken by the National Board of Medical Examiners at its Annual Meeting on March 28-29, 1985 with respect to the recommendations of the Study Committee to Review Part I and Part II:

(1) THAT THE NBME UNDERTAKE THE DESIGN AND DEVELOPMENT OF PART I AND PART II COMPREHENSIVE EXAMINATIONS AS DESCRIBED IN THE REPORT OF THE STUDY COMMITTEE;

(2) THAT THE SUBJECT EXAMINATIONS AS DESCRIBED IN THE REPORT BE DEVELOPED THAT WOULD BE DIRECTLY FOCUSED ON ASSESSING ACADEMIC ACHIEVEMENT IN SPECIFIC CONTENT AREAS; AND

(3) THAT THE BOARD DELEGATE TO THE EXECUTIVE BOARD THE RESPONSIBILITY FOR ASSURING THAT ALL NECESSARY ISSUES ARE APPROPRIATELY ADDRESSED IN RELATION TO IMPLEMENTATION OF THIS REPORT IN THE INTERIM BEFORE THE 1986 BOARD MEETING, AND REPORT PROGRESS AND MAKE FURTHER SPECIFIC RECOMMENDATIONS REGARDING IMPLEMENTATION STRATEGIES AT THE 1986 BOARD MEETING.

In taking the above action to endorse the Study Committee's recommendations, the Board explicitly recognized the need to assure that the proposed examinations are acceptable to those agencies and institutions served by these examinations. In this regard, the Board also took action to delegate to the Executive Board the responsibility for assuring that all necessary issues are appropriately addressed as this effort moves forward over the next several years.

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National Board of Medical Examiners
Ad Hoc Group for the Comprehensive Examinations

In accordance with the action taken by the Board at its Annual Meeting, an Ad Hoc Planning Group was appointed in May 1985 to consider and make recommendations concerning four major issues as set forth in the following charge:

1) **a charge to the Comprehensive Committee for Part I and the Comprehensive Committee for Part II;**

2) **the composition of each of the Comprehensive Committees in terms of disciplinary and geographic representation;**

3) **a process for seeking nominations/recommendations for membership of the Comprehensive Committees; and**

4) **NBME communications and/or interactions concerning the new Comprehensive Examinations during the process of their development.**

In order that these recommendations can be considered by the Executive Board at its fall meeting, the Planning Group is requested to submit its report by early October.

Membership:

* Robert L. Volle, Ph.D. (Chairman)
Vice President for
Academic Affairs and Research
West Virginia University

* As of 8/85 - Associate Dean of Research
and Basic Sciences
University of Kentucky
College of Medicine

Kenneth I. Berns, M.D., Ph.D.
Professor and Chairman
Department of Microbiology
Cornell University Medical College

Laurence Finberg, M.D.
Professor and Chairman
Department of Pediatrics
State University of New York
Downstate Medical Center

Marilyn Heins, M.D.
Vice Dean
University of Arizona
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William H. Luginbuhl, M.D.
Dean
Division of Health Sciences
University of Vermont
College of Medicine

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

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TRANSITION TO GRADUATE MEDICAL EDUCATION

The attached discussion papers were developed for the September, 1985 meetings of the AAMC Administrative Boards (Dr. Norma Wagoner, et.al.) and the Southern Council of Deans (Dr. Philip W. Felts).

Extracted from these two papers are the six questions below, focusing on issues directly under the aegis of the medical schools and the Association. Concerted effort of the medical schools in these six areas could reduce significantly the disruption of medical students' general professional education resulting from their pursuit of residency positions and the related recruitment and selection practices of diverse graduate medical education program directors.

1. Are all medical schools willing to establish a date prior to which they will not release dean's letters or transcripts? October 1st was recommended by the AAMC Task Force on Graduate Medical Education in 1981.

2. Are all medical school deans prepared to establish a colloquy with clinical department chairmen and gratuate medical education program directors at their own institutions to discuss:

   a. their selection policies and procedures?
   b. their recruiting practices and how these practices affect medical students at their own and other institutions?
   c. what can be done to move organizations of department chairmen and program directors to work together at the national level to reduce these disruptive forces?

3. Are medical schools prepared to limit the number of electives that can be taken for credit in a single specialty and to limit the number of electives that can be taken at other medical schools?

4. Should the AAMC and its constituent institutions and organizations petition the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to require all graduate medical education programs to use the National Resident Matching Program for selection of graduating seniors as a condition for accreditation?

5. Should the AAMC's Universal Application Form become the standard form used by all students and accepted by all programs? Should participation in the NRMP require the use of the universal form?

6. Should the AAMC and its constituent institutions develop a centralized common application system, modeled after AMCAS, for graduates of LCME accredited medical schools?

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TRANSITION TO GRADUATE MEDICAL EDUCATION: ISSUES AND SUGGESTIONS

A Report to the
Administrative Boards
Association of American Medical Colleges
September 11-12, 1985

Developed from an Analysis by:
Norma E. Wagoner, Ph.D.

With the Assistance of:
Jack C. Gardner, M.D.
Jon H. Levine, M.D.
Paula L. Stillman, M.D.

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TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

I. Graduate Medical Education and the Selection Process

A. Issues

A number of recurring questions and concerns center around the selection process and the associated matches:

- o With the limitation in positions, do program directors need to begin to define the population to whom they will give major consideration in the selection process?

- o We have yet to see the impact of the for profit hospital corporations on the recruitment and selection of medical students for positions funded by those corporations in certain medical centers.

- o Does any organization have the right to prevent, restrict or constrain any groups of individuals from establishing their own match process? Will the for profit hospital corporations move in that direction?

- o The NRMP has been in continual evolution since the late 1950's; does the system need further revision to accommodate contemporary needs?

Consideration of these questions and concerns have led to the identification of the following problem list for the graduate medical education selection process:

1. Too much splintering of specialty interest groups into their own match processes: Colenbrander matches, military matches, Urology match, and individual hospital or specialties which operate outside the boundaries of any match process (the no-match group).

2. No uniformity of applications. Some programs use the uniform application, while others use one that has been developed by their own hospitals. This creates enormous pressures on students who may need to submit 30 to 50 applications to one, two, or more specialties.

3. Points of entry into graduate training are many and varied, leading to massive communication problems for all participants.

4. The algorithm and terminology of the NRMP are complex and not easily understood even by the most experienced.

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5. In the competitive specialty programs, selection committees are insisting that candidates come for interviews (without any assurances) in order to be given consideration.

6. There is no composite information on available options through all forms of selection processes. This leads to difficulties in communication about entry points for postgraduate training. Each entity administering a match carries out its own form of advertising.

B. Suggestions

Short Term Changes

1. Request that NRMP review and evaluate current information that is being disseminated to program directors and students, including descriptions of the match algorithm and the types of positions offered.

2. There is a definite need for some entity (perhaps the AAMC) to develop comprehensive materials on the residency selection process. A prototype example might be the Medical School Admission Requirements handbook. Explore how this information can or should be communicated.

Long Term Changes

3. Consider a thorough examination and evaluation of the current NRMP process and staffing needs. The NRMP Board of Directors is the group with this responsibility. Perhaps the recently created advisory board could work with the NRMP to provide input from each specialty.

4. Consider development of centralized application service. While there is a uniform application, there is no agreed upon useage. If the program directors could be furnished a reduced administrative workload through such a service (e.g. AMCAS), the system could become sufficiently widely used to furnish a basis for the development of "traffic rules" (e.g. uniform dates).

5. Develop materials by specialty (including details of specific programs within each specialty) which could be sold at cost to students. Such materials should include the following types of information:

   a. Types of candidates that each program seeks. If possible, a greater specificity about the range of backgrounds sought: LCME graduates only, East coast schools only, AOA, National Board Part I scores of 550 or better, etc. This could reduce the "shot-gun" approach to program selection which currently exists and could markedly reduce the work-load of all parties concerned. If a book of this type is to be developed,

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program directors must be convinced that it helps them cut their own costs of communicaton, and reduces their work load.

b. Range of stipend. This may become increasingly important as students amass high debts. Students will need to know if they can afford particular programs.

c. Range of benefits - malpractice insurance, health benefits, etc.

d. Expected background -- "desirable to have electives in....."

e. How the interview process is administered.

f. Whether they have special programs: primary care track, research track, and other special features of the program.

6. Have teaching hospital directors assume authority over the recruitment and selection procedures of the programs sponsored by their institutions. The diversity of specialties and the sheer number of programs (over 5,000) makes the achievement of uniform policies and procedures almost impossible. In addition, the development of useful information about institutions' programs for students would be simplified if reliable communications were estabished with the institutions that sponsor programs rather than with each program director. The AAMC has pressed for greater institutional responsibility for graduate medical education since the late 1960s. The assumption of authority over recruitment and selection policies and procedures by the directors of COTH member hospitals, which provide more than 60 percent of residency positions, could set a precedent that other hospitals would follow.

II. Graduate Medical Education and the Clinical Curriculum

A. Issues

Another major dimension of the transition process is its impact on the clinical education of the medical student, as is evidenced by the following questions and concerns:

- o Do residency directors unduly influence the medical school curriculum now that students are being recruited and selected as early as the third year?

- o Are program directors suggesting (or even stating) to students that unless they take an elective in their hospital, they will not be interviewed or fully considered for a position?

- o Has the use of external examination scores (NBME Parts I and II) become a major selection factor, when it is known that

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these scores measure only a small fraction of the attributes necessary for the practice of quality medicine?

A careful review of these and related questions lead us to the following delineation of problems in the clinical education of medical students:

1. Students seeking positions in the very competitive specialties (particularly the surgical specialties, but also, ophthalmology and emergency medicine) are reported to be taking three and four identical electives in the specialty area of choice at various hospitals in the hope of bettering their selection chances. This compromises the general professional education of the physician.

2. A good portion of the fall of the senior year is devoted to completing multiple applications and seeking interviews. There appears to be little interest in assisting the students by grouping interviews for traveling to a particular region of the country. Often times students must make multiple trips back to an area because of the inflexibility of the interview process.

3. The cost of travel associated with the selection process discriminates against less affluent students and, if incorporated in the approved educational costs, increases their indebtedness.

4. The focus on education and learning is being lost in the increasing emphasis on preparing for the residency selection process.

5. Schools are being forced to change their third year curricular structures to accommodate pressures on their students for early exposure to various specialties. Similar pressures in the fourth year are acting to distort elective programs as students undertake earlier specialization.

6. Earlier selection and preparation for selection are forcing premature decisions about career choices upon students.

7. Because low or average NBME scores may preclude a student from being interviewed, schools now need to furnish considerable time for students to prepare for and/or to provide support services to assist them in preparation for these examinations.

8. The pressure upon schools to place their graduates is causing a grade inflation problem, thus lessening the credibility of grades as a measure of competence.

B. Suggestions

Short Term Changes

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1. Ask the program directors to work with the AAMC to facilitate communication with medical schools: traffic rules, general guidelines, uniform applications, interview time frames.

2. Undertake research to determine which selection factors provide the best residents. This may increase the quality of selection factors beyond those now currently being used.

Long Term Changes

3. Reduce the number of medical students commensurate with the reduction in residency positions.

4. Development of an examination of clinical skills which is both more comprehensive and more oriented to problem solving. Such an examinaton might well include a "hands on" performance evaluation.

5. Consider a fifth year of medical school. By the fifth year, students would have narrowed their specialty interest to three and would spend three months in each area. The three remaining months of that year would be devoted to a Match process with high quality evaluation techniques being utilized to provide maximum information about the students' skills, abilities and suitability for a particular professional area.

6. Consider extending medical school through four years of clinical education, incorporating residency training into the fourth, fifth, and sixth years of a pre M.D. program.

III. Graduate Medical Education and the Counseling Process

A. Issues

A third series of questions and concerns exemplify another area affected by the transition: the role of Deans of Student Affairs and the problems of counseling in residency selection.

- o In transmitting information to program directors, should Deans of Student Affairs be a student advocate or a factual reporter? Do they have an obligation to see that all medical students have a graduate medical education position?

- o In times of more limited resources, Deans of Student Affairs are being asked to take on greater responsibilities in the residency placement process, including working with graduates who are one, two, or more years out of medical school. How far in time does institutional responsibility extend?

- o What responsibility does an institution have to develop a comprehensive advising system? Should such a system include financial planning and debt counseling since graduates may

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have debts which are excessive in relation to residency salaries?

- o Advising is a demanding job and advisors need to have broad knowledge of programs, hospitals, specialties, understanding of selection factors and knowledge of financial matters. Is it realistic to expect our medical schools to expand the staffing for these advising functions?

These questions suggest the following problem areas which might be addressed:

1. In the past, medical students have usually been able to obtain a position in the specialty they wanted. Now, with fewer positions available, Deans of Student Affairs are being placed increasingly in the position of encouraging students to apply for two or three specialties. This emphasis on getting students placed, comes at the expense of the "career fit" counseling process.

2. A related problem with yet to be determined consequences is the possible effect of reduced funding for graduate medical education on the remuneration available and the possibility of significant variation in compensation levels.

3. Early Deans' letters for special matches often require supplemental letters for subsequent matches, compounding the administrative load.

4. Training new and or part-time Deans of Student Affairs in the development of counseling systems and in keeping up with changes in the selection process.

5. Advising the students who find themselves in difficult ethical dilemmnas regarding match situations. The ethics of the marketplace appears to be prevailing, and the sense that anything goes is creating major problems with agreements about current procedural guidelines. This is particularly true for the unmatched student who is seeking a competitive specialty. When very few places are available, the temptation to cheat increases.

6. Helping students reduce the anxieties involved in a competitive selection process where their years of work may not achieve a result supportive of their career goals. This may contribute to a loss of idealism about the practice of medicine and about themselves as practicing physicians.

B. Suggestions

1. Offer a national institute where program directors, Student Affairs Deans, and selected students can meet to develop some strategies and goals for increasing the effectiveness of the selection process.

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2. Develop a network of Deans of Student Affairs (computer bulletin board?) to provide a means for updating certain kinds of information. Such a network has been proposed by the NRMP for listing unfilled places throughout the year. This type of network might be extended more fully to provide a greater array of services through the NRMP office.

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ATTACHMENT

TRANSITION TO GRADUATE MEDICAL EDUCATION
ISSUES AND SUGGESTIONS

A Recent Chronology

1983

A. A presentation by Jack Graettinger (NRMP) at the Northeast GSA, Spring Meeting - 1983, was instrumental in beginning the most recent round of discussions regarding this set of interrelated problems.

B. Howard Levitin (Yale) took the concerns of the NEGSA to the Thirteen School Consortium who through Dean Robert Berliner (Yale) wrote to Dr. Cooper requesting that the AAMC undertake a major initiative to develop solutions.

C. The Council of Deans discussed this as an agenda item at their Scottsdale meeting (Spring 1983).

*D. The AAMC decided to study the problem from the perspective of the program directors. Dr. Cooper (AAMC) wrote to the clinical societies within CAS asking of each society whether it had an established position on the matter of the selection of applicants into residency training programs.

*E. A plan of action was discussed by The Executive Council (June, 1983). The GSA Steering Committee was charged with the preparation of a "White Paper."

*F. As requested by the Executive Council, Joe Keyes wrote an analysis of the CAS responses for the Executive Council agenda, September, 1983. The Executive Council concluded that the Executive Committee of the AAMC should meet with officials of those clinical disciplines using early match dates. (See H, Below)

*G. This problem area was the major topic of the CAS agenda at the AAMC Annual Meeting, Fall, 1983.

H. Dec. 7, 1983; AAMC Executive Committee met with specialties operating outside NRMP. Libby Short (AAMC) designed for this special meeting a flow chart showing how the NRMP match could meet all of the objectives of those disciplines currently operating outside the match. Minutes of this meeting were circulated to all participants who were, in turn, asked to comment.

* Reference documents available

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1984

*I. The minutes of the Dec. 7, 1983 meeting were adjusted for these comments and were mailed to the Executive Council with the agenda for the January, 1984 meeting.

J. The proposal developed by the Executive Council (September 1983) for an advisory committee to NRMP was vetoed by the AMA representative to the NRMP board. In late Spring, 1984, the advisory committee was approved, although it did not meet until Spring, 1985.

K. Spring and Summer of 1984, Dr. Cooper and Dr. Graettinger appeared before the Boards of some of the specialties which operate outside the match with the request that they participate in NRMP; little response.

*L. June, 1984, the CAS Administrative Board adopted a resolution supporting the position of a single match.

*M. September, 1984, the AAMC Executive Council approved a modified form of that resolution.

N. At the AAMC Annual Meeting, Fall, 1984, the Council of Academic Societies and the Council of Deans approved the Executive Council resolution.

1985

O. At the Spring, 1985, CAS meeting, a planned discussion on GPEP developed into a discussion of early match problems.

P. April, 1985, the Specialty Advisory Committee to the NRMP Board held its first meeting with Dr. Swanson representing the AAMC.

Q. April, 1985, new LCME guidelines approved; "Functions and Structure of a Medical School" (See R., below).

*R. Dean Arnold Brown (Wisconsin) requested further discussion at the Summer Meeting of the COD Administrative Board. The Board requested that AAMC Staff, GME officers, and GSA officers develop an Action Agenda for the September, 1985, meeting.

* Reference documents available

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FOR

THE SOUTHERN COUNCIL OF DEANS

Opryland Hotel - September 21, 1985

"Transitionitis"

Preparing for the transition into internship and residency training has been labeled the "pre-residency syndrome" by Gus Swanson in his terse but thoughtful editorial in the Journal of Medical Education for March, 1985. Therein, he calls upon specialty boards and residency review committees to mend their ways and provide relief for the Fourth Year medical student in this country. While awaiting any initiative on their part, the DEANS in this country can take steps to help alleviate some of the problems program directors have created. Towards that end, this presentation is made.

"Transitionosis" as the more specific diagnosic label was considered, and the condition does have some of the characteristics of metastatic malignancy. The term "transitionitis," however, seems more appropriate since this is epidemic in proportion and acute in nature but both curable and preventable. The DEANS' therapeutic intervention is urgently indicated. Some problems are presented followed by possible solutions.

What we have lost from the Fourth Year educational experience:

By virtue of the residency-seeking process as it now operates, no longer is it feasible for Fourth Year medical students to use:

- their third summer in medical school for research;
- their third summer and early fall academic units for clinical experiences (clerkships) to help decide among fields of potential interest;
- their Fourth Year for general professional education, emphasizing areas other than their intended field of specialization;
- their Fourth Year in imaginative and innovative ways to broaden their education and enhance the liberal and humanistic side of their education.

What we have instead in the Fourth Year:

Not only have we lost the above, but no longer can Fourth Year students approach the transition into residency training in an orderly, deliberate and thoughtful manner. Instead, what we have is a group of students:

- who have to spend half of their Fourth Year in a high state of anxiety and frustration;
- who have to spend time in visiting clerkships as a prerequisite even to be considered for a particular residency program with the attendent costs in terms of time applying, arranging temporary housing, paying registrations fees and/or tuition, and the dollar expense of all of it;

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- who have to spend a great deal of time and money in filling out applications, trying to schedule interviews, traveling to interviews, being interviewed, and paying for all of it;

- who have to compromise their own educational experience or risk not making the transition, which makes them indignant, dispirited and resigned.

The underlying problem:

- The real problem is the program director whose conduct is self-centered and self-serving, who disregards his role as chairman of a department or division in the medical school and his obligations to medical students, and who seems to have forgotten he, too, was once a medical student seeking a residency.

  As one of our junior faculty members in OB/GYN put it, "Our first priority is to get a good house staff rather than helping students get into the programs of their choice."

Specific problems:

- Programs which are not even in the Match.

  Such programs feel they are not bound by any constraints; they may not be the best programs; they are often the earliest to offer the student a position; and they are the most likely to pressure the student into premature commitment.

- Programs which are partially in the Match, offering perhaps half of their PGY-1 (or PGY-whatever) positions through the Match and keeping the other positions in their back pocket for under-the-table negotiations.

- Programs which are in the Match but do not abide by the spirit and intent of the Match.

- Programs which have banded together creating separate matching programs. The "Colenbrander matches" are the best examples:

  Ophthalmology (the original)
  Otolaryngology
  Neurology
  Neurological Surgery

  Dermatology and Colon & Rectal Surgery, although "Colenbrander" for a while, are now back with NRMP.

  The newest match but not "Colenbrander" is the First Annual (1985) AUA Residency Matching Program for Urology (For PGY-3 positions available July, 1988).

- √ There is new this year the "Central Application Service for Ophthalmology" from Colenbrander. The student must send to Colenbrander a completed Colenbrander "home-made" application form, the Dean's Letter, transcript, letters of recommendation and address list. All material is then photocopied and reduced for distribution. There is, of course, a fee ($35 for the first five addresses and $35 for each additional five) for the service.

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At least one program (West Virginia) initially announced it would accept applications only if they had been processed through Colenbrander. That program has since recanted. Apparently this is a "pilot program."

While I understand such a service represents a "convenience" for students (and therefore must be a good thing) and perhaps the idea even sprung from students, I object to it for the following reasons:

1) The University transcript is not longer "official" if it is duplicated and does not bear the seal of the University;
2) The Dean's Letter is null and void if it does bear the signature of the Dean or his designee;
3) There is considerable doubt in my mind whether Colenbrander has the resources to guarantee authenticity of submitted material in the manner of AMCAS, for example, where constant vigil uncovers fraud and deception.
4) There is doubt in my mind whether Colenbrander has the staff capable of duplicating and distributing such material in a timely manner.
5) The service imposes yet an earlier deadline to meet.

This year, I advised my students not to participate; Dr. Colenbrander himself phoned to learn my objections; and he said that the folders of Vanderbilt students would have to contain a letter explaining our students' non-participation.

It is interesting that Colenbrander's "Service" is trying to accomplish the reduction of duplication of effort at the same time we have been unsuccessful in gaining widespread acceptance of the AAMC's APPLICATION FOR RESIDENCY, which our students refer to as the "universal application form."

- Programs which require the student to serve in a visiting clerkship before even being considered for a residency.

- Programs which have "pre-application" in order to get an application form.

- Programs which interview on only two days in the entire fall.

- Programs which interview on only one day of the week.

  Our Department of Surgery is a good example, seeing applicants only on Saturday mornings. I understand that surgeons may be operating the other five days, and maybe it is a good thing to put a ceiling on the student since there are only so many Saturdays in the fall. But, it makes scheduling difficult for students.

- Programs which establish unreasonably early deadlines for application.

  I can see no justification whatever for a deadline of August 15th when interviews are scheduled after the 1st of November.

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- Programs which, although no early deadlines are announced, nevertheless have a cut-off at the first, say, 100 applications for their 2 positions and will not consider any applicants after that, regardless of their qualifications.

The process of applying for internships:

- The student writes off for descriptive material and application forms;
- The application folder must be "complete" with application, Dean's Letter, transcript, all recommendations and whatever, before it is submitted to "the committee" for review (this usually takes 2 weeks);
- The "invitation to interview" is extended either in writing or by phone, and the student must then schedule the interview date, interdigitating it with any other interviews already scheduled;
- In order to qualify for reduced airfare rates, the ticket must be bought at least 30 days ahead (adding another 4 weeks to the early deadline);
- On unlimited mileage tickets, the airline often requires the passenger to return to some focal point. For example, the student flying from Seattle to San Diego may have to fly to Denver first and then transfer. It is enormously time consuming.
- The student applying to PGY-1 and PGY-2 programs (most of the Surgical subspecialties, many Radiology programs, Emergency Medicine and others) simultaneously must invest at least twice the time and effort and money and two separate rounds of applications and interviews.

Vanderbilt's Dean's Letters:

Like approximately half of the medical schools in the country, Vanderbilt's Dean's Letters are written by a single individual. He enjoys the task but earlier and earlier deadlines place undue stress on the process. Another growing problem is the total number of applications being mailed out. Last year for 100 students, we sent out 1,850 Letters and transcripts. This year, we entered into a gentleman's agreement that a reasonable number of applications for the student applying to PGY-1 programs would be 15, and for the student applying to both PGY-1 and PGY-2 programs, a reasonable total would be 25. More than that, and we charge the student for each transcript. To show you how effective that agreement has been, we have one student this year applying for Orthopedics who has, to date, requested 94 copies of his Dean's Letter and transcript.

MATCH RELIEF, INC.:

"Created by medical students for medical students" is MRI, an entrepreneurial invention introduced this summer which, for a fee of $88, will perform some of the steps involved in NRMP application. We provide most of those for our students at no cost, such as addressing envelopes. It is designed to relieve "THE MATCH HEADACHE," but none of our students, to my knowledge, has used it.

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Some possible solutions:

To combat the entropy threatening the entire transition process,
DEANS should agree that there are problems,
that the problems can and should be resolved, and
that the problems shall be resolved by collective,
concerted action on their parts.
Each DEAN should inquire of the program directors within his own institution
as to their policies with respect to the transition process,
realizing the solutions will not come from them individually
or from their specialty associations without external force.

- Have LCME accreditation of medical schools include full participation of all its affiliated residency programs in the NRMP;
- Insist that specialty associations, if they must have separate matches, do so through the auspices of the NRMP;
- Encourage specialty associations and specialty boards to reconsider the whole training process and the undesirabilty of such early commitment on the medical students' part to specialty careers. Delaying selection of candidates for PGY-2 and PGY-3 positions until, at least, midway in the internship year would result in surer selection and fewer wipe-outs along the line.
- Encourage NRMP to continue reconsidering the entire process and to seek innovative solutions for implementation with the full support of the DEANS.
- Insist on the elimination of individual application forms in favor of the GRADUATE MEDICAL EDUCATION APPLICATION FOR RESIDENCY provided by the NRMP and developed by the AAMC.
- Refuse to release Dean's Letters and official university transcripts to any other than bona fide residency training programs.
- Honor the recommendation of the AAMC's Task Force on Graduate Medical Education in 1981 that no Dean's Letters and transcripts are to be released prior to October 1st, and this should include the Armed Services as well.
- Consider recommending that program directors accept residency applications only from students in medical schools approved by the LCME.
- Consider limiting the Fourth Year medical student to two clerkships in the area he intends to specialize, only one of which may be a "visiting clerkship."
- Insist that programs remove even the suggestion that a "visiting clerkship" might be pre-requisite to consideration for residency.
- Refuse to accept any "visiting students" except those from LCME approved medical schools.
- Cut back on class size.

Philip W. Felts, M.D.
Assistant Dean, Student Affairs
Vanderbilt University School of Medicine

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

Business Meeting

The Ballroom

The Cottonwoods Resort

Scottsdale, Arizona

March 23, 1985

I. Call to Order

The meeting was called to order at 8:00 a.m. by Arnold L. Brown, M.D., Chairman.

II. Executive Session

The Council immediately went into Executive Session to discuss the progress of the Presidential Search Committee. Minutes of that session are filed separately with the Search Committee. The Council reconvened in general session at 9:10 a.m.

III. Discussion Items

A. General Professional Education of the Physician

The Council considered several documents dealing with potential follow-up activities to the GPEP Report. These included a commentary on the GPEP Report by readers designated by the Council (Drs. Brown, Moy, Chapman, and Stemmler) and their identification of potential AAMC initiatives; draft minutes of the January 14, 1985 Administrative Board meeting regarding GPEP follow-up activities; and an Executive Council agenda excerpt dealing with GPEP follow-up activities. The discussion which followed was brief. Council members were advised that the Administrative Board was planning a joint meeting with the CAS Administrative Board to discuss follow-up activities and were encouraged to channel their ideas through the Administrative Board structure.

B. Graduate Medical Education

The Council considered several issues related to graduate medical education. The first was an action by the ACGME proposing an addition to the General Requirements of the Essentials of Accredited Residencies which required the AAMC's approval for ratification.

The new language indicated that accredited residency programs should be responsible for assessing the clinical skills of each resident entering the first year of their programs and that those residents found deficient in those skills should be assisted where appropriate in remedying such deficiences early in the first part of the PGY1 year. The addition also stated that residents who have not shown the requisite improvement should be dismissed from the program before completion of the first year. The genesis of this action by the ACGME was related to an earlier AAMC recommendation calling for a "hands-on" clinical examination for all foreign medical school graduates from non-LCME accredited schools prior to their entering approved residency programs. This ACGME response to the problem identified by the AAMC provoked a great deal of discussion. At one level, the statement merely reiterated the program directors' responsibility to evaluate, monitor, and remediate, a requirement of all accredited residency programs. As such, it was an insufficient response to the problem. Several members noted the difficulty of dismissing people once they begin a residency program and the interest of residency program directors in striving to retain those they had selected. The conflict between the view that more effective action was needed and the difficulty in voting against what was arguably a very desirable feature of all residency programs was addressed in a motion offered by Dr. Stuart Bondurant: that the Council of Deans suppport the addition but communicate to the ACGME its sense that program directors' evaluations alone are not a sufficient response to the FMG problem and that continued efforts to define the problem and develop more effective action to deal with it are needed. This was intended to put the ACGME on notice while not actually blocking the proposed action. The danger in this stance, noted by several Council members, was that if the additional language were ratified, the ACGME might view the issue as resolved. Dr. Bondurant withdrew the notion and introduced a second motion which read as follows: "The Council of Deans recommends that the AAMC disapprove the action of the ACGME with respect to PGY1 clinical competence because it is an insufficient response to the problem and further actions need to be taken." The motion was further amended by Dr. Richard Ross who proposed additional language that stated "Furthermore, the Council recommends an independent assessment of foreign medical graduates by someone other than program directors." Additional discussion emphasized the point that the AAMC Executive Council had already adopted a position and a proposal on this issue. The Council then approved the following language: "The Council of Deans recommends that the AAMC Executive Council reject the proposed language and encourage the ACGME to adopt the approach the Executive Council endorsed in 1981: an independent assessment of the clinical skills of foreign medical graduates prior to their entry into residency programs."

A second issue discussed was raised by Alton I. Sutnick, M.D. and William H. Luginbuhl, M.D. in a memorandum to the Council. It dealt with the increasingly stricter criteria used by the Residency Review Committees in approving residency programs. In certain cases, new criteria being developed were seen as having an adverse effect on residency programs in academic medical centers. An example highlighted was a proposed guideline by the Residency Review Committee on Pediatrics for an average daily census of 20 pediatric in-patients

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for a program to qualify for accreditation. While this proposal was not approved by the ACGME, and therefore a moot issue, it highlighted possible problems for academic medical centers in the accreditation process. Stricter criteria for residency programs were in general seen as desirable but detailed prescriptive requirements did not seem to take into account the particular strengths of residency programs conducted in the context of the academic medical centers. Dr. Kay Clawson, who has served on a residency review committee and on the Council of Residency Review Committees Chairmen, described the complicated structure of governance in those bodies and their relationship to the ACGME. The discussion of this issue by Council members reflected opinions that the entire interface between undergraduate medical education and graduate medical education was currently in disarray and that a comprehensive examination of this interface was needed.

The discussion which followed reinforced concerns regarding the problematic nature of this interface. These included the number of specialties which select students for residency programs outside of the NRMP and the growing trend for residency program directors to require applicants to take clerkships at their hospital in their junior and senior years, causing disruption to the undergraduate medical education program. Dr. Stoneman, who initiated this discussion at the Council level, indicated that the AMA had passed a resolution opposing premature choices of students encouraged by the behavior of residency program directors. The AMA had pointed out, however, that residency program directors are responsible to the deans of the medical schools. Dr. Elizabeth Short, Deputy Director of the AAMC's Department of Academic Affairs, indicated that this issue was discussed in the Council of Academic Societies, but the disciplines involved were unwilling to recognize the detrimental impact of their practices on students and their general professional education. Dr. Swanson urged each dean to sit down with chairmen at their schools who serve as residency program directors to discuss their recruiting practices.

C. Activities of the Federation of the State Boards of Medical Examiners

Dr. Edward Wolfson, Chairman of the FSMB, described that organization's plans to establish a Commission on Foreign Medical Education. The Commission would serve a fact-finding and information distribution function to help member boards evaluate the educational experiences of students in non-LCME-accredited foreign schools. It would not evaluate the schools as such. A structured instrument was being prepared including detailed questions on the nature and scope of clinical facilities. Survey teams would be trained to conduct site visits of each school to validate the survey data. All 54 members of the FSMB have signed letters of authority for the Commission as a fact-finding body that would provide information to assist them in defining educational criteria for determining eligibility for licensure.

The discussion following Dr. Wolfson's remarks centered on initiatives by state licensing boards in the form of prescribed curriculum requirements to tighten eligibility criteria for licensure. These

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initiatives were made in response to concerns about the influx of foreign medical graduates with poor educational experiences, but have had the effect of encroaching on the prerogatives of LCME-accredited schools in defining curriculum. Students in MD/PHD programs in LCME-accredited schools have found themselves ineligible for licensure in California as a result of new requirements set by that state's board. Council members supported efforts by state licensing boards to deal with the problem of inadequately trained foreign medical graduates seeking licensure but urged that the boards accept LCME accreditation as a substitute for any new specific requirements.

D. Use of Animals in Research-Planned Activities of the National Association for Biomedical Research

Frankie Trull, executive director of the Foundation for Biomedical Research and the newly formed National Association for Biomedical Research, described the current status of the animal rights movement and legislative activities in this area. Representative George Brown (D-CA) was planning to introduce a bill which contained little in the way of new proscriptions on animal research that were not already included in Public Health Service policies. Noting that the scientific community had not seen fit to support any legislation up to that point, Ms. Trull encouraged the members to support the Brown bill.

The National Association for Biomedical Research is a new organization formed by a merger of two groups. Its purpose will be to monitor legislation and educate the public on the benefits to society provided by the use of animals in research. Ms. Trull warned Council members not to underestimate the strength and intensity of animal rights activists and the attraction they have to the media. She described various media presentations designed to counter their impact by promoting the benefits to society realized by animal research. She also reported that a conference scheduled for May was designed to teach institutional representatives how to work more effectively with the media. The budget for NABR activities this coming year was set at $1 million. A total of $750,000 had been raised thus far; NABR was asking universities to contribute $10,000 for each of the next three years to enable them to continue their efforts.

In the brief discussion that followed Ms. Trull's presentation, Council members agreed that one of the major problems is that faculty conducting animal research were not sufficiently informed about policies and procedures to be followed and that the deans needed to take further steps at their institutions to assure that these regulations were known and adhered to.

E. Membership of Investor-Owned Hospitals in the Council of Teaching Hospitals

Richard Knapp, Ph.D., director of the Department of Teaching Hospitals at the AAMC, reported the discussions by COTH on amending membership policies to include investor-owned hospitals. A majority of COTH members appeared to support investor-owned hospital membership. Several steps were required to amend the membership requirements. First, the AAMC had to secure an IRS ruling on the effect of such an

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action on the AAMC's non-profit status. If that ruling were favorable, a motion for such a change must be made to the Executive Council. Executive Council approval must be followed by a two-thirds vote of the AAMC Assembly. Several Council members rose to voice approval for allowing investor-owned hospitals into COTH.

F. Proposal of Ad Hoc Group on Funding for Medical Research

Dr. John Sherman, vice president of the AAMC, reported on the proposal of the Ad Hoc Group on Medical Research Funding for fiscal year 1986 NIH/ADAMHA funding. The group had recommended an 11.7% increase in the NIH budget with a larger percentage increase in the ADAMHA budget based on the Mental Health Report.

IV. Information Items

Dr. Brown pointed out several information items prepared by AAMC staff that were included in the agenda materials provided to Council members: 1) a report on the AAMC Clinical Evaluation Program; 2) an analysis of the potential impact of prospective payment on clinical-research activities; and 3) a staff background paper prepared for the LCME on the use of NBME examination results in institutional evaluation.

V. New Business

Dr. Brown took the opportunity to note the departure from the Council of Dr. Allan Mathias, Dean of the University of Southern California School of Medicine. Dr. Mathias was retiring from the deanship after service to the University of Southern California and to the Council for many years. Dr. Brown expressed the feelings of Council members in wishing him well and expressing thanks for his years of service.

VI. Adjournment

The meeting adjourned at 11:08 a.m.

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REPORT OF THE NOMINATING COMMITTEE AND ELECTION OF OFFICERS

The Nominating Committee of the Council of Deans consisted of:

Stuart Bondurant, Chairman
Harry Jonas
Leonard Napolitano
James Pittman
Robert Tranquada

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated March 1, 1985. The returned Advisory Ballots were tabulated and the results distributed to the committee. The committee met at the COD Spring Meeting in Scottsdale, Arizona on March 22, 1985. Dr. Bondurant's report follows.

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UW Medical School
Dean's Office
APR 8 1985

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

Office of the Dean
The School of Medicine

The University of North Carolina at Chapel Hill
MacNider Building 202 H
Chapel Hill, N.C. 27514

April 3, 1985

Dr. Arnold Brown, Chairman
Council of Deans
University of Wisconsin
Medical School
1300 University Avenue
Madison, WI 53706

Dear Bud:

I write to report the slate recommended by the Nominating Committee of the Council of Deans for the year 1985-1986. As you know, the committee consisted of Harry S. Jonas, Leonard M. Napolitano, James A. Pittman, Robert E. Tranquada and me.

The committee enthusiastically support the nomination of Dr. Edward Stemmler for the position of Chairman-Elect of the Assembly and I will reflect this support in the meeting of the AAMC Nominating Committee.

For the position of Chairman-Elect of the Council of Deans, the committee nominates Dr. Louis Kettel.

For the two positions of Representatives from the Council of Deans to the Executive Council, the committee nominates Drs. William Deal and Richard Ross.

For the positions of Members-At-Large of the Administrative Board of the Council of Deans, the committee nominates Drs. Walter Leavell, John Eckstein and Fairfield Goodale.

The committee found its task to be a very difficult one because the number of outstanding and able individuals highly qualified to serve considerably exceeded the number of positions available. The committee regrets that it could not nominate all interested and able individuals and it urges the Council to find appropriate ways to involve as many others as possible.

Sincerely,

Stuart

Stuart Bondurant, M.D.

SB:jps

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ELECTION OF INSTITUTIONAL MEMBER

The following school has received full accreditation by the Liaison Committee on Medical Education and is eligible for Full Institutional Membership in the AAMC:

The Morehouse School of Medicine

RECOMMENDATION: That the Council of Deans approve the election of this school to Full Institutional Membership.

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INVESTOR OWNED TEACHING HOSPITAL PARTICIPATION IN THE COUNCIL OF TEACHING HOSPITALS

At its meeting at 8:15 am, Tuesday, October 29th, the Assembly will act on a recommendation of the Executive Council that an amendment to the AAMC Bylaws be adopted to permit investor owned hospitals to join or remain as members of the Council of Teaching Hospitals provided they otherwise meet membership requirements that apply to all other hospitals. The Assembly agenda provides a discussion of the process by which this issue reaches the Association for action. The Council of Deans Administrative Board has considered the matter on at least three occasions and a brief discussion was held at the COD Spring Meeting.

Arguments in opposition to COTH membership for investor owned hospitals have been presented as follows:

- Participation of investor owned hospitals would dilute the ability of the organization to develop the type of public perception necessary for effective advocacy in public policy forums;
- Inviting investor owned hospitals to participate would be one more step toward legitimizing them as an acceptable and productive component of the health care industry;
- One of the objectives of COTH is information and data sharing among member hospitals. Investor owned hospitals are reluctant to share basic data and information, particularly concerning financial matters;
- Investor owned hospitals have not demonstrated a long term commitment to medical education and research;
- The basic objectives and mission of for-profit corporations command the allegiance of investor owned hospitals to corporate goals;
- Inviting investor owned hospital participation could be a very divisive decision at this point since there is not a clear consensus in the COTH constituency.

Arguments in support of investor owned hospital participation in COTH have been set forth as follows:

- If investor owned hospitals are not invited to participate, another organization could develop representing teaching hospitals;
- The principal teaching hospitals (Humana Hospital University and St. Joseph Hospital in Omaha) at which two medical schools conduct their undergraduate medical education programs are not

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eligible for membership. In addition, the number of medical school affiliated teaching hospitals owned by investor owned corporation is growing;

- An open dialogue with investor owned hospitals would be beneficial to COTH/AAMC members;

- Representation in COTH should stand for commitment to education. If investor owned hospitals illustrate this commitment and judged to meet COTH membership requirements, they should be admitted as institutional members;

- If a hospital supports the COTH/AAMC goals an is interested in participation, it should be given the opportunity to do so.

RECOMMENDATION: That the Council of Deans endorse Assembly ratification of the proposed amendment to Article I of the AAMC Bylaws.

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ACQUIRED IMMUNE DEFICIENCY SYNDROME: ISSUES IN MEDICAL STUDENT AFFAIRS

"At no time in history has a public health crisis and our response to it been so interwoven with human values and attitudes; never have the social ramifications of our actions been so problematic. Not only is AIDS formidable in itself, it is complicated by our great mobility as individuals and groups, our instantaneous access to information through mass media and computer banks, and our sensitivity to issues such as sexual identity, medical confidentiality, civil liberties, and discrimination."

Mervyn F. Silverman, M.D., M.P.H.
Deborah B. Silverman, D.M.H.
"AIDS and the Threat to Public Health",
Hastings Center Report, Special Supplement;
August, 1985

It is difficult to imagine a situation in which the complex of ethical, legal, social, political, and medical issues of AIDS are more focused than in instances of medical students who have contracted this disease. In recent months a number of such cases have been reported; no doubt many medical schools will be confronted with this unfortunate situation within a short time. It would seem imperative that these experiences be shared and discussed to assist other medical schools in the development of appropriate mechanisms of response, established in the best interests of all of its constituencies and in sensitive support of the stricken student.

To that end, presented below is a list, incomplete at best, of some of the issues which must be confronted:

I. The Student

- Personal health care and emotional support/therapy for the student. Ethical counseling concerning the responsibility of the AIDS infected student to his or her patients, to classmates and hospital staff, and to the medical profession.
- The question of continuation in the educational program for such students, and possible individualized curricular modifications in support of continuation.
- Privacy rights of the student, including patient confidentiality.

II. Faculty, Staff and Classmates

- Responsibility for disclosure to faculty, staff and peers of the AIDS student, and the difficult conflict this engenders with privacy rights.
- Access to confidential counseling and health care for close friends or sexual partner(s) of the AIDS infected student.

III. The Patient

- Concern for the welfare of patients within the teaching hospital, including protection against iatrogenic infectious diseases such as AIDS and Hepatitis B.

- Public health concerns related to the source and pathway of the AIDS infection within the health center. In some instances this will require addressing the particularly sensitive issues of sexual preference and sexual transmission.

- Public information issues and the public's right to be informed about dangers to its health and welfare: media relations and public relations; reputation of the teaching hospital.

IV. Administration

- Crisis management and establishment of mechanisms for decision making. What medical school staff should participate, and how should they prepare or be prepared? Advance consideration of due process, civil rights, and discrimination issues.

- Exchange of information among medical schools on the management of this problem and the related issues of consequence. Role of the AAMC in that exchange process.

This issues list was developed in response to the recent identification of medical students with AIDS. Appropriate proactive planning in the medical center should also include anticipated occurrences of faculty and staff who may contract the disease, and of the role of the center in the education of the broader community in dealing with this public health crisis.

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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
WEEKLY SURVEILLANCE REPORT* - UNITED STATES
AIDS ACTIVITY
CENTER FOR INFECTIOUS DISEASES
CENTERS FOR DISEASE CONTROL
September 23, 1985

UNITED STATES CASES REPORTED TO CDC

1. DISEASE GROUPßß**	ADULT/ADOLESCENT CASES	(%)	KNOWN DEATHS	(%)	PEDIATRICßßß CASES	(%)	KNOWN DEATHS	(%)	TOTAL CASES	(%)	KNOWN DEATHS	(%DEAD)
Both KS and PCP	773	(6)	485	(63)	4	(2)	4	(100)	777	(6)	489	(63)
KS without PCP	2568	(19)	962	(37)	5	(3)	5	(100)	2573	(19)	967	(38)
PCP without KS	7574	(57)	3967	(52)	116	(62)	83	(72)	7690	(57)	4050	(53)
OI without KS or PCP	2301	(17)	1296	(56)	61	(33)	28	(46)	2362	(18)	1324	(56)
Total	13216	(100)	6710	(51)	186	(100)	120	(65)	13402	(100)	6830	(51)

2. AGE	CASES	(%)
Under 13	186	(1)
13 - 19	64	(0)
20 - 29	2809	(21)
30 - 39	6306	(47)
40 - 49	2802	(21)
Over 49	1235	(9)
Total	13402	(100)

3. RACE/ETHNICITY	ADULT/ADOLESCENT CASES	(%)	PEDIATRICßßß CASES	(%)	TOTAL CASES	(%)
White, not Hispanic	7924	(60)	36	(19)	7960	(59)
Black, not Hispanic	3262	(25)	104	(56)	3366	(25)
Hispanic	1858	(14)	42	(23)	1900	(14)
Other	63	(0)	0	(0)	63	(0)
Unknown	109	(1)	4	(2)	113	(1)
Total	13216	(100)	186	(100)	13402	(100)

*These data are provisional
ßKS = Kaposi's sarcoma; PCP = Pneumocystis carinii pneumonia; OI = Other opportunistic infections
**Groups listed are ordered hierarchically; cases with multiple characteristics are tabulated only in the group listed first.
ßßIncludes patients under 13 years of age at time of diagnosis.
***With a person with AIDS or at risk for AIDS
ßßßIncludes 346 persons born in countries in which most AIDS cases have not been associated with known risk factors.
****Epidemiologic data suggest transmission from infected mother to child before, at, or shortly after the time of birth.

September 23, 1985

4. PATIENT GROUPS**

	ADULT/ADOLESCENT				TOTAL	
	MALES	(%)	FEMALES	(%)	CASES	(%)
Homosexual or Bisexual Men	9711	(79)	-	(-)	9711	(73)
Intravenous (IV) Drug User	1790	(14)	459	(53)	2249	(17)
Hemophilia/Coagulation Disorder	89	(1)	4	(0)	93	(1)
Heterosexual Contact***	15	(0)	118	(14)	133	(1)
Transfusions with Blood/Blood Products	121	(1)	87	(10)	208	(2)
None of the Above/Other§§§	627	(5)	195	(23)	822	(6)
Total	12353	(100)	863	(100)	13216	(100)

	PEDIATRIC§§				TOTAL	
	MALES	(%)	FEMALES	(%)	CASES	(%)
Hemophilia/Coagulation Disorder	10	(10)	0	(0)	10	(5)
Parent with AIDS/or at increased risk for AIDS****	67	(65)	70	(84)	137	(74)
Transfusion with Blood/Blood Products	19	(18)	7	(8)	26	(14)
None of the above/Other	7	(7)	6	(7)	13	(7)
Total	103	(100)	83	(100)	186	(100)

*These data are provisional

§KS = Kaposi's sarcoma; PCP = Pneumocystis carinii pneumonia; OI = Other opportunistic infections

**Groups listed are ordered hierarchically; cases with multiple characteristics are tabulated only in the group listed first.

§§Includes patients under 13 years of age at time of diagnosis.

***With a person with AIDS or at risk for AIDS

§§§Includes 346 persons born in countries in which most AIDS cases have not been associated with known risk factors.

****Epidemiologic data suggest transmission from infected mother to child before, at, or shortly after the time of birth.

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5. RESIDENCE	ADULT/ADOLESCENT	(%)	PEDIATRICßß	(%)	TOTAL	(%)
New York State	4685	(35)	81	(44)	4766	(36)
California	3084	(23)	16	(9)	3100	(23)
Florida	880	(7)	24	(13)	904	(7)
New Jersey	779	(6)	22	(12)	801	(6)
Texas	656	(5)	6	(3)	662	(5)
Illinois	283	(2)	3	(2)	286	(2)
Pennsylvania	269	(2)	5	(3)	274	(2)
Massachusetts	257	(2)	4	(2)	261	(2)
District of Columbia	228	(2)	2	(1)	230	(2)
Georgia	221	(2)	1	(1)	222	(2)
Maryland	184	(1)	2	(1)	186	(1)
Puerto Rico	153	(1)	3	(2)	156	(1)
Washington	148	(1)			148	(1)
Connecticut	142	(1)	3	(2)	145	(1)
Louisiana	144	(1)	1	(1)	145	(1)
Virginia	136	(1)	3	(2)	139	(1)
Colorado	106	(1)			106	(1)
Ohio	87	(1)	1	(1)	88	(1)
Michigan	84	(1)	1	(1)	85	(1)
North Carolina	64	(0)	1	(1)	65	(0)
Missouri	61	(0)	1	(1)	62	(0)
Arizona	55	(0)			55	(0)
Indiana	47	(0)	1	(1)	48	(0)
Oregon	43	(0)			43	(0)
South Carolina	40	(0)	2	(1)	42	(0)
Minnesota	40	(0)			40	(0)
Hawaii	38	(0)			38	(0)
Wisconsin	30	(0)			30	(0)
Alabama	29	(0)			29	(0)
Kentucky	27	(0)			27	(0)
Oklahoma	25	(0)			25	(0)
Tennessee	23	(0)			23	(0)
Utah	21	(0)	1	(1)	22	(0)
Rhode Island	21	(0)			21	(0)
Delaware	16	(0)			16	(0)
New Mexico	16	(0)			16	(0)
Nevada	16	(0)			16	(0)
Iowa	11	(0)	1	(1)	12	(0)
Kansas	11	(0)			11	(0)
West Virginia	10	(0)	1	(1)	11	(0)
Other States/Territories (10)	46	(0)			46	(0)
Total - USA	13216	(100)	186	(100)	13402	(100)

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6. All AIDS Cases Per Million Population (from the 1980 Census), by Standard Metropolitan Statistical Area (SMSA) of Residence, Reported from June 1, 1981 to September 23, 1985 - United States

SMSA Of Residence	Cases	Percentage Of Total	Cases Per Million Population
New York, NY	4400	33	482.4
San Francisco, CA	1511	11	464.8
Miami, FL	439	3	270.0
Newark, NJ	328	2	166.8
Los Angeles, CA	1146	9	153.3
Elsewhere (irrespective of SMSA)	5578	42	27.3
Total - United States	13402	100	58.9

7. All Reported Cases of AIDS And Case-Fatality Rates by Half-Year Of Diagnosis, 1979 - September 23, 1985, United States

	Number of Cases	Number of Known Deaths	Case-Fatality Rate
1979 Jan.-June	2	1	50%
July-Dec.	9	8	89%
1980 Jan.-June	18	15	83%
July-Dec.	29	27	93%
1981 Jan.-June	85	72	85%
July-Dec.	173	146	84%
1982 Jan.-June	357	273	76%
July-Dec.	631	458	73%
1983 Jan.-June	1181	838	71%
July-Dec.	1520	1076	71%
1984 Jan.-June	2319	1431	62%
July-Dec.	2908	1335	46%
1985 Jan.-June	3386	1024	30%
July - Sep. 23	776	122	16%
Totals*	13402	6830	51%

* Table totals include 8 cases diagnosed prior to 1979. Of these 8 cases, 4 are known to have died.

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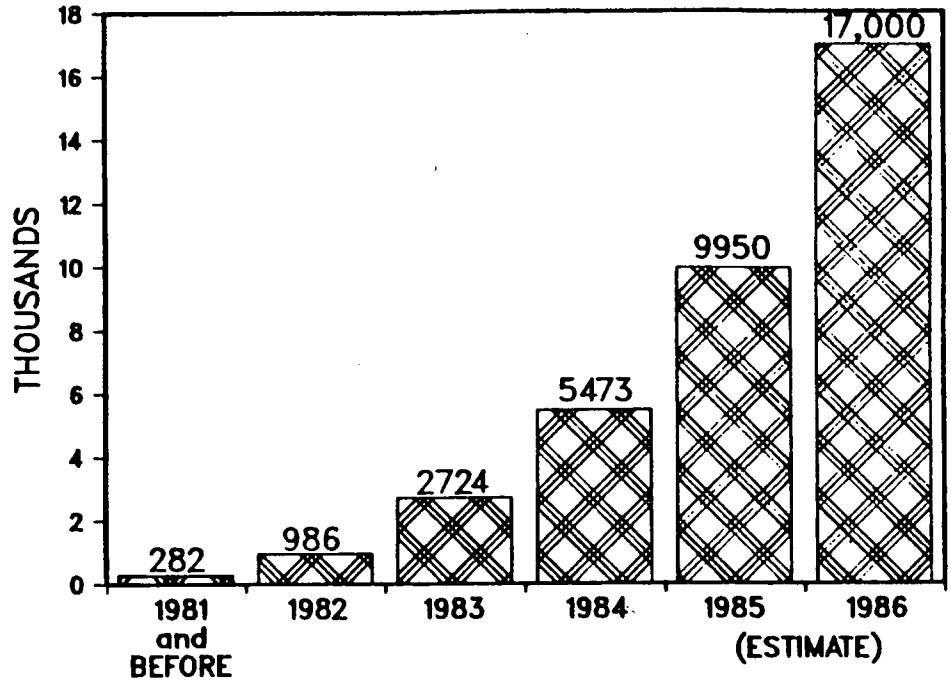
INCIDENCE OF AIDS IN THE UNITED STATES

By Year of Diagnosis



AIDS RISK GROUP PATTERNS

(Percentage of New Cases)

	1981	1982	1985
HOMOSEXUAL OR BISEXUAL MEN	77.7	71.6	73.8
INTRAVENOUS (IV) DRUG ABUSERS	12.2	16.7	16.6
PERSONS WITH HEMOPHILIA	0.4	0.6	0.8
HETEROSEXUAL PARTNERS OF HIGH RISK GROUPS	0.4	1.0	1.2
RECIPIENTS OF BLOOD OR BLOOD PRODUCTS	0.0	0.8	2.2
OTHER *	9.3	9.3	5.5

* INCLUDES HAITIANS WHICH WERE CLASSIFIED SEPARATELY BEFORE 1984

Source: Center for Disease Control, 9/25/85

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TRANSMISSIBILITY

- TRANSMISSION THROUGH:
  - INTIMATE SEXUAL CONTACT
  - NEEDLE SHARING AMONG IV DRUG USERS
  - INFECTED BLOOD AND BLOOD PRODUCTS
  - INFECTED MOTHERS TO NEWBORNS
- NO DOCUMENTED TRANSMISSION THROUGH:
  - CASUAL CONTACT IN WORK PLACE OR SCHOOL
  - SHARING OF MEALS
  - COUGHING OR SNEEZING

TRANSMISSIBILITY

(# of Cases of AIDS Unrelated to Known Risk Factors)

- Physicians working with AIDS patients* _____NONE
- Other health personnel working with AIDS patients* _____NONE
- Families of AIDS patients** _____NONE
- School children_____NONE
- Co-workers_____NONE

* POTENTIAL FOR INFECTION THROUGH NEEDLE STICKS
** POTENTIAL FOR INFECTION THROUGH INTIMATE SEXUAL CONTACT

Source: Center for Disease Control, 9/25/85

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AIDS PROGRESS

PROBLEMS	ACTION TAKEN
• UNDERSTANDING RISK GROUPS AND TRANSMISSION	• EPIDEMIOLOGY DESCRIBED
• UNDERSTANDING THE CAUSE	• VIRUS (HTLV–III) IDENTIFIED
• PROTECTION OF NATION'S BLOOD SUPPLY	• GUIDELINES FOR BLOOD BANKS • BLOOD TEST DEVELOPED & IN USE
• PROTECTING HEMOPHILIACS	• HEAT TREATMENT DEVELOPED
• TREATMENT THERAPIES	• SCREENING OF OVER 100 DRUGS • CLINICAL STUDIES OF PROMISING DRUGS UNDERWAY
• VACCINE DEVELOPMENT	• STUDIES UNDERWAY
• PREVENTION IN HIGH RISK GROUPS	• PUBLIC EDUCATION PROGRAMS • GUIDELINES DEVELOPED

Source: Center for Disease Control, 9/25/85

PRELIMINARY RESULTS FROM THE MCAT ESSAY PILOT PROJECT

Introduction

The Association of American Medical Colleges (AAMC) is investigating the desirability and feasibility of including an essay as part of the Medical College Admission Test (MCAT). This endeavor, entitled the MCAT Essay Pilot Project, calls for the administration of an essay topic on a trial basis with each of the Spring and Fall MCAT administrations in 1985 and 1986. The overall objectives of the MCAT Essay Pilot Project are to plan, develop, implement, and evaluate an essay written by MCAT examinees under standard conditions and in response to a topic developed with specific criteria.

The MCAT esay was administered for the first time in the Spring of 1985. The Spring essay topic was designed to provide examinees with an opportunity to demonstrate skill in: 1) developing a central idea, 2) synthesizing concepts and ideas, 3) separating relevant from irrelevant information, 4) developing alternative hypotheses, 5) presenting ideas cohesively and logically, and 6) writing clearly, observing the accepted pratices of grammar, syntax, punctuation, and spelling consistent with timed, first draft composition.

Under the guidance of an Ad Hoc Advisory Committee to the MCAT Essay Pilot Project, an evaluation program was developed to determine if the essay should become a part of the MCAT testing program on a permanent basis. The evaluation plan is divided into four phases. Within each phase, there are two primary questions:

Phase 1 -- What is the nature of the information provided by an essay? What are the performance characteristics of various examinee groups?

Phase 2 -- What is the impact of the essay on the selection process? Is the information provided by the essay unique and useful to student selection decisions?

Phase 3 -- What effect does an essay on the MCAT have on the attitudes and course selection of undergraduate students? Does the presence of an essay on the MCAT have any impact on the undergraduate curriculum or the types of applicants?

Phase 4 -- What are the costs associated with the development, administration, and distribution of an MCAT essay? What different methods (and their costs) are available for the evaluation and distribution of essays?

The data reported below provide preliminary information on Phase 1 and part of Phase 2 of the evaluation plan. The analyses will be discussed in detail at the Annual Meeting session

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entitled, "MCAT Essay Pilot Project: Preliminary Data", on Sunday evening from 7:30 to 9:30 at Lincoln East.

Sample Composition

Twenty-two thousand examinees were tested in the Spring of 1985. A sample of 3000 examinees was selected to represent the demographic and academic characteristics of the population of Spring Saturday examinees. Essays for these 3000 examinees were scored by 20 experienced readers from the California university system. The data in Tables 1 and 2 show that the study sample was representative of the Spring 1985 examinee population and generalization from sample data to the population of Spring examinees is warranted.

Table 1

Demographic Characteristics of Spring Examinees and Essay Sample

		Spring 1985 Examinees	Essay Sample
Sex	Male	63.3[a]	63.0
	Female	36.7	37.0
Race	Black	6.0	7.0
	White	77.5	76.2
	Asian	10.2	10.0
	Hispanic	3.9	4.4
Language Dominance	ESL	1.8	2.1
	Native English Speaker	98.2	97.9
College Year	Freshman	.6	.3
	Sophomore	4.8	2.4
	Junior	52.2	54.0
	Senior	19.3	20.1
	Graduate +	19.3	19.3
	Not Enrolled	3.8	3.9
Home Community	Rural[b]	17.9	16.4
	Urban	82.1	83.6
Multiple Testings	First-time Examinee	81.8	81.1
	Repeat Examinee	18.2	18.9

[a]Percent

[b]Includes examinees from towns < 10,000

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Table 2

MCAT Scores for Spring Examinees and Essay Sample

	Spring 1985 Examinees	Essay Sample
Biology	8.5[a]	8.5
	2.5[b]	2.5
Chemistry	8.4	8.4
	2.5	2.5
Physics	8.4	8.4
	2.6	2.6
Science Problems	8.3	8.3
	2.5	2.5
Skills Analyses: Reading	8.1	8.0
	2.4	2.4
Skills Analyses: Quantitative	7.9	7.8
	2.5	2.5

[a]Mean

[b]Standard Deviation

Research Questions

The following research questions were addressed using sample data:

1. What are the performance characteristics of the total sample and of sample groups differentiated by sex, home community, race, and language dominance?

2. What are the relationships between essay scores and such demographic/academic characteristics as age, years of post-secdonary education, and college selectivity?

3. What are the relationships between essay performance and scores on the science and skills analysis tests?

Essay Results for the Scored Sample

Essay results for the 3000 examinees in the scored sample appear in Figure 1. The score scale for the essay ranged from 2 to 12. The mean essay score for the sample was 6.8. The standard deviation was 1.7. The data were normally distributed and all score points were represented.

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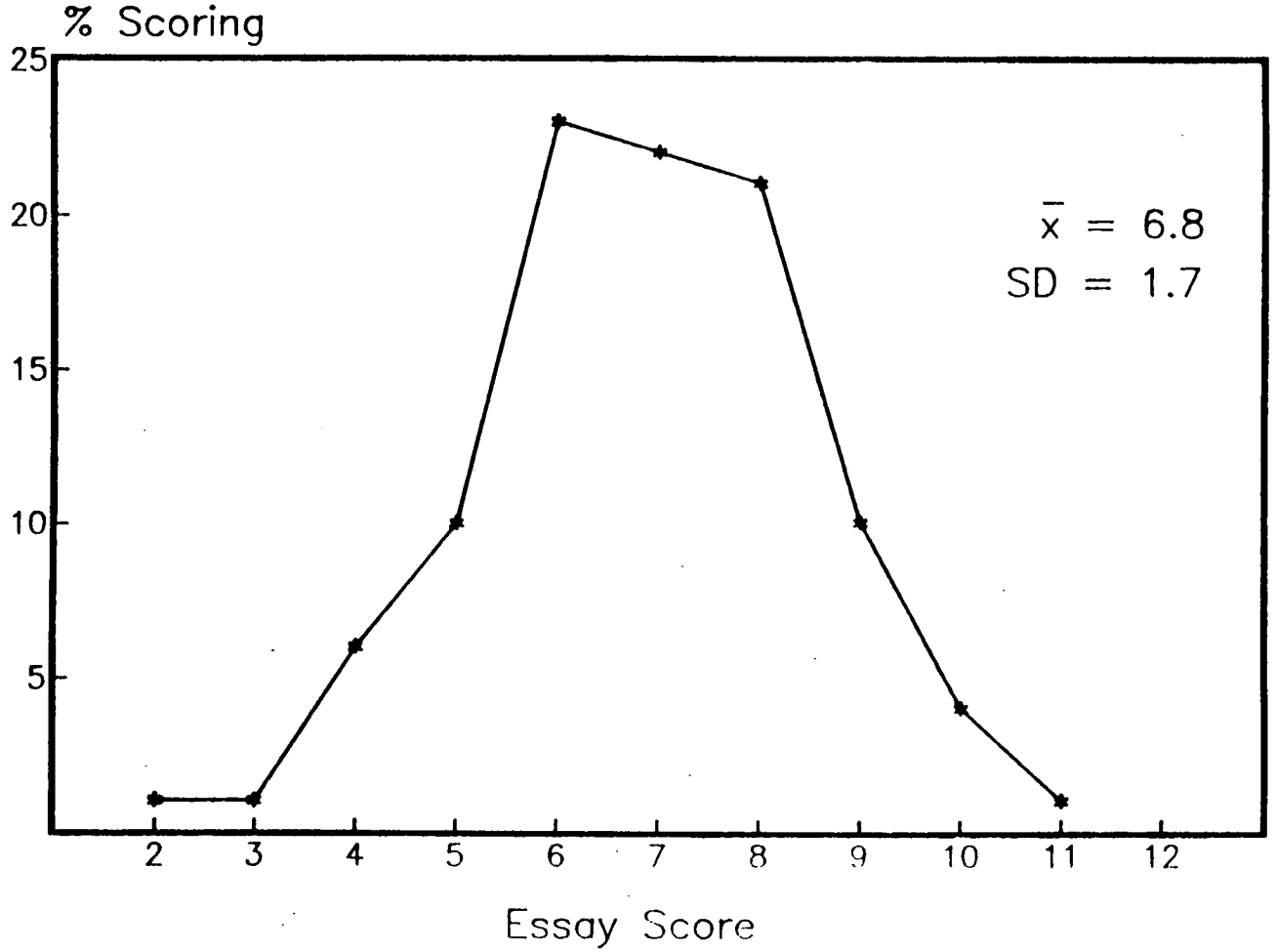
Figure I

Essay Sample Results



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Results for the Essay Sample Groups

Essay means and standard deviations were calculated separately for students grouped by sex, race, rural/urban status, and language dominance. Group data are presented in Table 3. Group differences were negligable for male/female and rural/urban examines. Group differences did appear, however, for race and language dominance groups. Figures 2 and 3 show test score distributions for blacks, whites, Hispanics, and Asians. Essay distributions are plotted for the four groups in Figure 2 and Biology results appear in Figure 3.

The distributions in Figures 2 and 3 help demonstrate that even though there were mean score differences between the race groups on the essay, these differences were smaller than those observed on the science and skills analysis tests. Average group differences on the essay were about 1/2 a standard deviation. Group differences were closer to a whole standard deviation on the science and skills analysis tests.

Table 3

Essay Results for the Sample Groups

		Mean Score	Standard Deviation
Sex	Males	6.8	1.7
	Females	7.0	1.7
Home Community	Rural	6.9	1.6
	Urban	6.8	1.7
Race	Black	5.9	1.6
	White	7.1	1.6
	Hispanic	6.5	1.7
	Asian	6.6	1.9
Language Dominance	ESL[a]	3.7	1.6
	Native English Speaker	6.9	1.7

[a]Includes only Commonwealth Puerto Ricans.

When average essay scores were examined across groups for students at the same Skills Analysis: Reading levels, blacks scored an average of 1/4 point below the mean essay scores for examinees at the same reading levels. Whites scored 1/10 point above the mean essay scores for test-takers at the same reading levels. Hispanics and Asians scored 1/10 point below the average

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Figure 2
Essay Results by Racial/Ethnic Status

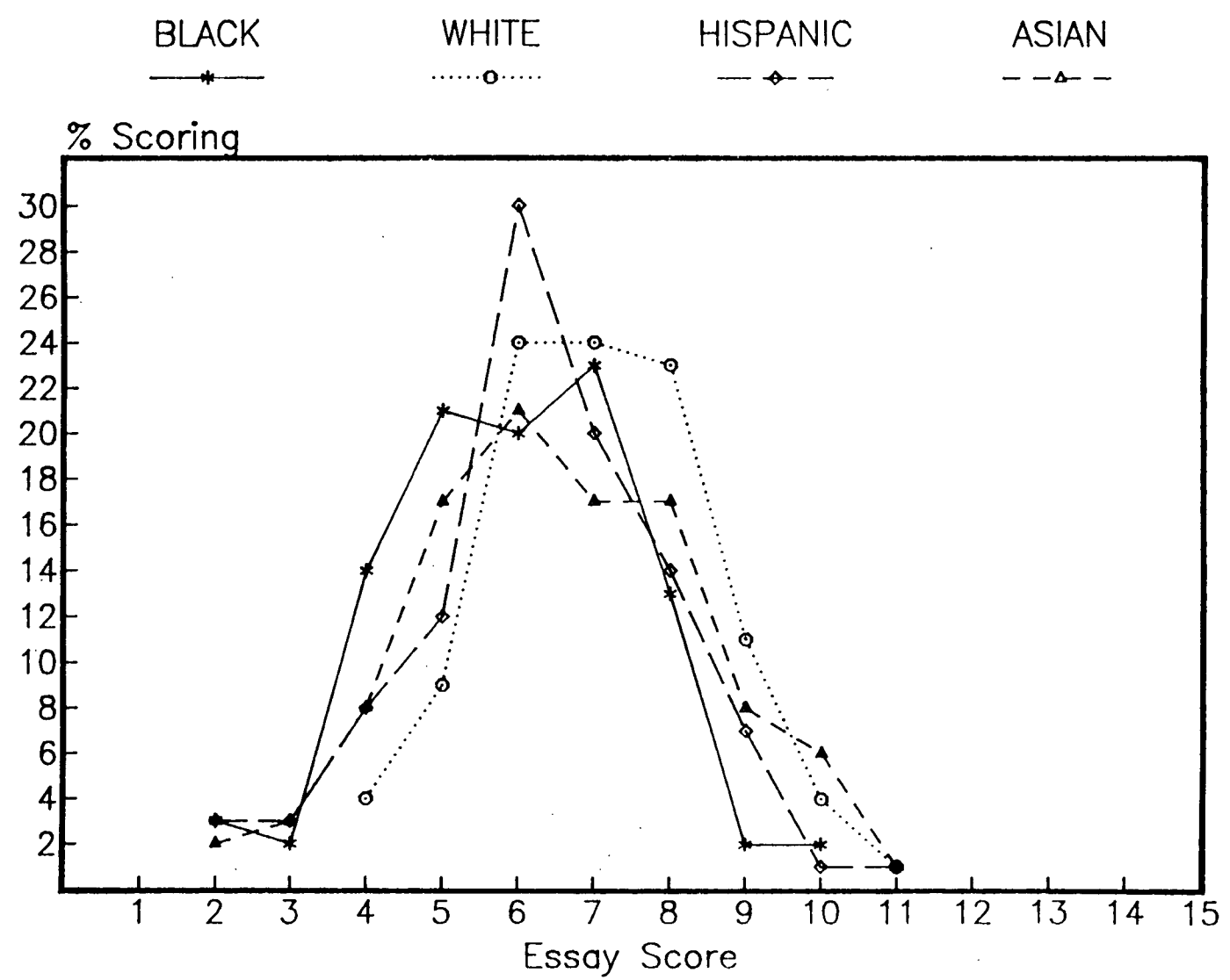

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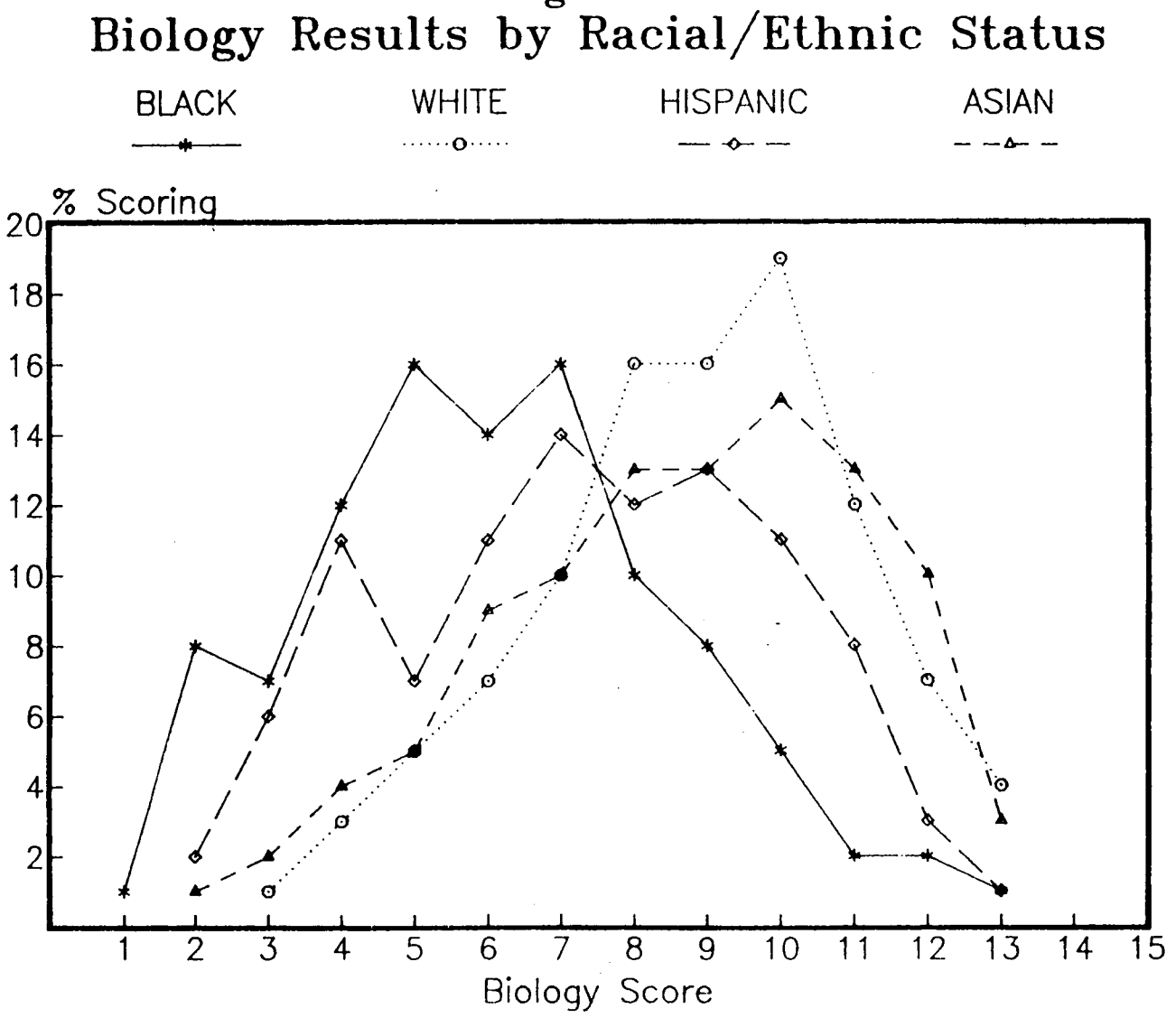
Figure 3
Biology Results by Racial/Ethnic Status



essay scores controlling for reading level. Hence, even though there were differences in essay performance for examinees of different racial groups, these differences were largely related to basic skills or reading level differences. That is, the writing exercise, itself, did not uncover differences between groups when data were examined for test-takers at the same reading score levels.

Data for Commonwealth Puerto Ricans, however, were less encouraging. These students scored 2 points below the mean essay score for examinees at the same reading levels. Factors other than reading level differences may have contributed to lower performance for these examinees. A special data collection is planned on Commonwealth Puerto Ricans for the Fall to investigate these differences.

Relation between Essay Scores and Demographic/Academic Characteristics

Means and standard deviations for essay data at levels of selected demographic/academic variables appear in Tables 4-9. These data show no relationship between essay performance and 1) age, 2) years of post-secondary education, and 3) number of English semester hours. There was a positive relationship between essay scores and examinees' self-ratings in writing and reading. That is, examinees proved to be good judges of their writing ability. There was also a positive relationship between essay performance and college selectivity. Students from selective undergraduate institutions received high essay scores, and those from less selective schools received lower scores.

Table 4

Mean Essay Scores by Age Group

Age	Mean	Standard Deviation	n
19	7.2	1.9	118
20	7.1	1.6	824
21	6.9	1.6	801
22	6.5	1.6	290
23	6.6	1.8	190
24	6.7	1.8	129
25	6.6	2.0	90

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Table 5

Mean Essay Scores by Years of Postsecondary Education

Years of Postsecondary Education	Mean	Standard Deviation	n
2	7.2	1.6	68
3	7.0	1.6	1498
4	6.6	1.8	671
5	6.6	1.8	492
6	7.1	1.8	58

Table 6

Mean Essay Score by Number of English Semester Hours

Course Hours in English	Mean	Standard Deviation	n
0- 4	7.0	1.6	384
5- 8	6.8	1.6	1103
9-16	6.8	1.8	852
17-24	7.0	1.7	62
24+	6.7	2.3	96

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Table 7

Mean Essay Scores by Self-Rating in Writing

Rating	Mean	Standard Deviation	n
Below Average	6.6	2.1	45
Average	6.2	1.6	551
Above Average	6.8	1.6	1020
Top 10%	7.3	1.6	771
Top 1%	7.6	1.8	154

Table 8

Mean Essay Scores by Self-Rating in Reading

Rating	Mean	Standard Deviation	n
Below Average	6.8	2.0	36
Average	6.3	1.6	497
Above Average	6.7	1.7	1066
Top 10%	7.2	1.6	741
Top 1%	7.5	1.7	196

Table 9

Mean Essay Scores by College Selectivity

College Selectivity	Mean	Standard Deviation	n
Mean SAT $\leq$ 892	6.3	1.7	396
893 $\leq$ Mean Sat $\leq$ 1036	6.7	1.7	1027
1037 $\leq$ Mean SAT $\leq$ 1181	7.0	1.6	773
Mean SAT $\geq$ 1182	7.5	1.6	494

Relation between the Essay and Science and Skills Tests for First-Time Examinees

Correlations between the essay and other tests are shown in Table 10. The correlations between the essay and science tests ranged from .27 to .29. The correlations between the essay and skills tests were higher; Skills Analysis: Reading had the highest correlation with the essay, r = .43. These intercorrelations were lower, however, than those observed among the science and skills analysis tests themselves; observed intercorrelations for these tests ranged from .55 to .88. This says that the essay was measuring a skill or skills that were different from those assessed in the current six-test battery.

Table 10

Correlations Between the Essay and Science and Skills Tests

	Essay
Biology	.29
Chemistry	.28
Physics	.27
Science Problems	.29
Skills Analysis: Reading	.43
Skills Analysis: Quantitative	.38

When essay scores were predicted from data for the six MCAT tests, the overall or combined correlation was .45. This means that 20% ($.45^2$) of the variance in the essay score distribution was common to or overlapped with variance on the other tests.

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Using this index of overlap and using data about the reliability of the essay and the science and skills analysis tests, an estimate of the amount of unique reliable variance in the essay distribution was derived. The resulting "uniqueness" estimate was 49%. This index says that 49% of the variance in the essay score distribution was reliable and related to abilities or traits that were unexamined by the other tests. These results do not necessarily say that the validity of selection decisions will increase by 49% when essay data are introduced. Data are not available on the relationship between the unique skills measured by the essay and performance in medical school. Performance data will be collected as the project progresses. If evidence for a positive relationship between essay scores and performance in school are obtained, an increase in the predictive validity of the battery will be realized.

Future Research

Validity data will be collected for a small number of students currently enrolled in medical school. The impact of the essay on the selection process will be investigated by schools paricipating in 1) simulated admissions decision-making exercises using the essay, 2) retrospective selection activities using the essay and 3) active use of the essay in admissions decision-making for Fall 1987. Research on the impact of the essay on the attitudes, course selection, curriculum, and application patterns of undergraduate students is currently being designed. Cost data on the development, administration and distribution of the essay will become available as the project progresses.

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INVESTIGATION OF THE VA INSPECTOR GENERAL REGARDING CONFLICT OF INTEREST

Attached is background materal relating to actions taken by the Veterans Administration Chief Medical Director in response to an investigation by the VA Inspector General. The first is a teletype sent to all regional directors, directors, and all department of medicine and surgery field activities. Eighty-eight letters were sent to employees with actions ranging from reprimands to terminations. The second document is a reproduction of the federal regulations being cited dealing with standards of ethical conduct and related responsibilities of employees.

The AAMC staff is working with the VA Central Office in an attempt to clarify the issues involved. Dr. John Gronvall will join the COD to discuss this matter.

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TO:
REGIONAL DIRECTORS: DIRECTORS, ALL DM&S FIELD ACTIVITIES

THE PURPOSE OF THIS MESSAGE IS TO EXPRESS MY DEEP CONCERN OVER DM&S EMPLOYEES ACCEPTING GRATUITIES, GIFTS, AND HONORARIA FROM DRUG COMPANIES OR OTHER COMPANIES AND INDIVIDUALS SEEKING TO DO OR CURRENTLY DOING BUISNESS WITH THE VETERANS ADMINISTRATION.

VA REGULATIONS ON EMPLOYEE CONDUCT AND OUTSIDE PROFESSIONAL ACTIVITIES CLEARLY AND SPECIFICALLY PROHIBIT AN EMPLOYEE FROM ENGAGING IN ANY ACTIVITY WHICH MAY BE CONSTRUED TO BE A CONFLICT OF INTEREST OR EVEN AN APPARENT CONFLICT OF INTEREST. THEY ALSO PROHIBIT EMPLOYEES OR THEIR FAMILIES FROM ACCEPTING, EITHER DIRECTLY OR INDIRECTLY, ANY GIFT, GRATUITY, FAVOR, ENTERTAINMENT, LOAN, OR ANYTHING OF MONETARY VALUE FROM A PERSON OR COMPANY THAT HAS, OR IS SEEKING CONTRACTUAL OR OTHER BUSINESS OR FINANCIAL RELATIONS WITH THE VA. IN ADDITION, VA EMPLOYEES ARE ALSO PROHIBITED FROM ENGAGING IN ANY ACTIVITY WHICH MIGHT RESULT IN OR CREATE THE APPEARANCE OF USING PUBLIC OFFICE FOR PRIVATE GAIN OR GIVING PREFERENTIAL TREATMENT TO ANY PERSON, GROUP, OR ORGANIZATION.

HONESTY, INTEGRITY, IMPARTIALITY, AND ETHICAL CONDUCT ON THE PART OF ALL EMPLOYEES ARE ESSENTIAL TO AN EFFECTIVE GOVERNMENT AND AN EFFECTIVE VA. AS CIVIL SERVANTS WE ARE ALL VESTED WITH A PUBLIC TRUST THAT MUST NOT BE COMPROMISED.

THEREFORE, AS CHIEF MEDICAL DIRECTOR, I WANT TO MAKE IT CLEAR THAT DISCIPLINARY ACTION WILL BE VIGOROUSLY PURSUED AGAINST ANY EMPLOYEE. NO MATTER WHAT LEVEL, WHO IMPROPERLY ACCEPTS OR CONDONES THE ACCEPTANCE OF ANY GIFT, GRATUITY OR HONORARIA IN VIOLATION OF APPROPRIATE LAWS AND VA REGULATIONS.

DIRECTORS ARE RESPONSIBLE FOR ENSURING THAT THIS MESSAGE IS DISSEMINATED TO ALL EMPLOYEES AND THAT EMPLOYEES ARE AWARE OF THE APPROPRIATE REGULATIONS GOVERNING STANDARDS OF ETHICAL CONDUCT AND OUTSIDE INCOME.

John W. Ditzler, M.D.
Chief Medical Director (10)
6/28/85

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Following are the federal regulations being cited by VA officials in their letters charging VA employes with conflicts-of-interest as a result of the Smith Kline & French investigation:

Standards of Ethical Conduct and Related Responsibilities of Employes

0.735-10 General Requirements

(a) Each Veterans Administration employe shall be expected to serve diligently, loyally and cooperatively; to exercise courtesy and dignity; and to conduct himself, both on and off duty, in a manner reflecting credit upon himself and the Veterans Administration.

(b) An employe shall avoid any action which might result in, or create the appearance of:

(1) Using public office for private gain;

(2) Giving preferential treatment to any person, group or organization;

(3) Impeding government efficiency or economy;

(4) Losing complete independence or impartiality;

(5) Making a government decision outside official channels; or

(6) Affecting adversely the confidence of the public in the integrity of the government.

(c) Employes shall not discriminate on the ground of race, color sex, religion or national origin in providing benefits under any law administered by the Veterans Administration. They shall not discriminate on those grounds or any other improper ground in any employment matter. Employes are responsible to cooperate in making equal opportunity for all a reality in the Veterans Administration.

(d) An employe shall not attempt to accomplish indirectly—through his immediate family or otherwise—any activity which he is prohibited from doing directly.

(e) Veterans Administration management and supervisors shall encourage the good conduct of employes by setting the example, by dealing with them considerately and impartially, and by showing sincere concern for them as individuals.

0.735-11 Gifts, entertainment and favors.

(a) Except as provided in paragraphs (b) and (f) of this section, an employe shall not solicit or accept directly or indirectly for himself or any member of his family, any gift, gratuity, favor, entertainment, loan or anything of monetary value, from a person (individual, corporation, company, association, firm, partnership, society, joint stock company, or any other organization or institution) who:

(1) Has, or is seeking, contractual or other business or financial relations with the Veterans Administration;

(2) Conducts operations or activities regulated by the Veterans Administration;

(3) Has interests that may be substantially affected by the performance or nonperformance of his official duty; or

(4) Is attempting to influence the employe's official actions.

(b) The restrictions set forth in paragraph (a) of this section do not apply when:

(1) It is clear that the motivating factor is the family or personal relationship (such as that between the employe and his parents, children, or spouse) rather than the business relationship of the persons concerned;

(2) Food and refreshments of nominal value are infrequently accepted when offered in the ordinary course of a coffee break, luncheon or dinner meeting, or other meeting, while on official business or on an inspection tour where an employe may properly be in attendance;

(3) Loans from banks or other financial institutions are sought on customary terms to finance proper and usual activities of employes, such as home mortgage loans;

(4) Advertising or promotional material is unsolicited and of nominal instrinsic value (such as pens, pencils, note pads, or calendars);

(5) Common courtesy gifts such as flowers are indicated on appropriate occasions.

(c) An employe shall not solicit a contribution from another employe for a gift to an official superior, make a donation as a gift to an official superior, or accept a gift from an employe receiving less pay than himself....However, this paragraph does not prohibit a voluntary gift of nominal value or donation in a nominal amount made on a special occasion such as marriage, illness or retirement.

(d) An employe is prohibited from accepting gifts or gratuities such as goods, money, services, purchases at discount, entertainment or similar favors from claimants, patients, ex-patients, or other beneficiaries of the Veterans Administration, or their relatives, friends, or agents, since it could be interpreted that the favors are in return for official services rendered. The administrator may authorize exceptions to this prohibition where such action would not contravene the overall intent of this part.

(e) An employe shall not accept a gift, present, decoration or other thing from a foreign government unless authorized by Congress as provided by the Constitution and in 5 USC 7432.

(f) Neither this section nor 0.735-12 precludes an employe from receipt of bona fide reimbursement, unless prohibited by law for expenses of travel and such other necessary subsistence, as is compatible with this part for which no government payment or reimbursement is made. However, this paragraph does not allow an employe to be reimbursed, or payment to be made on his behalf, for excessive personal living expenses, gifts, entertainment, or other personal benefit, nor does it allow an employe to be reimbursed by a person (individual, corporation, company, association, firm, partnership, society, joint stock company, or any other organization or institution) for travel on official business under Veterans Administration orders when reimbursement is proscribed by Decision B-128527 of the Comptroller General dated March 7, 1967.

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0.735-12 Outside employment, activity or compensation

(a) An employe shall not engage in outside employment or other outside activity not compatible with the full and proper discharge of the duties and responsibilities of his government employment. Incompatible activities include but are not limited to those which:

(1) Involve the acceptance of a fee, compensation, gift, payment or expense or any other thing of monetary value in circumstances in which acceptance may result in, or create the appearance of, conflicts of interest;

(2) Tend to impair his mental or physical capacity to perform his Veterans Administration duties and responsibilities in an acceptable manner;

(3) Bring discredit upon, are disadvantageous to, embarrass, or cause or may cause unfavorable and reasonable criticism of the federal government or the Veterans Administration;

(4) Conflict with the interests of the Veterans Administration or the federal government or can possibly be construed by the public to be official acts of the Veterans Administration;

(5) Involve the use of information obtained as a result of employment in the Veterans Administration, to the detriment of the Veterans Administration or those served by it;

(6) Take time or attention during duty hours, or consist of the private practice or a recognized profession to the extent that the employe appears to be privately practicing his profession during official duty hours;

(7) Violate a regulation, executive order, or a federal, state or local statute or ordinance.

(8) Tend to create suspicion of prejudice or favoritism in the administration of benefits to eligible veterans that could be of embarrassment to the Veterans Administration.

(b) An employe shall not receive any salary or anything of monetary value from a private source as compensation for his or her services to the government. This does not apply to employes working without compensation. (18 USC 209)

(c) Employes are encouraged to engage in teaching, lecturing and writing not prohibited by law, executive order...or any other agency policy. An employ shall not, however:

(1) Engage, with or without compensation, in teaching, lecturing or writing, including teaching, lecturing or writing for the purpose of the special preparation of a person or class of persons for an examination of the Civil Service Commission or of the Board of Examiners for the Foreign Service, that depends on information obtained as a result of his or her government employment, except when that information has been made available to the general public or will be made available on request, or when the administrator gives written authorization for the use of nonpublic information on the basis that the use is in the public interest;

(2) If he or she is a Presidential appointee covered by section 401(a) or Executive Order 11222, receive compensation, an honorarium or anything of monetary value for any consultation, lecture, discussion, writing or appearance, the subject matter of which is devoted substantially to the responsibilities, programs or operations of his agency, or which draws substantially on official data or ideas which have not become part of the body of public information;

(3) Accept any honorarium of more than $2,000 (excluding amounts accepted for actual travel and subsistence expenses for such person and his or her spouse or an aide to such person, and excluding amounts paid or incurred for any agents' fees or commissions) for any appearance, speech or article, or honorariums aggregating more than $25,000 in any calendar year....

(d) Employes are not prevented from:

(1) Receiving reimbursement in accordance with 0.735-11(f).

(2) Participating in the activities of national or state political parties not proscribed by law.

(3) Participating in the affairs of or accepting an award for a meritorious public contribution or achievement given by a charitable, religious, professional, social, fraternal, nonprofit educational and recreational, public service or civic organization.

(4) Engaging in outside employment permitted under this part.

(5) Taking part as a citizen or his or her community in civic, charitable, religious and other community efforts.

(e) Employes are encouraged to take part in service organization activities that do not conflict with, or give the appearance of conflicting with, Veterans Administration employment.

Thus, any employe may hold an office or position, at any level, provided that the combination of Veterans Administration position and service organization position cannot be construed as giving advantage to that organization, and if the employe agrees to disqualify himself or herself from taking part in any activities directed at the Veterans Administration, its policies, procedures or programs, or claims for benefits administered by the Veterans Administration. An employe may not act as a service officer preparing and presenting claims against the government.

Each employe is responsible for assuring that his or her intended actions are proper and, when in doubt, shall use the interpretation and advisory service established by 0.735-4. As used in this paragraph, a service organization is an organization usually composed of ex-servicemen, which presents claims from veterans and their dependents for benefits under laws administered by the Veterans Administration.

(f) An employe who engages in any outside work while on sick leave is required to report that fact to his or her supervisor.

(g) An employe shall not hold membership in any subversive organization or in a political party which advocates the overthrow of the government by force or violence.

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REPORT ON ASSOCIATION COMMITTEES

Since the last meeting of the Council of Deans the Executive Council has authorized the appointment of three new committees: the Ad Hoc Committee on Faculty Practice; the Ad Hoc Committee on Research Policy; and the Ad Hoc MCAT Review Committee. The following pages contain a statement of the charge to each committee, a list of members of these committees, and background material developed for the consideration of the committees, or in the case of the MCAT Review Committee, the discussion of issues which led the Executive Council to the decision to appoint the committee.

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AAMC AD HOC COMMITTEE ON FACULTY PRACTICE
STATEMENT OF CHARGE

The appointment of the ad hoc Committee on Faculty Practice was motivated by growing concerns among the AAMC constituency about the impact of changes in the health care delivery system on the ability of academic medical centers to fulfill their traditional missions of teaching, research, and patient care. Teaching hospitals have been the first to experience these changes and are actively engaged in re-positioning themselves in an environment of changing government reimbursement policies, price-consciousness, and growing commercialization. The AAMC has been active in representing the interests of these hospitals on policy issues and providing forums for exchange of information on how best to insure their survival amidst these currents.

The AAMC has had a less active and visible presence in assisting medical school faculties to cope with the new demands of purchasers of medical services. Its efforts have generally been limited to cataloging descriptions of faculty practice organization although grant-supported programs in the past have addressed the relationship between health maintenance organizations (HMO) and academic medical centers. Arguments in support of a renewed and more active effort are several:

1) the growing proportion of medical school revenues that faculty practice income represents;

2) rising concern that the commercialization of medical practice may be destructive of academic values and overshadow the academic mission of our institutions;

3) the emergence of HMOs and PPOs as a force in health care delivery mandating different organizational forms for providers of services;

4) a potential for growing division between physicians and hospitals created by changes in reimbursement policies and the movement to marketplace economics in health care delivery;

5) nagging skepticism that current governance mechanisms are adequate to respond to these challenges.

As with teaching hospitals, each medical school and its faculty practice organizations will have to decide on an institutional response to these developments. The AAMC has traditionally respected this autonomy of its member institutions. However, it is the feeling of many that there are initiatives that the AAMC could undertake that would help medical schools in this area.

Charge

The Committee is charged with the following:

1) to identify critical issues facing academic medical centers as a result of the changing practice environment;

2) to specify those issues in which the AAMC can and should have a role;

3) to recommend projects or programs the AAMC should undertake to assist its member institutions to deal with these issues.

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ISSUES RAISED BY THE FACULTY PRACTICE SURVEY AND QUESTIONS FOR DISCUSSION

The results of the AAMC Faculty Practice Survey highlight a number of interrelated issues that respondents believed to be critical to their institution's faculty practice activity. Below is a further distillation of the main issues raised and related questions which might serve as a basis for the committee's discussion. With respect to each of these areas, the committee needs to identify the specific issues involved and roles for the AAMC in serving its members.

Dependence on Practice Income

> *Most observers agree that medical schools are increasingly dependent upon patient care revenue for their fiscal viability.*
>
> *Ronald R. Kaufman*
> *HMOs and AMCs - A Status Report, 1984*

Respondents to the survey suggested that schools are in different positions with respect to the kind of problem this may represent. Some expressed concern that this dependence on practice income to support school and department budgets has become too great while others suggested that practice income represented a not yet fully-exploited source to replace other funds now becoming increasingly constrained. A cursory review of the data indicates that practice income is a significant and growing percentage of total revenues or general operating revenues. The growth in this source of support has paralleled the growth in

size of full-time faculties and faculty practice plans. Since the income-generating ability of clinical faculty varies by specialty, some departments are more able than others to provide a surplus (exclusive of direct physician compensation, fringe benefits, and operating expenses) to support education and research activities. Section V of this background book contains a review of AAMC data showing different perspectives on the dependence issue.

- To what extent is the medical school's dependence on practice income a concern for the AAMC and its members?
- Do changes in reimbursement policies and increased competition in the medical care system threaten medical schools? Medical faculties? Teaching hospitals? If so, in what ways are these threats similar or different for each? Is the AAMC sufficiently cognizant of and responsive to these threats?
- Does the AAMC have adequate monitoring and reporting systems to serve its members' interests?
- What are the consequences of decreased service income as a result of changing reimbursement policies and increased competition for the medical school's academic programs?

Preserving Academic Mission

> *To survive, [teaching hospitals] must consider several alternatives to meet the new challenges.... To some extent, each increases the commercialization of the enterprise and could threaten the traditional*

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balance of education, research, and service functions of the academic medical center.

John A. D. Cooper
JME, Jan. 1982

As generation of professional fee income becomes increasingly important for individual and special groups of full-time faculty, it follows that their commitment to and time spent in real medical school pursuits -- teaching and research -- will decline.

Leighton E. Cluff
JAMA, Dec. 1983

A consequence of this increased emphasis on practice and of the increasing size of the faculty is that it has placed many academic departments on a treadmill. As they get busier, they need more help.... I wonder, however, whether the change in ambience in which teaching and research take a back seat to practice should be driving medical schools.

Robert G. Petersdorf
JAMA, May 3, 1985

The perceived need for increased clinical income to support medical school programs, financial incentive systems that reward practice activity, and the need to maintain or increase the census of teaching hospitals are encouraging faculty to spend more and more time in practice. Fiscal concerns are not the only driving force. There is a fear that the changing practice environment is threatening the patient base needed for educational and research programs. The apportionment of faculty time was ranked as the most frequently mentioned issue by all but one of the groups surveyed. Some survey respondents see practice demands detracting from the teaching and research missions of the school. Others feel that survival depends on clinical faculty

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being more active and involved in practice, and that active clinical practice and teaching (if not research) are supportive of each other. (The affirmative responses to the survey question regarding the perceived conflict between clinical practice and the academic mission ranged from a low of 35 percent to a high of 68 percent.)

- Have these (and other) commentators identified a problem to which the AAMC should be responsive?
- In what ways can the AAMC assist its members to preserve their academic missions?
- Are our members adequately informed about the nature and significance of increased competition in the practice environment? Do they have access to strategies for coping successfully?

Faculty Appointments

> *The concept of full-time clinical faculty today has little resemblance to that enunciated by Flexner and adopted by most medical schools several decades ago. As initially defined, "full-time staff are so salaried that the hospitals and medical school command their entire time for the care of patients, for the instruction of students, and for research.... He is simply freed from the necessity of earning any part of his livelihood by private and consulting practice -- free that is, to devote himself in what is for him the most effective fashion to the care of patients, the training of pupils and the increase of knowledge."*
>
> *Leighton E. Cluff*
> *(Quoting Flexner)*
> *JAMA, Dec. 2, 1983*

> *We need to reintroduce the use of part-time faculty, either paid or unpaid. It is no longer sensible or wise for medical schools to have full-time people in every specialty or subspecialty. The volume of business simply does not warrant it. Part-time faculty have the advantage of practice experience.... They do*

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not require laboratory space and rarely require offices or other support systems. They will save the medical school money and, with proper leadership, will constitute valuable teaching and training resources for both medical students and house staff.

Robert G. Petersdorf
JAMA, May 3, 1985

These commentators suggest that a change in conception of the full-time faculty and the role of the part-time faculty would both ease the financial pressures on the school and increase the focus on the academic enterprise.

- Does it make sense for the AAMC to take a public position encouraging deliberation on such proposals?
- Is there a way in which these approaches could be tested and the results monitored for the benefit of the membership?

To handle the already heavy practice load that has evolved on medical schools, it is essential that they recruit a second faculty of clinician-teachers in addition to the traditional researchers. In recruiting such faculty, the schools must accept that this second faculty will differ from their more research-oriented colleagues. In fact, they make up one platoon in a two-platoon system.... Both [platoons] will be academic, and both should insist on scholarship, but both are necessary.

Robert G. Petersdorf
JAMA, May 3, 1985

So far, the experience at the University of Pennsylvania has been that the clinician-educator faculty members seem to feel as secure in their positions as tenured faculty members.

Edward J. Stemmler
JME, June 1984

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There seems to have been an imbalance in the rewards in favor of basic research compared to clinical activity. The clinician often is perceived as a second class citizen despite a great deal of rhetoric to the contrary. The young faculty members all recognize this status and are offended by it.... (G)iven the high service load placed on them for clinical activities and the lack of free time to do clinical research, they are routinely going into private practice.

Hospital Director
Respondent, AAMC Faculty Practice Survey

- Does the model of the two-platoon system: clinician-educators and researcher-teachers with varying appointment, promotion, and tenure policies reflecting their respective contributions present an attractive alternative to current practice?
- Would it create or resolve the second class citizenship problem?
- Does it support or compromise the standards of scholarship of the university faculty?

Faculty-Hospital Relationships

In our culture it is customary for physicians, including academic physicians, to think of the financial difficulties faced by the hospital as someone else's problem.

Robert Ebert
NEJM, May 19, 1983

The symbiosis of the medical school and its primary clinical affiliate, which have been a major source of strength during the long era of prosperity, may turn into a hindrance, if not a fatal liability, for the hospital in the years ahead.... It is far from clear that the medical school faculty is the most

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suitable, much less the only, party to such [necessary] restructuring.

Eli Ginzberg
Health Affairs, Summer 1985

The future competition in health care will not be between doctors and hospitals, or between hospitals and other hospitals, or between doctors and other doctors. Rather, the competition will be between groups of doctors and hospitals and other groups of doctors and hospitals.

Michael D. Bromberg
Review, December 1984

Unfortunately, the regulatory environment has focused (at least to date) principally on the hospital; it has put the hospital (the enforcer of regulations) increasingly at odds with its physicians and increasingly at risk for the consequences of their clinical practice.

Vice Chancellor for Health Affairs and Hospital CEO
Respondent, AAMC Faculty Practice Survey,

Rather than working toward a common mission and set of goals and objectives for the AHC, the faculty practice plan is doing what's best for itself and the hospital is doing the same. Thus, we find ourselves competing against one another and the faculty practice plan beginning to set up services/programs in direct competition with the university hospital.

Vice Chancellor and Hospital Director
Respondent, AAMC Faculty Practice Survey, 1985

Hospital directors responding to the AAMC Faculty Practice Survey placed the matter of hospital-faculty relationships at the top of their agenda. They recognized and were sensitive to the

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academic mission. They appreciated the potential for conflict between traditional faculty values and the demands of competition. They perceived little comparable sensitivity on the part of faculty who seemed either to be oblivious to the need to change or to be charging off to advance their own interests.

- Are we as a community as vulnerable and in such disarray as these commentators suggest?
- Are there undertakings at the national level which will assist in local recognition of the problem? In motivating the parties to action? In setting out the framework of effective strategies to follow?

Practice Organization

A new survey of medical group practice conducted by the AMA's Division of Survey and Data Resources reported a rapid rise in the number of groups in less than five years. In the last nineteen years, the number of identified group practices has nearly quadrupled from 4,289 to 15,484.... Most groups (5,579 of the 1984 total) are comprised of 3 or 4 physicians, but the number of groups with 100 or more physicians is growing too; there were 76 such groups four years ago and by 1984 the number had increased to 158. One force driving physicians to cluster in groups is a concern that they be well positioned to compete for patients in the future.

David A. Crozier and John K. Iglehart
Health Affairs, Winter 1984

The other side of the coin is that academic faculties need to form true group practices to meet the competition. In order to achieve this goal, the traditional and often confining practices based on the academic departmental structure are probably not the way of the future.

Robert G. Petersdorf, M.D.
JAMA, May 3, 1985

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In my opinion, the clinical practice of our faculty must be viewed as a large group practice rather than a confederation of individual clinical departments.... In addition, the group must have a governing body which is able to negotiate with outside parties to deliver a total health care product at a competitive price.

Faculty Representative,
Respondent, AAMC Faculty
Practice Survey

Since it [faculty practice plan] is departmentally organized, the departments themselves are not well positioned to meet the market with too few general internists and too many specialists, etc.

Hospital Director
responding to the AAMC
Faculty Practice Survey

It is important that some institutional philosophy be developed that neither permits exploitation of the institution by individual clinical departments nor gives a free ride to parts of the academic health center that are remote from the concerns of the medical school and the teaching hospital. That means that the practice should be a multispecialty group practice that plans its staffing on the basis of the needs of the multispecialty group instead of those of the department.

Robert H. Ebert, and
Sarah Brown
NEJM, May 19, 1983

Medical and health services are increasingly available through brokered systems in which the buyers are no longer interested in purchasing separately physician services or hospital services but rather are seeking the guaranteed availability of necessary medical services at a predetermined fixed price. This development is undoubtedly spurring the growth of group practices as described above. It also is the source of frequent statements

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in the AAMC Faculty Practice Survey that medical school faculties need to re-organize their practice activities along interdisciplinary lines and form a "true group practice." While the definition of a true group practice is not clear, apparently several characteristics need to be present: the coordinated management of patients, internal referral systems, income sharing arrangements that recognize the contribution of each member to the group, and mechanisms to develop joint ventures with hospitals and negotiate with prepaid managed care systems.

- Is there a need for re-organized practice arrangements in academic medical centers?
- Do medical schools need to re-organize their practice plans into multidisciplinary groups?
- Is there an appropriate model for this re-organized arrangement currently in an academic medical center?
- What are the main obstacles to such a re-organization?
- What could the AAMC do to help centers surmount these obstacles?
- Should the AAMC develop educational programs addressing the re-organization of practice plans?
- Should the AAMC serve as a resource center to provide periodic reports on the current characteristics of practice plans?

Governance

Many of the preceding issues are inextricably entwined with governance mechanisms in academic medical centers and the

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relationships among the department chairmen, dean, hospital director, and vice-president. While strong departmental structures have been a source of strength of American medical schools, there is a fear that their relative autonomy hinders effective action on a number of problems facing academic medical centers. Several observers have commented on the autonomy of many department chairmen:

> *We noted earlier that in the years of open-handed funding for medical research and GME, power shifted from the deans to departmental chairmen and principal investigators. It will not be easy for medical schools to reverse this trend, but if they are to respond to the many critical needs that have been identified, from reforming the curriculum to implementing constructive personnel policies that will assure a vital faculty, a strengthening of the central medical school administration is essential.*
>
> *Eli Ginzberg*
> *Health Affairs, Summer 1985*

> *(T)his new income is not evenly distributed. "Those who earned the most acquired the most power on medical school faculties," Cluff noted. At one institution with which he was familiar, the departments of radiology and ophthalmology were "generating so much income that the department of medicine, which was providing 32 percent of all teaching in the medical school, to a large extent lost most of its influence and power.... This had profound effects on the educational process," Cluff said, "and I don't think we should over look it."*
>
> *Richard A. Knox*
> *(Quoting Leighton Cluff),*
> *Health Affairs, Summer, 1985*

> *It is our contention that academic departments can no longer function each as "a tub on its own bottom, sailing in whatever direction it wishes." Indeed, if administrative anarchy is to be avoided, the multiple*

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demands on the medical school and hospital must be addressed through coordinated actions.

Robert G. Petersdorf and
Marjorie P. Wilson
JAMA, February 26,1982

There is perceived to be a danger that unfettered departmental autonomy in the practice arena results in a variety of separately negotiated arrangements which strengthen individual departments but do not advance the institutional mission.

- Is this danger real and growing?
- Are current governance mechanisms adequate to cope with this trend?

Perhaps the experience of medical schools in the development of NIH-funded research centers provides an analogue to the problems in developing interdisciplinary practice organizations.

These large and complex programs [NIH funded research centers] have specific management, personnel and resource requirements which are not entirely congruent with those of the educational institutions in which many of them are best housed.... A... problem is the occurrence of branched or ambiguous lines of institutional authority. Centers and targeted research create new intra- and extra-institutional constituencies to which institutional systems of governance must adapt. This is often reflected in the creation of a center advisory board which does not fit into the institutional decision-making procedure.

Stuart Bondurant
Presentation to the President's Biomedical Research Panel, 1975

- Are there lessons to be learned from the history of NIH-funded research centers in academic medicine that

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apply to the governance issues surrounding the development of an interdisciplinary practice organization?

Governance mechanisms that encourage departments to function in the service of medical school objectives are not sufficient. Competition and regulation make visible the interdependency of medical schools and their teaching hospitals. These highlight the need for coordinated medical center wide strategies that recognize the different businesses medical schools and teaching hospitals are in.

> *It is not unusual for the hospital director to disagree with the medical staff on the one hand and the medical school administration on the other. Such conflicts must be brought into the open to be resolved.... The director must do more than keep his eye on the bottom line, and the dean must view the hospital as more than a laboratory for research and a classroom for teaching.*
>
> *Robert G. Petersdorf and Marjorie Wilson, JAMA, February 26, 1982*

> *The real question is how to conduct, direct, and manage the complex of institutions engaged in different businesses that make up an academic medical center. There is a need to define the market for the businesses, that is, the consumers and their expectations.... They are the most important people -- not deans, directors, vice presidents or faculties.*
>
> *Robert M. Heyssel JME, March 1984*

> *Traditionally, faculty have been encouraged in their entrepreneurship and much of the growth of the system may be attributed to the success of their efforts. Academically, a substantial level of autonomy has been regarded as essential to the creative and scholarly missions of academic medicine. Now, however, it appears that changed financial incentives in the*

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practice arenas as well as the potential need for better management of the size and content of the educational program at both the graduate and undergraduate levels, raise the question of whether our institutional structures and processes are equal to the task of institutional management.

From the AAMC Officer's Retreat Agenda, December 1983

- How will strategic decisions affecting the medical school and hospital be made?
  - What is the role of the dean?
  - What is the role of the department chairman?
  - What is the role of the hospital chief executive officer?
  - What is the role of the vice president?
  - What options are available?
- How can the academic model of governance in the medical school be reconciled with the corporate model in the hospital to set strategy for the medical center?
- In what ways can the AAMC assist its members in exploring these options and developing strategy?

Prepaid Managed Care Systems

While the patient, government, and insurance carriers have been unable to prevent the increase in health care costs, they are now prepared to mandate that the physician accept the responsibility for constraining them. In those areas where physicians are already in over supply, they are agreeing to assure this burden. Medical centers in such areas must be prepared to either form large HMOs and/or develop very strong referral programs.

R. B. Friedman
JME, July 1984

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...There will be attempts at vertical integration resulting in "brand name medicine," in which different levels of care are furnished under a single name, sophisticated marketing and sales operations are the rule, and patients are locked into a health provision system from birth to death for anything from one-shot emergencies to long-term geratric care... Given the academic medical center's lack of price competitiveness, as a consequence of teaching costs, an unusually high incidence of indigent patients, and a preponderance of sick patients, this change in environment represents a very real threat to their fiscal solvency and perhaps even their academic viability.

Robert G. Petersdorf
JAMA, May 1985

As described above, competition for patients by hospitals and practitioners is on the rise and price is an increasingly important factor in purchasing decisions by patients. HMOs and PPOs are rapidly emerging in the health care delivery system and will lock an increasing percentage of the population into closed panels. Academic medical centers for their own survival may have to negotiate for referrals from HMOs or sponsor their own in order to have access to these patients. Association with or sponsorship of an HMO raises a number of problems which must be addressed and resolved:

There are several conclusions that most observers have drawn from past medical school/HMO affiliations. They are:

(1) The initial development of a HMO requires substantial capital investment...

(2) Faculty physicians have difficulty functioning in the HMO environment. A common difficulty in establishing an HMO in an academic setting is the need to set productivity standards that interfere with teaching or run counter to faculty attitudes. A related problem is the difficulty of finding sources

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of funds to subsidize the teaching cost of an HMO...

Bernard W. Nelson
HMOs and AMCs - A Status Report, 1984

To date, HMOs have shown considerably more interest in participating in graduate rather than undergraduate medical training. At the graduate level HMOs receive the service benefits of residents' clinical participation and may recruit these residents for their staffs. Involvement in undergraduate medical education, on the other hand, is generally viewed by HMOs as a more costly proposition. Medical students offer limited service benefits and require more instructional time from staff physicians.

Joseph Isaacs
HMOs and AMCs - A Status Report, 1984

- What changes are required for a medical center to become a part of HMO referral systems?
- Is an academic medical centered-sponsored HMO viable?
- What are effective models of medical center-HMO affiliations?
- Can the concept of risk-sharing, inherent in the new modes of medical care delivery, be integrated with faculty practice organizations and hospital systems under university and/or state control?

...the academic medical center must realize that the sponsorship of an HMO requires a major commitment to develop well-organized and effective primary-care services and that only after substantial growth will the HMO membership contribute noticeably to the use of the existing secondary- and tertiary-care services of the academic medical center.

Richard H. Hoft and
Robert J. Glaser
NEJM, December 30, 1982

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Historically, medical schools and teaching hospitals have emphasized secondary and tertiary services over primary care. The sponsorship of an HMO would seem to require new faculty staffing patterns. Other developments, such as outreach satellite clinics, are also pushing medical schools and teaching hospitals to expand primary care services to ensure the referral system which is threatened by greater involvement of community physicians and hospitals in specialized services, formerly the exclusive province of the academic medical center.

- Is the medical school faculty organized and staffed in a way to deliver primary care?
- What are the implications of greater primary care emphasis for staffing patterns and educational programs?
- Are there different strategies taken by medical schools and teaching hospitals to preserve a referral system?
- Is there assistance that the AAMC can provide schools in deciding on a strategy.

The AAMC is currently planning four regional workshops addressing alternative delivery systems and the challenges posed to academic medical centers. At the first meeting of the committee, a description of these seminars will be presented.

- Are there additional activities or efforts the AAMC should undertake to assist its members in understanding the complexities of these ventures?

Practice Plan Management

To be competitive and maintain their market share, AMCs will have to spend more of their resources on

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developing professional managers...and on other expertise needed to promote their faculty practice plans and/or alternative delivery systems.

Ronald Kaufman
HMO's and AMCs - A Status Report, 1984

The changes in the health care delivery system have increased the importance of professionals in the field of health care management and organization. The AAMC has had extensive involvement with hospital directors but a less visible involvement with faculty practice plan administrators. The AAMC's involvement with hospital directors is based on its mission of representing them on broad national policy issues affecting teaching hospitals and not on increasing their expertise in hospital management. Since practice plan managers have not been formally recognized as those directly responsible for policy setting, the AAMC has not supported their activities in a similar fashion. However, the complexity of practice management today has given practice plan administrators an influential role in the development of policy because of the technical expertise these administrators bring to questions of physician reimbursement, new practice organizations and joint venture arrangements, etc. The Medical Group Management Association Academic Practice Assembly (MGMA-APA) has emerged as the principal professional development organization for these administrators. Some participate in the activities of the AAMC's Group on Business Affairs (GBA) but that group traditionally has served the needs of medical school financial and business officers. (See Section VII for a description of these organizations).

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- Should the AAMC make a more concerted, direct, and visible effort to involve practice plan administrators in its activities?
- What form should this new initiative take?
- Should the AAMC consider developing a relationship with MGMA-APA?

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AAMC RESEARCH POLICY COMMITTEE

The ad hoc Committee on Research Policy of the Association was established in June 1985 at the request of the Council of Academic Societies to provide a focus for Association review and analysis of federal biomedical research policy. The Committee will respond to a series of initiatives by the NIH, the Executive Branch -- especially the OMB and the Office of Science and Technology Policy -- and various committees in Congress to examine, and in some cases alter, the present framework of policy for the conduct of biomedical research.

The ad hoc Committee has been charged to review and further develop Association positions on the federal role in biomedical and behavioral research in regard to these six contexts:

- goals of biomedical research
- research manpower and training
- the extramural award system
- support for institutional infrastructure
- funding for research
- formulation of biomedical research policy.

The Committee held its first meeting in August and plans further meetings in October and December.

The Committee anticipates formulation of its overall research policy positions sufficient to permit discussion with the constituent councils by Spring. The Committee also anticipates a role in facilitating an integrated Association participation in the public debate engendered by the recently constituted Science Policy Task Force of the House of Representatives as it conducts hearings and prepares a series of recommendations on federal research policy for public review in May 1986. The Science Policy Task Force, chaired by Representative Don Fuqua (D-FL), chairman of the present Science and Technology Committee of the House, is engaged in the first major congressional review of American Science Policy in nearly twenty years. The Task Force is conducting an in-depth examination of the major government policies for the conduct and support of basic and applied research across all the major scientific disciplines. It is examining the significant changes which have occurred in the science-government relationship and the overall environment for scientific research in the last twenty years, and attempting to identify and anticipate the proper role for government and the appropriate policies which should govern the federal investment in science in the coming decades.

A background paper delineating the key policy issues which will be addressed by the AAMC Research Policy Committee is attached, as is a list of the membership of the committee.

AAMC AD HOC RESEARCH POLICY COMMITTEE

CHAIRMAN: Edward N. Brandt
Chancellor
University of Maryland at Baltimore

MEMBERS:

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

Stuart Bondurant, M.D.
Dean
Univ. of North Carolina at Chapel Hill School of Medicine

Thomas Q. Morris, M.D.
President
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David H. Cohen, Ph.D.
Chairman, Dept. of Neurobiology
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Robert E. Fellows, M.D. Ph.D.
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Peter C. Whybrow, M.D.
Chairman, Dept. of Psychiatry
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John T. Potts, Jr., M.D.
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David B. Skinner, M.D.
Chairman of Surgery
University of Chicago, Pritzker School of Medicine

Benjamin D. Schwartz, M.D.
Professor of Medicine
Howard Hughes Investigator
Washington University School of Medicine

EX OFFICIO:

Richard Janeway, M.D.
Chairman, AAMC
Dean, Bowman Gray School of Medicine

Virginia V. Weldon, M.D.
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Associate Vice Chancellor for Medical Affairs, Washington University School of Medicine

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BACKGROUND PAPER FOR RESEARCH POLICY COMMITTEE

Introduction

The unfortunate paradox that confronts this nation's biomedical and biobehavioral research enterprise is that at a time of scientific opportunities unparalleled in the struggle to seek knowledge and limit disease, the resources essential to pursue these opportunities are not keeping pace. As an example, in fiscal 1973, 3.8 percent ($3.8 billion) of the $99.4 billion expended nationally for health care went to research and development. By fiscal 1983, however, research and development accounted for only 3.0 percent ($10.4 billion) of the $350.8 billion in health care costs.

More specifically, obligations for the National Institutes of Health (NIH) in fiscal 1972 totalled $1.506 billion. By fiscal 1982, NIH obligations in terms of 1972 constant dollars were $1.696 billion -- an increase of only 1.3 percent per year in purchasing power over the decade. Only within the last three years, under concerted pressure from all sectors of the health research community, has the NIH budget again experienced real growth to $2.145 billion in 1972 constant dollars by fiscal 1985. The ADAMHA budget for research and training exhibited virtually no growth in purchasing power between 1972-1984, going from $149.5 million to $152.4 million in constant 1972 dollars. FY 85 saw some improvement to an appropriation of $163.5 million in constant dollars.

The recent gains, however, are threatened by congressional preoccupation with deficit reduction and the recent actions of the Office of Management and Budget (OMB), which has, in effect, impounded a portion of the fiscal 1985

appropriations for the NIH and ADAMHA. These are only the latest indications that the federal largesse for biomedical and biobehavioral research is limited. Faced with the likelihood of continued constraints on the federal resources available for biomedical science, the foremost questions in any discussion of research policy must be:

- How should these limited resources be invested?
- Who should be charged with the responsibility for these investment decisions?

Underlying these fundamental questions are a number of separate but related policy issues that also require resolution. The public debate has been clouded by efforts to expand the goals of biomedical research beyond the acquisition of knowledge and the improvement of health. The post-industrial evolution of the United States into a society based on knowledge, communications, and high technology has created a series of new expectations for science. Increasingly, biomedical research is charged with responsibility to protect not only the nation's public health, but since the emergence of the biotechnology industry, its economic health as well. Responsible policy discussions need to be based on an understanding of what can and should be expected from biomedical science.

There are policy issues related to each of the three roles that the federal government has traditionally assumed with regard to biomedical research -- its role in supporting research itself, and as a derivative, its roles in assuring the manpower supply and contributing to the research infrastructure. At various times the validity or appropriate extent of each of these roles has been questioned. Ten years ago there was considerable concern whether the support of research training was a legitimate responsibility of the federal government. More recently, the obligation of the federal government to

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support the infrastructure at the research institutions has been discussed, most notably in the context of the administration's desire to limit payments for the "indirect costs" associated with NIH research grants, and the increasing clamor over the lack of federal investment to stem the deterioration of research facilities. At present, the NIH, OSTP, and the Congress are engaged in an examination of whether the government is actually investing in a system of research or simply purchasing research results with little responsibility for the milieu from which these scientific products are drawn. This debate about the extent of federal responsibility for infrastructure is critical because the growth of the biomedical research enterprise has long passed the point where the milieu can be sustained by the institutions without the assistance of the federal government.

The AAMC ad hoc Committee on Research Policy has been charged to review and further develop Association positions on the federal role in biomedical and biobehavioral research in regard to these six contexts:

- goals of biomedical research
- research manpower and training.
- the federal research award system.
- support for institutional infrastructure.
- funding for research.
- formulation of biomedical research policy.

In each of these areas a series of policy issues and questions are identified which may serve to guide the deliberations of the committee.

The Goals of the Federal Research Effort

Biomedical research in this country has traditionally been driven by two fundamental goals: the advancement of knowledge and the conquest of disease. The pursuit of these goals has resulted in the development of a research

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establishment internationally recognized for its excellence that has contributed immeasurably to advances in health and the conquest of disease. The federal goal as embodied in the missions of NIH and ADAMHA is even more unitary; it is to use science to improve health. The AAMC has traditionally espoused the view that basic biomedical research itself should be a national goal as the foundation of applied science related to health, and that improvement in the health of the nation should be one of the primary concerns of government. The 1971 AAMC Committee stressed that world leadership and excellence in science itself were appropriate national goals and that, in the long term, improvements in the nation's health rested upon the willingness of the federal government to be the principal sponsor of biomedical research and to award a high priority to basic research.

Today the biomedical research enterprise is being increasingly subjected to pressures to achieve other objectives and meet other societal needs beyond improvement of health, as well as to pressures to adopt specific and limited goals and seek immediate solutions to a shifting array of public perceptions of the nation's health needs. Thus, there are two fundamental policy questions to be considered.

First, to what extent should the goals of biomedical research encompass broader societal concerns? Examples of such concerns are using scientific investment as a tool for regional economic development, assuming the burden of transforming society from an industrial base to a high technology base, maintaining the competitiveness of American industry in the world marketplace, supporting small businesses, assuring equity of access to career opportunities for underrepresented minorities, promoting geographic diversity of research centers, and enabling participation of all segments of the population in a society based on science and technology. Many of these legitimate societal

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objectives have been at least partly achieved as an indirect result of a science policy directed toward the traditional goals of advancing knowledge and improving health. Is a reordering of priorities to emphasize these societal aims desirable or warranted?

Second, to what extent should the biomedical research enterprise acknowledge and respond to public pressures to produce immediate solutions to specific disease-related concerns? These understandable societal demands highlight the tension between investing in basic research to generate knowledge and investing in targeted research that is directed toward the cure of specific diseases. Debate must center on the extent to which biomedical research can and should be directed toward categorical disease themes, the degree to which it should be directly responsive to public pressures for specific disease initiatives, and the extent to which it should focus on translation of new knowledge into improved health care.

The Federal Role in Research Manpower and Training

The AAMC has traditionally maintained that a strong, viable program of research training is absolutely essential to ensure the quality and quantity of skilled scientists necessary to fulfill the nation's biomedical and biobehavioral research needs. The Association has continued to stress the need for a major federal role and reaffirmed the self-renewing nature of American research training, which yields highly trained investigators but also assures the critical core of academicians needed to sustain the cycle for the future. The AAMC has long endorsed the desirability of a diversity of support mechanisms for training with an emphasis on institutional training grants, which have education as the primary product and provide support for the training milieu. It has also emphasized efforts to attract more individuals

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to careers in clinical research, and the desirability of a "generic" authority for research training under Section 301 of the Public Health Service Act.

The exponential expansion of the "new" biology requires of its investigators a depth of sophisticated knowledge and a high degree of technical capability, which are obtained only after a lengthy and rigorous program of research training. This is particularly true for clinical investigators, who must undertake both research and clinical training upon completion of their medical degrees. While affording a wealth of scientific opportunities, the demands that this increase in the depth and breadth of the biomedical research base place on the current research training mechanisms, and the resources needed to maintain an educational effort of this scope warrant a reexamination of the role of the federal government in support of biomedical and biobehavioral research education. This review should focus on the appropriate role and policies of NIH and ADAMHA in:

- stimulating interest in careers in science, particularly during baccalaureate and medical school education.
- insuring the necessary intensity and length of preparation for a research career as well as the breadth and flexibility needed to be productive in rapidly advancing disciplines.
- enhancing the adaptability of mid-career professionals in keeping abreast of changing research priorities.
- maintaining the appropriate elements of the training environment.
- ensuring the training of an appropriate number of M.D. investigators in the face of pressures generated by the increasing debt burden of medical graduates, efforts to limit support for subspecialty clinical training, and the difficulties of clinical investigators

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and clinical research projects in competing successfully for grants.

- identifying and diminishing other career obstacles such as the National Research Service Award payback provision or the perception of instability in funding for meritorious investigators.

The AAMC Committee should also consider the role of the National Academy of Science Committee on Personnel Needs in Biomedical and Behavioral Research in setting the scale of federal investment in research training by its manpower projections. In particular it should consider the effects of the model used by the NAS committee to make manpower predictions. A model based on projections of available jobs leads to recommendations to expand the research training effort during periods of high federal investment in biomedical research and expanding enrollments in medical schools but would shrink that effort under current conditions. Should models that might project manpower needs based on anticipated scientific opportunities or numbers of qualified applicants for training be considered?

The Federal Research Award System

At issue in any examination of the present federal system advancing knowledge in the biomedical sciences to improve health are two aspects of the system for extramural research; the portfolio of grants or instruments used to invest in science and the system for allocation of the funds within and between components of this portfolio. The Association has traditionally maintained that a diverse portfolio is appropriate, with emphasis on individual investigator-initiated research grants, and that all levels of research should be supported with a greater emphasis on basic than targeted or applied research. Decisions regarding allocation of funds should be based on technical merit review, which incorporates judgments about scientific opportunity as well as the quality of the proposal and applicant.

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The current system of allocating support for biomedical science is being subjected to a number of severe stresses. The quality of the grant applications submitted has increased, while the volume of applications is rising, thus necessitating more reviewers and involving heavier work loads for the initial review groups (IRGs). At the same time, the current economic climate imposes funding constraints that prevent the system, no matter how frenetically it struggles, from supporting all good proposals.

A disparity exists across the entire portfolio of funding mechanisms between these high quality proposals, with their inherent opportunities for scientific advancement, and the limited availability of financial resources to support these proposals. As a result, research funding is being increasingly dominated by a shift to individual project grants, with a three year funding cycle. This trend and the distortions it has produced in the grant application, grants portfolio, and review and funding processes necessitate an examination of the present system of research support.

For example, there is the perception that these pressures have caused the IRGs to become more conservative, stifling creativity by not supporting high risk proposals. There is a perception that the IRGs have recently tended more to reduce the budgets of individual grants. It is suggested that there are serious inadequacies with the process of scientific review; recently questions have been raised about the credibility of the reviewers, the validity of the grading system, and the integrity of the process itself.

There are concerns that this pressure on the grant application process also hampers research creativity by increasing the frequency, complexity, and multiplicity of applications, as well as increasing career instability for meritorious individual investigators. Lastly, there is the perception that

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the system may be responding with a diminuition of the heterogeneity and redundancy of project support that is both desirable and necessary in rapidly evolving areas of science.

Two policy question arise out of this increased pressure on the system:

- What should be the diversity of the research portfolio and how can this be maintained?
- Is there evidence that the present system of competition based on project merit and expert judgment should be modified?

Federal Support for Institutional Infrastructure

The AAMC has long recognized the fragile ecology of the academic medical center and has continually advocated increased federal support for the structure and function of these institutions, which are responsible for the conduct of the majority of the nation's biomedical and biobehavioral research effort. This ecology, which is based on a delicate synergism of federal, state, and institutional resources, is being threatened by a variety of forces, such as the deterioration of the physical facilities, the obsolescence of instrumentation, the potential loss of income from patient care revenues, and federal and institutional bureaucratic accretion.

In an effort to provide support for the same number of grants with decreasing resources, the federal government has created a situation wherein it is widely believed that the research support dollar is increasingly directed toward procurement rather than investment; that is, that research is being "purchased", with little regard to the key elements of the infrastructure responsible for the research, such as support personnel, institutional training support, and facilities and equipment needs.

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Beyond this question of whether the federal government should procure or invest in research are several other issues that require review by the AAMC ad hoc Committee on Research Policy. One is the appropriate locus for biomedical research; that is, what are the advantages and disadvantages of conducting biomedical research in academic medical centers, in partnership with industry, in autonomous research centers, or in the intramural programs at the NIH and ADAMHA? Is the present system of decentralization, which provides for a number of heterogeneous research units with the vast majority located in academic settings, desirable? Should there be more or fewer research centers? What needs to be done to strengthen these research centers?

Another important policy question is whether the current convention of distinguishing between "direct" and "indirect" research costs is the most efficacious mechanism for reimbursing the institutions for the costs related to the performance of research.

Federal Funding of Biomedical Research

The AAMC has traditionally espoused the essential role of adequate federal funding for biomedical and biobehavioral research in order to continue the scale of scientific effort that is currently established. The Association has also supported the concept that the amount of funding should be determined in part on the basis of "annual adjustments for inflation, for the increased cost of sophisticated investigative tools, and for investment in new and promising areas of research."

The tension between the scientific goal of exploiting new research opportunities and the economic goal of reducing federal obligations has resulted in efforts by both the Congress and the academic research community to determine what is the "optimum" amount of federal funding support for

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biomedical research. These deliberations have focused on several policy questions; should biomedical research funding equal a fixed percentage of national health care costs or a percentage of the gross national product; should there be a requirement for annual growth; what would be the effects of curtailing federal funding for biomedical research, and has limited funding diminished the support of innovative or "high risk" research? Several other concepts that have been discussed are support for all good scientists or all meritorious projects, funding for a stable number of grants, and establishment of a base level of support for biomedical research.

At the same time, pressures continue to allocate funds to achieve other societal objectives, such as geographic diversity, health care delvery, or industrial competitiveness, which place even further strains on the availability of already limited fiscal resources.

The AAMC ad hoc Committee should consider which criteria are meaningful and appropriate for use in determining the amount of funding support that the federal government should supply for biomedical research. The "price tag" for desirable federal initiatives identified during previous committee discussions should be considered. The basis for recommending increased federal funding should be seriously debated in the light of the current economic realities.

Formulation of Federal Research Policy

Given the Association's positions in these five major policy areas, the AAMC ad hoc Committee should examine the process by which national policy for biomedical and biobehavioral research is formulated. Among the issues to be considered are the respective roles for the Congress, the administration (OSTP, OMB, and the Department of HHS), the agencies (NIH and ADAMHA), the institutions, the individual investigators, the voluntary health

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organizations, and the public. At what level does each participant have a responsibility for the formulation of research policy? What should be the relationship between the participants, particularly in terms of oversight and providing appropriate checks and balances within the system? This is perhaps most critical in the interaction between the scientists, who possess expert judgment about scientific priorities, and the Congress, which is charged with the responsibility to represent the interests of the public. The tenor of Congress within the last decade has shifted increasingly to a view that scientists cannot be trusted to run the scientific enterprise: that they tenaciously defend the status quo against societal concerns and that they are suspect as expert witnesses because they are interested parties who stand only to gain from increased investment in an unfettered research enterprise. The clamor of single interest groups and their representatives for patchwork allocation of funds to narrowly targeted areas has grown steadily. This vox populi has increasingly emerged as a counterforce to decisions based on scientific judgment and research opportunity.

Other relationships also are changing. Historically, the Congress has had the primary task of establishing the broad brush strokes of research policy through the legislative and appropriations process, while the administration has fleshed out and implemented policy via the department and the individual agencies. Recently, however, various elements within the administration, most notably in OSTP and OMB, have attempted to assume a more central role in regard to biomedical research policy. At the same time, various public interest groups and even some academic disciplines and institutions have become much more direct in importuning the Congress or the administration to redirect research policy and funding. Thus, the changing roles of each of

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these key groups interested in research policy should be a major concern to the AAMC Committee.

The discussions of who should set research policy at what level raise questions as to how these policy and funding allocation decisions should be evaluated or justified. As the federal investment in health research has grown, the pressure to provide "accountability" for the use of these funds also has increased. Congress and others wish to have more defined and measurable outcomes than the "improvement in the health of the American people" by which to judge the scope and merit of their investment in specific projects, programs, or theme areas of research. Various forms of fiscal accountability have increased during the last 10 to 20 years as a surrogate for a more "research planning" or goal directed approach to documenting the "pay-off" from the federal investment in research. However, the pressures to justify program investments or define outcomes tied to specific funding allocation continue. The AAMC Committee should consider to what extent accountability concepts should be applied to biomedical research.

The Committee should consider the extent to which a recent Association position paper "Preserving America's Preeminence in Medical Research" addresses these concerns or needs further development as an Association position on how science policy should be formulated.

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AD HOC MCAT REVIEW COMMITTEE

At its June 1985 meeting, the Executive Council established an *Ad Hoc* Committee to review the Association's MCAT program. The committee is charged to explore how the MCAT examination is used in the selection of medical students and to make recommendations to the Executive Council on possible improvements in the program. The committee members are:

Sherman M. Mellinkoff, M.D.
Dean
UCLA School of Medicine, Chairman

Richard S. Ross, M.D.
Dean
Johns Hopkins University
School of Medicine

Nathan Kase, M.D.
Dean
Mount Sinai School of Medicine

Walter F. Leavell, M.D.
Dean
Meharry Medical College
School of Medicine

Douglas E. Kelly, Ph.D.
Chairman
Department of Anatomy
and Cell Biology
University of Southern California
School of Medicine

Daniel D. Federman, M.D.
Dean, Students & Alumni
Harvard Medical School

Frederic D. Burg, M.D.
Associate Dean for Academic Programs
University of Pennsylvania
School of Medicine

Billy B. Rankin
Director, Admissions
Baylor College of Medicine

Andrew G. Wallace, M.D.
Vice Chancellor for Health Affairs
and Chief Executive Officer, Duke
University Hospitals
Duke University School of Medicine

John Dejong
Medical Student
University of Kansas School of Medicine

William H. Luginbuhl, M.D.
Dean
University of Vermont
College of Medicine

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REVIEW OF THE AAMC MCAT PROGRAM

The Medical College Admission Test (MCAT), its use by medical schools in their selection process and the effects of this use on undergraduates and undergraduate institutions have been the subject of substantial interest and attention over the recent period. So called "truth-in-testing" legislation has attacked the very premise of standardized testing, coaching courses have exploited the anxieties of eager students, and multiple choice examinations have been accused of eroding the capacity for problem solving. Admissions tests are viewed as distorting curricula of the educational segment which precedes them and of contributing to student behavior which is neither scholarly nor socially desirable. The MCAT itself has been stolen, litigated over, legislated against, repudiated by one member institution and tagged by others as such an important source of revenue for the AAMC as to create conflict of interest which precludes effective oversight by the AAMC, its staff and governing bodies. This state of affairs suggests the appropriateness of an Executive Council consideration of the issues associated with the MCAT program.

Background

The current MCAT Examination was first offered in 1977 after an extensive, nearly six year planning process which engaged the active participation of pre-professional advisors, medical school faculty, practicing physicians, medical students, and admissions officers, with a particular emphasis on including the perspectives of women and minorities in the process. The result is an exam almost unique among admissions tests in its prior specification of the competencies identified as relevant to the study and practice of the field and the design of the instrument to assess those particular competencies. Thus, no longer is there a general science portion of the exam. Rather, the test assesses achievement and problem-solving skills in 54 specific topics in chemistry, physics, and biology judged by the extensive panel of medical faculty and students to be most relevant to the study and practice of medicine. In order to avoid stimulating an undue emphasis on science at the pre-baccalaureate level, the topics are examined only to the extent that they are covered in the introductory level courses at the vast majority of colleges supplying candidates for the study of medicine. Similarly, the general knowledge, verbal and mathematic components of the predecessor examination were abandoned in favor of assessments of thinking skills applied to information presented in prose and quantitative formats. Identified as desirable, but never implemented after an examination of its feasibility, was a component designed to assess noncognitive personal characteristics. In response to suggestions emanating from the Council of Deans and endorsed by the Executive Council, the Association is now engaged in an extensive pilot project designed to evaluate the utility of an essay component to the examination.

Immediately upon offering the new examination the AAMC enlisted the cooperation of member schools to assess its utility in the admissions process, its impact on the selection of women and minorities and its validity in terms of the correspondence between MCAT scores and performance in medical school as measured by grades in the basic sciences courses and performance on the NBME Part I examination. Few have been surprised that there is a high positive correlation between MCAT scores and performance in the first two years and an inverse relationship between scores and academic mortality and morbidity. Criticism has been focused on the relative paucity of research on the relationship between MCAT scores and performance in the clinical studies or as a physician. This, notwithstanding the non-specificity of available criterion measures and the significant correlation between scores and Part II of the NBME examination.

Research has also been conducted and replicated on the impact of commercial coaching courses on both first-time and repeating examinees. The results are consistent in showing a general score improvement for all repeaters and score differential favoring coached examinees *which is limited to the four science subtests*. The score differences average approximately *one-half* of a scale score point in each science area of assessment. (In the mid-range, 7-9, changes in scores of a *full* point increase the probability of acceptance 10 percentage points.) Additional findings were that coaching effects on science performance are trivial for examinees with low skills scores (1-6), for examinees with very low GPA's, and for examinees from very selective undergraduate colleges and/or with very high GPA's. This leads to the relatively unremarkable conclusions that: 1) science is teachable to (or learnable by) students with reasonably well developed fundamental skills; 2) learning science is difficult for those who have reached this stage of their career without well developed skills; and 3) scientifically sophisticated students will not appreciably improve an already high performance by means of a short term effort. These conclusions tend to be reinforced by more recent studies which demonstrate that the inverse relationship between MCAT scores and academic morbidity is the *same* for both coached and uncoached students. In summary, the improvement in performance by coached students does not appear to be short term, artifactual, or undeserved; rather it seems to be a reflection of their capacity, desire and effort to learn and the achievement of this objective. This is not to deny that there may be undesirable consequences of the large and growing resort of applicants to commercial coaching.

Legislative activity of the "truth-in-testing" variety has been mostly quiescent since the AAMC successfully invoked the protection of the Federal copyright laws in New York. That case has not yet gone to trial, but may be expected to do so within the next year unless a legislative resolution is achieved--an outcome not now foreseeable.

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Current Issues

It has been asserted that the current use of the MCAT is frequently inconsistent with the GPEP report's exhortation that "premedical" students should aspire to a "broad" education prior to entry into medical school.

- Is the MCAT so focused on science as to frustrate a liberal education? Is this inherent to the examination or a result of incorrect use?

- Does the MCAT have an unavoidable role in stimulating the "premed" syndrome? Would changes in its use or design affect this situation? What impact would an essay component have? Changes in course prerequisites?

- What role, if any, does a standardized test properly play in medical school admissions? Is there a need for more than letters, grades and interviews to assess candidates? How are grades from unknown or less prestigious institutions to be assessed?

- Are coaching courses a problem? Are there ways to alleviate the adverse effects of coaching courses?

- Is the Association in a conflict of interest situation created by an undue dependence on revenue from the examination? (See attached report to the State of California)

RECOMMENDATION: That the Executive Council discuss these and other issues and determine whether some further action with respect to the MCAT program is warranted at this time.

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RECOMMENDATIONS FOR GOVERNANCE AND MANAGEMENT OF INSTITUTIONAL ANIMAL RESOURCES

Preamble

During the last quarter century, the momentum of discovery in the biological, behavioral and medical sciences has steadily increased, while the application of this new knowledge has brought incalculable health benefits to mankind. Laboratory animals have played an indispensable role in these advances and in the education of professionals who serve the medical and health needs of humans and animals.

If the public's rising expectations for relief from disease, disability, and premature death are to be realized, research involving laboratory animals must continue. Thus, significant responsibility for the governance and management of laboratory animal resources devolves upon individual investigators and faculty, as well as the institutions in which their research and instruction are performed. All individuals whose work requires them to use animals in education or scientific inquiry must understand and be committed to fulfilling the legal and moral responsibilities of such use for both ethical and

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An ad hoc Committee for the Governance and Management of Institutional Animal Resources was established at the direction of the Association of American Medical Colleges and the Association of American Universities and was charged to review systematically institutional policies and procedures regarding the governance and management of animal resources and to recommend general guidelines that would support good practices in the management of institutional animal resources. This report was endorsed by the Executive Council of the AAMC on September 12, 1985 and by the _____ of the AAU on _____.

scientific reasons. Only healthy, well-cared for animals yield valid scientific data, and thus both practical and philosophical considerations enjoin us to the highest standards of care.

The academic community has a responsibility for meeting two challenges. First, it must assure that all animal facilities, as well as research and training procedures, are beyond reproach and are in compliance with all applicable laws, regulations and guidelines. Though deficiencies in compliance with these standards may be rare, those that do occur only serve to undermine public confidence in all research and must be corrected. Where fiscal constraints have limited the development of state-of-the-art facilities, efforts to obtain the necessary resources should be redoubled. Second, the academic and scientific community must educate the non-scientific public about the important benefits to be derived from the use of animals in research and education.

This document has been prepared to assist universities, medical schools and hospitals in their efforts to support research and instruction involving animals by making recommendations for improving coordination and communication among the many units of the university involved in animal use. It does not prescribe specific technical procedures or guidelines for the treatment of animals; rather, it is intended to augment the Animal Welfare Act, the NIH Guide for the Care and Use of Laboratory Animals, the PHS Policy on the Humane Care and Use of Laboratory Animals by Awardee Institutions, the U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training, the standards of the American Association of Accreditation of Laboratory Animal Care, and the many existing institutional policies.

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The recommendations set forth below are addressed to those individuals -- administrators, animal resource managers, investigators, faculty, and public affairs officials -- whose wholehearted support is needed to maintain research and education in the current open environment. Their adoption may be of assistance in avoiding deficiencies in research protocols and instructional practices involving animals and may help to promote awareness among all segments of the institution of the importance of animals to the success of the scientific and education missions. These recommendations should not be construed as organizationally prescriptive, but should serve as guidelines, recognizing that institutions are organized differently and may meet obligations in different ways.

Responsibilities of Institutional Chief Executive Officers

In order to develop and maintain a viable animal resource program at any institution, a strong commitment to the humane care and use of animals must be a high priority within its administration. Therefore, the following recommendations are directed specifically to institution presidents and deans, especially of medical, veterinary, and dental schools.

1. Establish firm, centralized administrative and financial support for animal use in research and instruction, and ensure that high standards for animal care are an institutional priority.

2. Designate one high-ranking "institutional official", reporting directly to the chief executive officer, to be responsible for the entire animal resource program and to coordinate with the administration, investigators, faculty, veterinarians and animal care committees to ensure a clear, visible chain of authority for the program.

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In some of the larger decentralized universities, it may be desirable to have more than one "institutional official."

3. Move as rapidly as possible to meet the standards required for accreditation by the American Association for the Accreditation of Laboratory Animal Care (AAALAC) at each of the institution's animal facilities.

4. Encourage open communication and be receptive to needs for resources, facilities improvement, and better security measures.

5. Establish an institution-wide public education campaign to educate the public regarding the need for animals in research and instruction and the important benefits that accrue from such use.

6. Establish procedures for and assume direct institutional leadership of any crisis situation that may arise. An assault upon animal use threatens the integrity and reputation of the entire institution.

7. Be prepared to prosecute to the full extent of the law any individual(s) involved in crimes against the institution such as laboratory break-ins and theft or destruction of property.

Responsibilities of the Institutional Official

The primary role of the institutional official is to administer the animal program and to promote open communication with each functioning unit of the institution (e.g., medical school, veterinary school, psychology department) involved in animal care and use. The following recommendations are offered to facilitate those responsibilities.

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1. Ensure that all animal facilities are in compliance with applicable requirements of the Animal Welfare Act and pertinent state and local laws and regulations, and adhere to the PHS Policy, the NIH Guide, and the U.S. Interagency Research Animal Committee Principles.

2. Coordinate the institution's public education campaign regarding the benefits of animal use, seeking input from investigators, faculty, veterinarians and students.

3. Establish or modify animal care committees to meet the standards specified in the PHS Policy on the Humane Care and Use of Laboratory Animals. Expect these committees to insist upon the highest quality animal care and facilities, and to support and promote research in compliance with existing standards.

4. Ensure that the use of animals in education is reviewed to make certain that all regulations and guidelines are being followed.

5. Require good recordkeeping practices for all aspects of the animal program, particularly APHIS inspection reports and records of all actions taken to correct deficiencies, AAALAC reports, animal welfare assurances, and animal care committee reports, activities and recommendations.

6. Systematically review the status and condition of each functioning research unit. Each unit should prepare a periodic assessment of its animal program, fully describing any problems or deficiencies and the schedule for corrective action, the resource needs of the facility (i.e. repairs, renovation, new construction), and its accreditation status.

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7. Develop and implement when necessary an institutional plan for dealing with an attack on animal facilities or an assault on the merit or validity of specific research projects. Involve the administration, veterinarians, principal investigators, animal care committee(s), public affairs officials and the general counsel.

Responsibilities of the Animal Resource Director

The following recommendations are provided for animal resource directors or veterinarians-in-charge, who are in a unique position to ensure the smooth functioning of the animal care program on a daily basis.

1. Provide a comprehensive program of veterinary medical care for all animal colonies, employing properly trained veterinarians, technicians and caretakers. Diagnostic resources, preventive medicine, post-surgical care and mechanisms for emergency care are important components of a sound animal program.

2. Develop institutional guidelines which incorporate the applicable requirements of the Animal Welfare Act, NIH Guide, PHS Policy, IRAC Principles, and AAALAC standards, taking into consideration the occasional inconsistencies in those requirements.

3. Provide full support for each approved research protocol, assisting the investigators in achieving the highest standards of animal care in the particular context of their research.

4. Ensure that animal care personnel are aware of the high institutional priority of keeping all animal facilities (including off-campus sites) in compliance with the standards of the Animal Welfare Act, the NIH Guide, or where applicable, the requirements of AAALAC.

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Develop a comprehensive plan to serve the sanitation, housekeeping and maintenance needs of each research and teaching unit.

5. Prepare and distribute manuals and guides which summarize the institutional policies and procedures regarding procurement, housing, care and use of laboratory animals to all individuals/departments that are involved in animal research or instruction.

6. Ensure that hiring policies promote the selection of employees who are professionally dedicated to the appropriate care and use of animals.

7. Establish and promote continuing education and training in animal care for those individuals involved in the use of animals in research or classroom instruction.

Responsibilities of Investigators

Since the support of investigators is crucial to maintaining high standards of animal care in any research setting, the following recommendations are provided for implementation by research faculty and staff.

1. Become knowledgeable about and conduct all research and inquiry in accordance with approved policies governing the care and use of laboratory animals.

2. Submit research protocols, as required by animal care committees, accompanied by a short lay description of the project and its intended benefits for use as needed by the institution's animal care committee or public affairs representatives.

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3. Maintain complete records of procedures undertaken during all animal experiments.

4. Meet research protocol requirements in approved, centralized facilities whenever possible. Where research protocols dictate unusual environmental, dietary or colony requirements that cannot be met in central facilities, be sure the research team and animal resource personnel appreciate the need for these special conditions.

5. Conduct a thorough orientation for students, postdoctoral fellows, technicians, animal care workers, and others participating in research on the rationale for the use of animals in each protocol. Be sensitive to the needs of newcomers to adjust to participating in research performed on animals.

6. Maintain a scholarly, sensitive, respectful environment during all animal experimentation.

7. Participate in continuing education and training programs designed to keep investigators abreast of the latest techniques and procedures in animal research.

8. Devote time and effort to institution-wide activities to promote a general understanding within the academic community and the lay public of the need for animals in research and instruction.

9. Emphasize the role of laboratory animals when presenting research results or discussing human diseases with lay audiences and describe the contributions of humanely conducted animal studies to the development of new technologies and treatment capabilities.

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Responsibilities of Faculty Using Animals for Instructional Purposes

Although there has been a dramatic reduction in the use of animals for instructional purposes over the past two decades, live animals remain an important and necessary adjunct teaching model in certain courses. The following recommendations are therefore directed to faculty members involved in this type of instruction.

1. Ensure that animals used for instructional purposes in classrooms or laboratories receive the same humane care and treatment as those used for research purposes.

2. Review any teaching methods involving animals to ensure that all regulations and guidelines are being followed.

3. Promote sensitivity and concern among students for the need for humane care and treatment of animals.

Responsibilities of Institutional Animal Care and Use Committees

Institutional Animal Care and Use Committees (IACUCs), in addition to their prescribed duties, act in an advisory capacity to the institutional official and serve as a valuable resource in the conduct of research and instruction at institutions. In order to further enhance the role of these committees, the following recommendations are offered.

1. Evaluate existing institutional policies, standards, procedures, guidelines and manuals relating to laboratory animal care and use and conduct reviews regarding the adequacy of animal facilities. Make recommendations for any appropriate modifications to the institutional official.

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2. Maintain and promote an open and cooperative relationship with investigators, faculty, the animal resource director and the the institutional official.

3. Support scientific justifications for research protocols that necessitate a departure from conventional care and use requirements, and document the committee's rationale for its approval of such departures.

4. Keep careful records and ensure the confidentiality of all committee proceedings and activities, including any information that relates to trade secrets, research protocols and procedures, and other privileged data.

Responsibilities of Institutional Public and Government Affairs Officials

Public and government affairs officials are often called upon by the media and the public to respond to inquiries about research being conducted at their institutions, and may be the first persons contacted in the event of a demonstration or criminal act directed at the institution. The following recommendations are therefore directed toward these officials.

1. Become familiar with the types and objectives of the research being conducted at your institution.

2. Identify and train several articulate, effective speakers from the research and teaching faculty who could be called upon to explain to the public the need for and benefits of using animals in research projects and instruction.

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3. Participate in the institution-wide public education campaign to educate the lay public, the media, and political and governmental officials regarding the importance of animals to research and teaching at your institution.

4. Nurture community relations by scheduling speakers to elaborate on the necessity of animal research to civic and lay groups.

5. In your contacts with federal, state and local officials and their staffs, keep them informed of the importance of animal research.

6. Develop methods to keep institutional officials, investigators, veterinarians and lab personnel informed of the concerns and activities of animal rights organizations.

7. Ensure that, where applicable, the role of laboratory animals is emphasized appropriately in press releases on scientific discoveries at your institution.

8. As part of the crisis management plan, provide spokespersons to discuss the nature and objectives of research with the media. While it is helpful to respond immediately to allegations of animal abuse, it is equally important for an articulate expert to discuss objectively this research and the generic need for animals in research.

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REFERENCES

Animal Welfare Act of 1966 (Public Law 89-544), as amended by the Animal Welfare Act of 1970 (Public Law 91-579) and by the 1976 Amendments to the Animal Welfare Act (Public Law 94-279).

Regulatory authority under the Animal Welfare Act is vested in the Secretary of the U.S. Department of Agriculture (USDA) and implemented by the USDA's Animal and Plant Health Inspection Service (APHIS). Rules and regulations are codified in the Code of Federal Regulations (CFR), Title 9 (Animals and Animal Products), Subchapter A (Animal Welfare), Parts 1, 2, and 3. Copies can be obtained from the Deputy Administrator, USDA, APHIS-VS, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782

National Institutes of Health Guide for the Care and Use of Laboratory Animals, prepared by the Institute of Laboratory Animal Resources of the National Research Council for the National Institutes of Health of the U.S. Department of Health and Human Services. NIH Publication No. 85-23, revised, 1985. Copies may be requested from the Division of Research Resources, NIH, Building 31, Room 5B59, Bethesda, MD 20205.

Public Health Service Policy on Humane Care and Use of Laboratory Animals by Awardee Institutions, revised, June, 1985. Copies may be requested from the Division of Research Resources, NIH, Building 31, Room 5B59, Bethesda, MD 20205.

U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training, prepared by the Interagency Research Animal Committee for the Office of Science and Technology Policy. Adopted May, 1985. The Principles appear in the appendix of the PHS Policy on Humane Care and Use of Laboratory Animals by Awardee Institutions.

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MEDICAL STUDENT ALTERNATIVE LOAN PROGRAM

In recent years, medical students have been forced to rely increasingly on market rate loans (ALAS, PLUS, HEAL) as a major component of their financial assistance, with concomitant problems of rising indebtedness, interest capitalization, and repayment limitations. Further, the agglomeration of medical students with other health professions students (Title VII P.H.S.A. aid) and with all higher education students (Title IV H.E.A. aid) has presented us with the worst of both worlds: in the public view, we are labeled with higher default and delinquency rates than actually exist, and yet the special cost and repayment problems of medical students cannot be taken into account within these Federal programs.

For these and other reasons, including the desire to disembark from the roller coaster of Federal loan program authorizations and appropriations, the GSA Committee on Student Financial Assistance has for some time been searching for an alternative loan program which could be sculpted to the special needs of medical student borrowing, loan consolidation, and repayment; a program which could take into account the lower default and delinquency rates of medical professionals and the higher professional remuneration subsequent to postgraduate training.

Recently, officials of the Higher Education Assistance Foundation (HEAF) have indicated their desire to work with us in the development of a loan program which would cover GSL & PLUS loans as well as the proposed alternative loan, and could incorporate many of these special characteristics and needs:

- guaranteed access for all medical students
- refinancing (consolidation) options
- repayment options
- coordinated application and delivery of major loan programs
- replacement of HEAL loans for most students, possibly at lower interest rates
- possible lower loan guarantee/insurance rates
- flexible (variable or fixed) interest options
- incorporation of debt management analysis and counseling

The Higher Education Assistance Foundation is the largest private, non profit student loan guarantor in the United States, and a member of the HEMAR Group (St. Paul, Minnesota) which also includes the HEMAR Service Corp. (loan servicing for GSL loans), Higher Education Loan Programs (HELP; the lender of last resort for Title IV programs in the District of Columbia, West Virginia, Kansas, and Tennessee); HEMAR Foundation; HEMAR Finance Corporation (secondary finance market) and HEMAR Insurance Corp. (proposed loan guarantor for other than Title IV programs).

HEAF is the loan guarantor and administrative agent for four major higher education loan programs; UNCF (black colleges), LULAC (hispanic student access), AICS (independent schools and colleges) and most importantly for the development of a medical student program, LSAAP - the Law School Assured Access Program which has guaranteed 125 million dollars in loans to law students and which is administered through the Law School Admissions Council's centralized application system.

The Task Force on Alternative Loan Programs, made up of members of the GSA Committee on Student Financial Assistance, medical student representation, and AAMC staff, have now held four meetings with top level HEAF officials. The most recent meeting involved a full day review of a draft proposal from HEAF; a more definitive proposal will be considered by the Task Force during the Annual Meeting.

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June 20, 1985

REPORT ON THE COUNCIL OF DEANS OF PRIVATE FREESTANDING MEDICAL SCHOOLS

The Council of Deans of Private Freestanding Medical Schools was formed in 1979. The first Chairman was Edward J. Lennon (Medical College of Wisconsin). The second Chairman elected in 1983 was Alton I. Sutnick (Medical College of Pennsylvania). The third, elected in 1985, is Robert L. Friedlander (Albany Medical College). Fourteen of the private freestanding medical schools have joined the Council, including:

Albany Medical College
Baylor College of Medicine
Eastern Virginia Medical School
Hahnemann University School of Medicine
Jefferson Medical College of Thomas Jefferson University
Loma Linda University School of Medicine
Medical College of Pennsylvania
Medical College of Wisconsin
Meharry Medical College
Morehouse School of Medicine
New York Medical College
Ponce School of Medicine
Rush Medical College
University of Health Sciences/Chicago Medical School

A number of projects have been carried out by the Council. They include:

1. A definition of the advantages and disadvantages of the status of the private freestanding medical schools.

   It was clear from this analysis that the flexibility, autonomy and fiscal independence were advantages that allowed these institutions to control their own destiny. It permits a context for more rapid decision making and the prompt response time of an independent medical school permits a more expeditious pursuit of a strategic plan to adapt to the changing socio-economic and political environment. Although there were some disdavantages identified, it was felt that it is not difficult for a medical school to meet its needs for a broad based university relationship by a series of agreements and affiliations with liberal arts colleges and universities.

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2. An analysis of the student financial aid activities at the Council member institutions.

   In early 1981, a questionnaire was designed to gain basic information about the private independent schools programs and resources in financial aid. The following findings were of some interest:

   1. Nearly 40% of the students were determined to have financial need.

   2. Average aid disbursement was approximately $4 million per school.

   3. Most were low interest loans.

   4. Average debt on graduation in 1981 equalled $22,000; highest equalled $68,000. The cost of maintaining a financial aid office was apparently the same irrespective of the size of enrollment.

   It was recommended that:

   1. The Private Freestanding Medical Schools should not pursue sources of financial aid by the use of an outside consultant firm.

   2. A representative should be recommended to participate in the AAMC Committee studying new approaches to student financial assistance.

   3. The school should try to share individual experiences and success in obtaining additional source of financial aid.

3. Comparison of the administrative organization of the member institutions.

   Tables of organizations of all schools were collected, compiled, and distributed to all of the Deans. This was of particular value to Deans considering modifying their administrative structures and to recently appointed Deans.

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4. An analysis of the organization and compensation of the faculty.

A complete review and survey of the organization of the faculty of the member medical schools was prepared including relevant appointments and promotions policies, faculty compensation and fringe benefits. The policies have been collated into a binder for easy use and comparisons.

5. Feasibility of a collaborative program in summer remedial basic science courses.

The Council evaluated the need for cooperative summer courses as remedial programs in basic sciences. It was thought that the need for this was minimal and only involved an occasional student. Consequently, it was not pursued further.

6. Coordination of laboratory animal billing systems.

The laboratory animal billing system that is used by the Medical College of Wisconsin was distributed to all of the members for their potential use.

7. Comparison of health insurance policies.

A listing of the health insurance provided to the faculty at each of the medical schools was collected and distributed to the Council members.

8. Development of conflict of interest policies for faculty members.

Baylor distributed their conflict of interest policy for informational purposes to all members of the Council. At least one of the other medical schools has used it as a basis for its conflict of interest policy.

9. Development of patent policies.

Patent policies were submitted by the Council members and distributed to all members. These are now in use for comparison purposes.

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10. Financial data reporting system, to coordinate with AAMC reporting.

A new questionnaire for reporting of financial data was developed for the Private Freestanding Medical Schools. These are data that may be compared between these schools and may not be available from university medical schools. After an extensive preparation and editing procedure, in coordination with Dr. Paul Jolly, the form was provided to Dr. Jolly who will distribute it to the Private Freestanding Medical Schools at the time the AAMC financial survey is conducted. The first such financial survey has already been completed.

11. Graduate education survey.

An extensive survey is being conducted on Graduate Education Programs in the Council member medical schools. A full report will be distributed to all of the members.

12. Feasibility of collaboration in malpractice insurance policies.

A survey of professional liability insurance was conducted regarding the possibility of developing a consortium to self-insure or purchase insurance. It was ultimately determined that, because of differences in state law, this will not be a practical solution to the problem.

13. Comparison of alumni by-laws.

By-laws of the Alumni Associations of all of the member medical schools were collected and distributed.

14. Feasibility of research incentive plans.

Research incentive plans, their feasibility and legitimacy, were discussed. The existing plan of one medical school and the proposed plan of another were presented for consideration by the other Council members.

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15. Consideration of alternatives to TIA-CREF.

Various options to TIAA-CREF were presented. One medical school offers 14 different mechanisms. Another offers six. This is to be discussed in greater detail for more formal distribution.

16. Symposium for the discussion of deaning, perquisites of administration and faculty, and other administrative issues.

A panel discussion was presented for the benefit of the Deans, regarding senior management of medical schools. Dr. Marjorie P. Wilson gave a presentation on "Deaning". Mr. John D. Baron, Partner of Ernst and Whinney made a presentation on "Senior Management: Compensation, Employment Contracts and Retention". Mr. William C. Booker, of Booker and Mauck gave a presentation on "Senior Management: Search Techniques and Evaluation". This was followed by a panel discussion on managing senior management.

17. Personal security for executive managers at academic medical centers.

Because of the assassination of a hospital administrator in Houston, there was extensive discussion on personal security for top management of medical schools. Several schools have instituted security measures including panic buttons and portable radio communications.

In addition to these specific topics, time is provided at every meeting for a free wheeling round table discussion for the purpose of informing colleagues of new programs or activities at member institutions.

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