



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ANNUAL BUSINESS MEETING**

**Monday, October 27, 1986  
2:00 PM - 5:00 PM  
Ballroom A**

**New Orleans Hilton Hotel  
New Orleans, Louisiana**

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

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF DEANS  
ANNUAL BUSINESS MEETING**

Monday, October 27, 1986  
2:00 pm - 5:00 pm  
Ballroom A  
New Orleans Hilton

**AGENDA**

	<u>Page</u>
I. Call to Order	
II. Quorum Call	
III. Chairman's Report -- D. Kay Clawson, M.D.	
IV. President's Report -- Robert G. Petersdorf, M.D.	
V. Consideration of Minutes . . . . .	1
VI. Report of the Nominating Committee and Election of Officers	
--George S. Bryan, M.D. . . . .	12
VII. Election of Institutional Member . . . . .	14
VIII. Discussion Items	
A. Reporting of NBME Scores . . . . .	15
B. Report of the Ad Hoc Committee on Graduate Medical Education and the Transition From Medical School to Residency . . . . .	20
C. Legislative Update -- Thomas J. Kennedy, M.D.	
D. Report on Staff Activities -- Joseph A. Keyes, Jr.	
IX. Information Items	
A. AAMC Projects on Teaching in the Ambulatory Setting . . . . .	31
B. Model Federal Policy for Protection of Human Subjects . . . . .	32
C. Biomedical Ethics Board . . . . .	33
D. Council on Health Care Technology . . . . .	34
E. Physician Payment Review . . . . .	36
F. Council on Graduate Medical Education . . . . .	37
X. Old Business	
XI. New Business	
XII. OSR Report	
XIII. Installation of Chairman	
XIV. Adjournment	

APPENDIX -- Council of Deans Roster

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

BUSINESS MEETING

Poinciana/Frangipani Rooms

The Ocean Reef Club

Key Largo, Florida

Session I - April 2, 1986

5:30 - 7:00 p.m.

Session II - April 5, 1986

8:00 - 11:00 a.m.

SESSION I

I. CALL TO ORDER

D. Kay Clawson, M.D., chairman, called the meeting to order at 5:30 p.m.

II. CHAIRMAN'S REMARKS

Dr. Clawson thanked the members of the program planning committee, Drs. Fogel, Kettel, Leavell, Rosenberg, Samuelson, and Sawyer, for their work in arranging what he hoped would be an excellent meeting. He welcomed to the meeting the Canadian deans who were in attendance, Drs. Cox, Cruess, and Gauthier, as well as other guests of the Council: Dr. William Mayer, president, Eastern Virginia Medical School, Dr. David Challoner, vice-president, University of Florida (distinguished service members), Drs. Virginia Weldon and Richard Janeway, chairman and past-chairman of the AAMC, and Dr. David Cohen, chairman of the Council of Academic Societies.

III. REMARKS BY DR. PETERSDORF, PRESIDENT-DESIGNATE

Dr. Petersdorf announced that his appointment as president would take effect September 1, 1986 but that he would be spending time at AAMC offices prior to that and would attend all Executive Council meetings. He expressed his view that academic medicine in an environment typified by the enactment of the Gramm-Rudman Act would likely have to accommodate to constrained resources and that the AAMC would also have to make

the necessary adaptations. He strongly encouraged the deans to consider the AAMC as their organization, to come to it for assistance, and to express their views on the job it was doing.

#### IV. PRESIDENT'S REPORT

Dr. Cooper expressed his pleasure at the selection of Dr. Petersdorf as his successor and asked the deans to give him the same strong support he had received over the years.

Dr. Cooper reported that, upon the recommendation of the COD, a Committee on Institutional Responsibility for Graduate Medical Education and Problems at the Transition Between Medical School and Residency had been formed. He reviewed the schedule of seminars conducted by the Management Education Programs, including those on alternative delivery systems, clinical evaluation systems, information technology management, VA-academic medical center affiliations, and executive development, and encouraged the participation of deans and their staffs. He also reported the progress of the AAMC's alternative student loan program.

Dr. Cooper indicated that the AAMC Finance Committee, in an interim report, was recommending that a portion of the AAMC's endowment income be used in the future to support operations and that members' dues, currently only 25 percent of the AAMC budget, be raised. These changes were seen as necessary to compensate for expected shortfalls in AMCAS and MCAT revenues because of a declining applicant pool. The committee's recommendations would be discussed at the next Executive Council meeting.

Dr. Cooper proceeded to give a report of federal government activities and legislative initiatives. The Administration was attempting through regulation to limit the direct medical education pass-through under Medicare to medical resident stipends and benefits. It had proposed a 5.8 percent indirect medical education adjustment, significantly less than the 8.1 percent which the AAMC believed appropriate. Also proposed were limitations on Medicaid payments to states.

Dr. Cooper reviewed the Consolidated Omnibus Budget Reconciliation Act (COBRA) which contained a number of provisions of concern to the AAMC membership. He encouraged the deans to review his memoranda on budget resolutions and tax reform legislation. Other items of interest were an OMB proposal to cap indirect costs for departmental administration and a counter proposal by the AAU and COGR, a VA proposal for cut-backs in personnel, and proposals for dealing with low-level radioactive waste.

Final items of interest and concern were a government-university-industry roundtable sponsored by the National Academy of Sciences and the use of animals in research. The roundtable, in a discussion of strategies for coping with the long period of fiscal stringency foreseen, was raising questions about the size and scope of federal research. Activists opposed to the use of animals in research were sponsoring a Day for Laboratory Animals on April 24 and had written to many deans that they were intending to visit their institutions. Dr.

Cooper urged the deans to take this attempt to attract national attention seriously.

#### V. DISCUSSION OF TAX REFORM LEGISLATION

Mr. Keyes provided written information on current proposals to reform the tax laws, including a bill passed by the House (H.R. 3838) and a proposal by Senator Packwood, and discussed these with the group. The latter was more favorable to medical school and teaching hospital interests, particularly with respect to the elimination of state per capita limits on tax-exempt bonding authority, more reasonable arbitrage rules, and preservation of the tax-exempt status of TIAA-CREF pension funds. Nevertheless, the caps placed on 403(b) elective deferrals, limits on IRA's, and other provisions carried forward from the House bill continued to be worrisome. Mr. Keyes and Dr. Clawson reiterated the need for deans to get individual faculty members to write letters to their Congressmen urging them to retain current provisions in the law.

### SESSION II

#### VI. REPORT OF THE AD HOC COMMITTEE ON FEDERAL RESEARCH POLICY

Dr. Edward Brandt, chairman of the AAMC ad hoc Committee on Federal Research Policy, discussed that committee's draft report. The Committee was charged to review Association policy in six areas: goals of the federal research effort, research manpower and training, research infrastructure, research awards system, federal funding for research, and formulation of science policy.

The Committee recommended that the appropriations for the NIH and ADAMHA research and research training should be increased by 10 percent per year for the next 5 years to maintain stable purchasing power in the face of the increased cost of research because of advanced technology and by an additional 5 percent to 10 percent per year for 5 years to take advantage of currently unmet scientific opportunity. The Committee also recommended a one-time infusion of additional funds to ADAMHA to restore purchasing power to the level of the mid-1970s.

The Committee felt that the present system of federally supported biomedical and behavioral sciences research had several underlying strengths that should be preserved during periods of fiscal stringency. It recommended continued emphasis on support for fundamental biological and clinical research, which is the cornerstone for efforts to develop new knowledge to advance health care, and stressed that the highest funding priority should be for investigator-initiated research. This type of research, which is conducted in a number of settings, including multi-investigator and multidisciplinary, is the most productive in terms of new information and research opportunities and provides maximum creativity and flexibility. The federal system of biomedical and behavioral sciences research should remain predominantly extramural and academically based. At the same time, the Committee acknowledged the crucial and vital contributions in research, training, and leadership made by the intramural programs at the NIH and ADAMHA.

The Committee reaffirmed the Association's long-standing support for peer review, stating that it is the appropriate primary basis for the allocation of federal funds. The Committee also recommended that priorities of funding to meet national goals should be determined by the individual institute advisory councils, and funding decisions within these priority areas should be based on scientific merit as determined by study section review. At the same time, the Committee recognized the potential for problems within the peer review system and endorsed the efforts of the NIH and ADAMHA to maintain the quality of the review process. The Committee suggested that there be a periodic formal evaluation of the mechanisms for scientific merit review of grant applications.

The Committee endorsed the concept that the federal government should bear the full cost of the research it supports. Thus, appropriately audited research costs assigned by convention or choice to the indirect costs category are a legitimate component of the total cost of research, and their payment is as critical to research productivity as the payment of direct costs. The Committee recommended that all segments of the research community should join together in a concerted effort to agree on the components and accounting of indirect costs. The Committee also called for efforts to streamline current bureaucratic requirements that add unnecessary administrative burdens to research institutions and divert scarce research funds.

The Committee believed that the federal government should assume the responsibility for an ongoing assessment of the condition of research facilities at universities and medical centers, and that this data should be the basis for policy decisions and program planning to ensure that the capacity of the nation's biomedical research enterprise is sustained. The Committee decided that the implementation of facilities revitalization should be through the competitive grants mechanism. The Committee also recognized that there are methods for institutions to recover private investment through the indirect costs mechanism. Thus a two-pronged approach was recommended, which included programs of direct merit reviewed capital grants and opportunities for phased recovery of capital investments from non-federal sources.

The Committee recognized the need to maintain a reservoir of highly trained research investigators in the biomedical and behavioral sciences. The Committee endorsed continued federal support via heterogeneous mechanisms, particularly for postdoctoral trainees, who rely heavily on federal funds. Career development awards were acknowledged as appropriate mechanisms to support the transition of young trainees to fully qualified, independent investigators. The Committee endorsed the practice of giving the majority of NRSA grants to institutions to support the optimal research training milieu.

The Committee also focused on two areas of future concern. First is the decline in the number of individuals preparing for careers in biomedical research. It was felt that the NAS should monitor this trend, and studies should be undertaken to identify reversible causes for this decline. Second, the Committee was concerned that there are fewer physician investigators in the biomedical sciences. The Committee strongly endorsed specific initiatives by the NIH to increase the

length and quality of research training opportunities available for clinical scientists.

In the discussion which followed Dr. Brandt's presentation, the primary focus was on the wisdom of the Committee's recommendation that the NIH and ADAMHA research and research training budgets should be increased by 10 percent per year for the next 5 years to maintain stable purchasing power and by an additional 5 to 10 percent to take advantage of currently unmet scientific opportunity. Several deans were concerned that this was both unrealistic in an era of constrained resources and unwise as a political posture. It would be regarded as intransigent self interest. Others supported the Committee's position acting on the advice of our advocates such as Senator Weicker. In their view, it is in the public interest as good policy. Furthermore, our failure to speak forcefully in support of this approach significantly weakens the ability of our advocates to advance the public good in this regard.

The Council as a whole endorsed the Committee's report and recommendations.

## VII. REPORT OF DISCUSSION GROUPS

### A. Attractiveness of Medicine as a Profession

Dr. Kettel presented seven recommendations for Council action, that had been distilled from a consensus of the reports of the discussion groups.

1. Dr. Foreman's kickoff message should be condensed and used as a preamble to a strategy paper and action plan which places emphasis on pride in the profession and restraint from an attitude of panic.
2. The applicant pool data should be further analyzed and refined to seek trends within or among categories, such as private, public, community based, and freestanding schools. Individual school applicant pool data analyses and trends should be made available on an individual, but confidential request basis. Analyses of minority and underrepresented groups are especially important.
3. Strategies should be developed, especially by individual schools, which assure that premedical advice through "the official advisor" system is accurate and based on current information about the profession.
4. Demographically stratified opinion surveys of high school and undergraduate college students, including both applicants and non-applicants to medical school, should be conducted to characterize and quantify the present attitudes toward medicine as a profession, a career and an academic endeavor. Our objective should be to better identify the problems, issues and the target populations to which attention should be directed.
5. The Medical School Admissions Requirement handbook should be revised, based on the insight gained from additional data analysis

and surveys. Emphasis should be given to the chapter which describes the profession and opportunities in medicine. This material should be reprinted as a brochure to give to high school advisors and others who counsel students regarding the selection of medicine as a career.

6. All medical schools should analyze individual applicant pool data seeking negative factors that can be corrected and positive factors that can be emphasized in their local areas.
7. The AAMC as a national policy and schools individually should emphasize the historic role of medicine as a socially responsible profession. Especially to be noted are opportunities to act as patients' advocates and the key role physicians can play in seeking to correct defects in the delivery system which allow inadequate health care for large segments of our population. As some groups put it, we should "seek the high road and accept as opportunity the challenges being made available in this changing health care world." Implicit is the development of appropriate sensitivity to the needs of underrepresented minorities in the profession and their role in the delivery of care.

Two other points raised in discussion, related to physician manpower, were 1) whether the COD should take a position regarding medical school class size and 2) the problem of U.S. medical school faculty members supporting off-shore schools by their participation as visiting faculty.

Action: On motion, seconded and carried, the COD unanimously endorsed the seven points stated above and recommended that they be moved into an action mode by taking them on to the Executive Council.

Action: On motion, seconded and carried, the COD requested each school to analyze its class size in reference to the size and quality of its applicant pool, and in reference to its ability to maintain high internal standards of education with the changing scene of the health care field. The COD declined to endorse the development of any Association position regarding physician manpower issues at this time.

Action: On motion, seconded and carried, the COD unanimously requested that the Administrative Board put in a prominent place on its agenda the issue of U.S. medical school faculties participating in, and thereby giving credibility to, foreign medical schools.

#### B. Institutional Responsibility for Medical Student Education

Dr. Moy reported that in none of the groups which discussed mechanisms to enhance institutional responsibility for medical student education was there a call for a separately identified cost accounting budget to support medical education or a separate structure for governance of the curriculum as called for in the GPEP report. The discussions did result in five points that could be labeled as advice to schools and one recommended action item:



1. The dean is felt to be a key person in the implementation of institutional responsibility. As the chief executive officer, the personal priority and advocacy of the dean for medical education can have a strong positive influence on the school. It was suggested that the dean should establish out of his office a central resource unit to provide technical support for education and that there be some central funds available to encourage, drive and reward the educational system. It was pointed out that the dean is able to express the high priority for education in the evaluation of departmental chairmen, budget priorities, the many occasions he has to express his own attitudes and values, his charge to search committees, his own interviews and candidates for administrative and faculty positions, and his interaction with students.
2. It was felt that the call for more self-directed, problem-based learning in the medical curriculum is appropriate, but that its introduction might be most productive in interdisciplinary courses, since it would increase the amount of faculty interaction across traditional departmental lines and a sense of faculty ownership of the curriculum activity outside of their own disciplines.
3. There was a call to rotate the primary responsibility for teaching from year to year so that in any one year fewer faculty are involved with the students and will know them better and be more sensitive to their learning needs. A major national student complaint is the "parade of stars."
4. Acknowledging the truth that the examination drives the system, there was a call for more "faculty examinations" as opposed to discipline examinations. These would be examinations which would evaluate developing physician characteristics beyond the cognitive, which also would cross departmental lines and involve such things as problem-solving skills, technical skills, relating to patients and other professionals, and the ability to handle stress. If successfully done, this could unify the faculty in institutional concern about the total maturation of the student, rather than simply the cognitive conquest of the faculty's own discipline.
5. There was a call for more shared accountability across departmental lines, especially clinical and basic science. For example, the phrase "they just don't teach anatomy" should be replaced by a direct faculty interaction among surgery, pathology, and anatomy to determine what the facts really are and what the expectations should be.

The action step requested was that the AAMC staff, through its research of activities and from the member medical schools, should identify and collect valid criteria for measuring excellence in teaching by faculty members.

Action: On motion, seconded and passed unanimously, the Council approved the recommendation that the AAMC staff work to identify and collect valid criteria for measuring excellence in teaching.

### C. Institutional Responsibility for Graduate Medical Education

Dr. Naughton reported that five recommendations had been gleaned from the discussion groups regarding institutional responsibility for graduate medical education. These recommendations were based on three general assumptions: 1) that general and multiple external forces are moving institutions to take on more centralized responsibility for graduate medical education; 2) that the new ACGME requirements and standards being set force that issue; and 3) as more ambulatory care education is required, the dean's office will get more involved in graduate medical education whether it wants to or not. The five specific recommendations were:

1. Medical schools which have not already done so should begin developing mechanisms for assuming a larger share of the responsibility for the governance of graduate medical education programs. As a corollary to this recommendation, the AAMC role in graduate medical education should be expanded.
2. Medical schools together with their teaching hospitals should align themselves in a cooperative relationship to form a common organization which governs each school's graduate medical education programs.
3. The dean and hospital directors should be directly involved in every residency program review at their institutions.
4. Representatives from the COD and COTH should be placed on various residency review committees through some agreement developed between the AAMC and ACGME.
5. A national commission, composed of medical educators, teaching hospital directors, and representatives of industry and government should be appointed to evaluate the state of graduate medical education in the U.S. and to recommend strategies for the future.

Action: On motion, seconded and passed unanimously, the Council endorsed the first three recommendations.

Discussion focused on the last two recommendations failed to achieve a consensus among Council members that it was reasonable and feasible to increase COD representation on residency review committees, or that the creation of a national commission would have uniformly positive consequences. A consensus did develop which emphasized a need to instruct better the AAMC's representatives to the ACGME of its position on those policy matters important to the organization and to develop a strategy designed to ensure continued representation from the AAMC to the ACGME by its appointees. This matter should probably be reviewed at regular periodic intervals by the Executive Council and the results of those deliberations should be reported back to the COD. The Council also suggested that the concept of a national commission required further study and elaboration.

D. The Transition to Residency Education

Dr. Daniels presented the recommendations emerging from discussion of this topic in the form of the following resolution:

Be it resolved that,

- 1) All medical colleges through their deans, department chairpersons and faculty ensure the continuity and quality of medical education in the third and fourth year. This effort will include:
  - a) Dean's letter and transcripts will not be sent before October 1.
  - b) Core clerkships will occur only in their own institutions and electives will not be permitted to intrude on these clerkships.
  - c) Fourth year experiences will be carefully evaluated as to quality and balance of education.
  - d) Every effort will be made within each College for department chairpersons and residency program directors to give up independent match systems and informal actions about residency selections.
- 2) The AAMC will advocate to the LCME that the evaluation of these policies and practices in each College be included as an important part of the accreditation processes (a must, not a should) for all medical colleges. Support from the AMA will be sought in establishing these criteria.
- 3) The AAMC will take the initiative in establishing an AMCAS-like system for residency application and selection.
- 4) The NRMP can and should manage the match for all applicants.

Dr. Daniels also reported three additional suggestions that were made:

1. Expand the information in and computerize the "Green Book."
2. Initiate additional interactions with the Residency Review Committees and the Boards to communicate about the problems involved and the solutions proposed to try to gain their understanding and agreement.
3. Try to have included in the "Essentials" that the ACGME requires use of NRMP.

Action: On motion, seconded and passed unanimously, the Council endorsed these recommendations for AAMC action to ameliorate the problems at the transition between medical school and residency.

The following timetable was suggested. In their April and June meetings the Administrative Boards and the Executive Council of the AAMC should discuss and hopefully approve the resolution. The matter should

be considered at the Fall meeting of the Association in its Assembly. Implementation should begin as soon as possible, but would occur with residents entering the first year of training July 1, 1988. The Council expressed the hope that the Committee on Graduate Medical Education recently appointed will include these sentiments of the COD in its deliberations and conduct its work expeditiously so that the above timetable could be accommodated.

#### VIII. INFORMATION ITEMS

Dr. Clawson directed the deans' attention to an analysis of Congressional proposals dealing with professional liability insurance. He indicated that the midwestern deans had identified malpractice insurance, as well as indigent care, as a major problem to which their fall meeting would be addressed. A suggestion was made that the AAMC should cease using the terminology "malpractice insurance," as it contributed to the implication that widespread malpractice is causing the problem. The preferred term was "professional liability insurance" or "professional and director's liability insurance" to reflect the expansiveness of the issue.

Dr. Clawson further commended to the deans a written report on the MCAT Pilot Essay Project.

#### IX. NEW BUSINESS

Dr. John Sherman, AAMC vice-president, noted that a sizable number of medical schools was not currently providing financial support to the National Association of Biomedical Research (NABR). He emphasized the importance of NABR to AAMC member institutions and urged the deans to provide support in response to upcoming solicitations from that organization.

Dr. Sherman also noted demonstrations by animal rights activists to occur on April 24. The deans were advised to contract the Foundation for Biomedical Research, a companion organization to NABR, for a strategy paper in dealing with the media and counteracting the unfavorable press that may occur as a result of these demonstrations. Dr. Clawson reiterated a suggestion made by Dr. Cooper that support be garnered by having faculty write to discharged patients attesting to the importance of animal research in the development of procedures used to treat them.

Dr. Louis Kettel, chairman-elect of the COD as well as chairman of the AMA's Section on Medical Schools, was asked to speak on the activities of the latter group. Dr. Kettel noted that the AMA was expanding its activities related to medical education. Within the last year a resolution was introduced to start a section on faculty. Dr. Eckstein currently serves on a committee discussing that proposal.

Dr. Cooper's role in working with Dr. Sammons over the years to coordinate the efforts of the two organizations was recognized. The sense of the discussion which followed Dr. Kettel's remarks was that the AAMC's

relationship with the AMA and delineation of roles was an important issue for the Association to address.

X. ADJOURNMENT

The meeting was adjourned at 10:40 a.m.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION OF OFFICERS

The Nominating Committee of the Council of Deans consisted of:

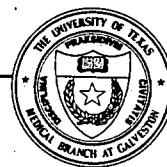
George T. Bryan, Chairman  
Henry H. Banks  
Robert L. Friedlander  
Tom M. Johnson  
Joseph w. St. Geme, Jr.

The committee solicited the membership for recommendations of persons to fill the available positions by memorandum dated March 14, 1986. The returned Advisory Ballots were tabulated and the results distributed to the committee. The committee met at the COD Spring Meeting in Key Largo, Florida on April 3, 1986. Dr. Bryan's report follows.

The University of Texas Medical Branch at Galveston

Medical School  
Graduate School of Biomedical Sciences  
School of Allied Health Sciences  
School of Nursing

Marine Biomedical Institute  
Institute for the Medical Humanities  
UTMB Hospitals at Galveston



April 15, 1986

Office of the Dean of Medicine  
(409) 761-2671

D. Kay Clawson, M.D.  
Executive Vice Chancellor  
University of Kansas School of Medicine  
39th Street at Rainbow Blvd.  
Kansas City, KS 66103

Dear Kay:

On behalf of the Nominating Committee, I submit herewith our unanimous recommendations:

For Chairman Elect, Council of Dean: William T. Butler.

For Executive Council: Walter F. Leavell and John Naughton.

For Members at Large, Administrative Board: L. Thompson  
Bowles, Henry P. Russe and W. Donald Weston.

Since Dr. Butler will leave an unexpired term on the Executive Council when he becomes Chairman Elect, we nominate Hibbard E. Williams for that position.

Thank you for this opportunity to be of service to the Council.

Sincerely yours,

A handwritten signature in cursive script that reads "George T. Bryan".

GEORGE T. BRYAN, M.D.

GTB:pt

cc: Henry H. Banks, M.D.  
Robert L. Friedlander, M.D.  
Tom M. Johnson, M.D.  
Joseph W. St. Geme, Jr., M.D.

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:

Mercer University School of Medicine

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



## REPORTING OF NBME SCORES

**Issue:** Should the AAMC take a position favoring the reporting of NBME examination scores solely on a pass-fail basis?

### Background

Prompted by the Organization of Student Representatives, the COD and CAS Administrative Boards discussed the issue of NBME examination score reporting at their June, 1986 meetings and the COD Administrative Board initiated consideration of the question at the meeting of the Executive Council. Spurred by the unanimous backing of the COD Administrative Board, the Executive Council voted to take the position that the AAMC should use its influence to encourage the NBME to report its examination scores solely on a pass-fail basis. The rationale for that position was that such a change would ameliorate the perceived negative influences of the examinations on medical education. Subsequent to that meeting, concerns were expressed that for such a position to be effective, further discussion within the AAMC constituency was desirable. This would assure the Executive Council that the position had the strong backing of the academic community which the AAMC represents. Thus, the question is being posed to the Council of Deans, Council of Academic Societies, Group on Medical Education, and Group on Student Affairs at their fall 1986 meetings. The Executive Council will consider the issue further at its January, 1987 meeting.

### Description and Implications of the AAMC Recommended Score Reporting Change

To understand the implications of the AAMC recommended change in score reporting, it is contrasted in Table 1 with the current score reporting scheme and a scoring scheme proposed by an NBME study committee for the new "comprehensive" examinations. It should be emphasized that this last scheme is only a committee proposal and not yet NBME policy.

Under the present system, scale scores (overall and by discipline) are reported along with a pass-fail status. This allows the examination results to be used not only to see which students pass minimum standards (licensure purpose) but also provides a comparison of individual student achievement. By aggregating and comparing scale scores, schools may and do use the results in curriculum/program evaluation at the departmental and institutional level. (Table 2 provides a statistical summary of the uses of NBME examinations in U.S. medical schools for the most recent year). It is these latter uses which are seen as having various stultifying effects on curricular reform and innovation (see arguments below). The major change in the scoring scheme proposed by the NBME study committee for the "comprehensive" examinations is the abandonment of individual discipline scores to students, although group performance data by discipline would continue to be available to schools in a manner similar to that reported currently. The committee proposal includes additional diagnostic score features, directed primarily to students who fail, which are not directly relevant to this discussion. The AAMC position would encourage further elimination of all scale scores in score reporting for Parts I and II, as unnecessary to the licensure purpose. The separate subject

**TABLE 1**  
**CURRENT AND PROPOSED NBME SCORING SCHEMES**

	<u>Current</u>	<u>NBME Study Committee Proposal for the "Comprehensive" Exam*</u>	<u>AAMC Proposal</u>
Overall scale scores for Parts I and II	Yes, to students and schools	Yes, to students and schools	No
Overall pass-fail status for Parts I and II	Yes, to students and schools	Yes, to students and schools	Yes, to students and schools
Individual discipline scale scores for Parts I and II	Yes, to students and schools	No, but current group performance data reports to schools would continue	No

\*The NBME Study Committee for Parts I and II recommended these changes in score reporting for the comprehensive examination. At present the process for developing the comprehensive Parts I and II examinations are just under way. The committees selected to steer the development will meet in September. Thus far, the NBME has not made a firm policy decision on how the results of the examinations will be reported either to the examinees or the medical schools. We are informed that this decision will most likely occur in 1987.

**TABLE 2**  
**USE OF NBME EXAMINATIONS BY SCHOOLS 1985-86**

	<u>1985-86</u>	
	<u>No.</u>	<u>Percent</u>
<u>(N=127)</u>		
<b>Use of the NBME Exam, Part I</b>		
Exam optional	29	22.8
Student must take exam	30	23.6
Student must take exam and achieve a passing total score	65	51.2
Student must take exam and achieve a passing score in each section	2	1.6
Scores used to determine final course grades	14	11.0
<b>Use of Selected Sections of NBME Exam, Part I, by Department to Evaluate Students</b>		
Anatomy	3	2.4
Behavioral Sciences	1	.8
Biochemistry	9	7.1
Microbiology	8	6.3
Pathology	6	4.7
Pharmacology	5	3.9
Physiology	5	3.9
<b>Use of NBME Exam, Part II</b>		
Exam optional	36	28.4
Student must take exam	38	29.9
Student must take exam and achieve a passing score to graduate	50	39.4
Scores used to determine final course grades	15	11.8
<b>Evaluation of Educational Programs by the School Based on Results of the NBME Exams</b>	65	51.2

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Source: AAMC Curriculum Directory 1985-86

(shelf) examination program of the National Board is expected to continue and presumably would not be affected by the AAMC recommended change.

### Discussion and Arguments

Proponents for a pass-fail only scoring system assert the following:

- 1) The historical purpose and chief value of the NBME examinations is the licensure of physicians. Scale scores make no contribution to this decision.
- 2) The reporting of scale scores tends to have various detrimental effects on medical education.
  - a) It reinforces the tendency for the examination to drive the curriculum. For example, it focuses the faculty's attention on the competencies and skills measured by the exam at the expense of other competencies of equal or greater importance. Also, the examination format tends to promote an excessive emphasis on memorization and information recall.
  - b) The need to make distinctions among a very able group of medical students invariably results in questions focusing on the recall of minutia having only a very indirect relationship to the knowledge and skills students should acquire.
  - c) Internal pressures to produce high scores stifle curriculum innovations.
  - d) It encourages faculties to abrogate their evaluation responsibilities to an external agency.
- 3) Scale scores are too easily abused. By the NBME's own assessment, the examinations evaluate only 25 percent of the competencies expected of graduating students. Yet these scores are viewed by the LCME as evidence of institutional effectiveness. Also, at times political bodies such as state legislatures request score information as a way of evaluating the institutions they support. Under such pressures it is difficult to decrease the emphasis placed on maximizing performance on the examination.

The counter-arguments presented including the following:

- 1) While licensure is the NBME's primary purpose, the examinations can serve other purposes, e.g., student evaluation, program (curriculum) evaluation, and institutional self-study.
- 2) Whatever disagreements exist about the importance of the material tested, the questions are written by medical school faculty members. Thus, it is not an external agency but our own faculties which are making judgments about the relevance of the material.
- 3) If abuses occur in the uses of the scores, the proper remedy is improved education on appropriate and inappropriate uses.

- 4) NBME scores are the single dependable numerical measure of competence and achievement referenced to national norms available to program directors who must assess a large number of applicants to residency positions.
- 5) The LCME's focus on NBME performance is primarily on the institution's failure rate. However, institutional score distributions, which would not be available if a pass-fail only score reporting was effected, can be quite valuable to the LCME in helping it identify areas of strength and weakness, particularly in newer schools where resources are not fully developed.
- 6) In the final analysis, each medical school faculty has the prerogative to determine institutional policy regarding the use of NBME scores. The information provided by scale scores should not be denied them.

### Conclusion

The role of NBME examinations and their influence on medical education has been discussed at the fall 1985 COD annual meeting program and various meetings of the COD Administrative Board over the years. The issue was directly addressed by the GPEP panel which suggested, in its 1984 report, that movement to a pass-fail scoring system would diminish "the heavy influence of these examinations on medical school educational programs." (p. 29). These concerns are pitted against assertions that the information provided by scale scores is of value to students, residency program directors and other medical school faculty members, the institutions themselves, and the LCME as an accrediting body.

The Council of Deans is requested to consider whether the position taken but not as yet implemented by the Executive Council is one in which it supports. If not, the Council is requested to advise its Administrative Board of its views on alternative changes they would like the AAMC to recommend to the National Board as it prepares to develop policy on the new "comprehensive" examination program.

# CAS

COUNCIL OF ACADEMIC SOCIETIES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
1 Dupont Circle, N.W.  
Washington, D.C. 20036

September 26, 1986

TO: CAS Representatives

FROM: CAS Administrative Board

RE: Report of the Ad Hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency

Many medical schools, graduate education programs, faculty and students have in recent years become increasingly dissatisfied with the transition from medical school to residency training. An AAMC ad hoc committee, chaired by Spencer Foreman, M.D., was charged to identify the problems and develop possible solutions. A preliminary report to focus discussion was distributed in July to all AAMC members, including members of the Council of Academic Societies, as well as the specialty boards, residency review committees, and members of the American Board of Medical Specialities (ABMS) and the Council of Medical Specialty Societies (CMSS).

The CAS Administrative Board appointed a working group to examine the ad hoc Committee report and its recommendations in detail. The full Administrative Board discussed the report in September. As a result of these discussions and the comments received from faculty on the report itself, the Administrative Board has prepared an annotated version of the preliminary report, which it believes addresses many of the concerns that faculty may have with the report. In distributing this modified report to the Council for comment, the Board wishes to emphasize several points.

First, this is a working document. The AAMC Executive Council approved the ad hoc Committee's preliminary report for distribution to stimulate discussion of the issues raised in the report. The Administrative Board hopes that the Special General Session to discuss these issues on October 26 during the AAMC Annual Meeting will be the beginning of a meaningful interaction among all interested parties to resolve these problems and to improve the environment for both undergraduate and graduate medical education.

Second, this report addresses a broad range of problems and solutions. The Board urges you to consider each section carefully and independently, and not to focus exclusively on one set of recommendations. In its analysis of this report, the Board identified the following areas that it believes should each be considered on its own merits: Institutional Responsibility, Institutional Accreditation, The Quality of Clinical Education, Selection Criteria, Procedural Problems, Implementation.

Third, the Association and the CAS Administrative Board seek an open consideration of these issues and their resolution by all parties involved in the transition and in graduate medical education. The Special General Session is part of this process; the Council's discussion during its business meeting on Monday, October 27, is another. Active, informed participation by faculty is necessary for a meaningful discussion of these issues to take place. The Board's comments on the preliminary report are an attempt to emphasize the central concerns of medical faculty and promote full deliberation. Discussion should focus on whether the problems have been correctly identified and whether the proposed solutions are appropriate and feasible.

AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION  
AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY  
PRELIMINARY REPORT

The ad hoc Committee which convened to identify problems in the Transition and propose solutions circulated a report for constituency comment in July 1986. The CAS Administrative Board has considered the report and prepared this annotated commentary to facilitate discussion by the CAS Council. Text of the original document with some proposed revisions appears on the left side of the page and CAS Board Commentary on the right. The six key areas for discussion are:

1. Institutional Responsibility
2. Institutional Accreditation
3. Quality of Clinical Education
4. Selection Criteria
5. Procedural Problems
6. Implementation

September 1986



## Institutional Responsibility

Clinical medicine has evolved into a loose coalition of disciplines and subdisciplines with specialists in each principally identifying with and sharing the values and goals of their peers.

This allegiance to specialties <sup>may</sup> detracts from common understanding

among disciplines and fragments our institutions. Nowhere is

<sup>has the potential to be disruptive</sup> fragmentation more evident than in the organization and conduct

of graduate medical education.

The committee considered the question: "If there were greater institutional responsibility for graduate medical education, would problems at the transition be more readily solvable?" It was concluded that if each sponsoring institution had a system of academic governance for graduate medical education in place, solving problems generated by the selection process would be facilitated. A functioning governance structure could bring all of an institution's programs together to establish common policies and procedures for the selection of residents.

~~At present, who, how, and when students are selected for residency positions are the prerogative of each specialty program.~~ The selection practices of each specialty <sup>currently</sup> are attuned to the national practices of the specialty rather than to institutional policies and procedures. Thus, if nationally the programs in a specialty begin to use certain selection practices, each program follows <sup>this</sup> the national practice. Reinforcement of these practices by ~~internal~~ <sup>solely</sup> consultation within a specialty makes it very difficult for programs to accept arguments for changing how and when their candidates are selected. The committee believes that <sup>national</sup> institutional policies and procedures should govern who, how, and when residents are selected, rather than having them determined ~~de facto~~, according to the national practice<sup>s</sup> of each specialty.

## 1. Institutional Responsibility

This section proposes to give the institution, which is not specifically defined, rather broad responsibilities with regard to resident selection as an alternative to the current situation in which each specialty develops its own national procedure.

The CAS Administrative Board is concerned that, as currently worded, the report seems to simply replace the procedures of the individual specialties with those of individual institutions; thus, it proposes clarifying this section to stress common national rather than institutional procedures. In addition, the Board emphasizes that these procedures should address only the mechanics, the "how and when" of resident selection. The "who," that is, which applicants are selected, should remain the prerogative of each specialty.

The CAS Board does not see any rationale for a centralized application processing system within the institution because application for residency positions is made to the individual disciplinary programs. Compliance with institutional and national procedures should be attainable without imposing a cumbersome centralized pass-through of all applications.

As graduate medical education faces increasing pressures due to limited resources and potential manpower constraints, some process of institutional governance for graduate medical education will evolve. The CAS Board foresees the advantage of an academic governance mechanism for GME that ensures representation of all disciplines in addressing such key issues as resource allocation, quality control, and integration of training sites, as well as traffic rules for resident selection. Implementation of institutional responsibility for graduate medical education in such an interdisciplinary fashion should result in better integration and coordination of residency training programs within the institution.

It is recognized that establishing ~~common-institutional-poli-~~  
~~national~~  
~~cies-and~~ procedures is not sufficient unless each sponsored pro-  
gram abandons ~~nationally~~ <sup>specialty.</sup> determined practices and adheres to in-  
~~stitutional~~ <sup>common.</sup> rules. Therefore, the committee recommends:

- o That each institution providing graduate medical education  
~~develop common policies-and~~ <sup>adhere to</sup> procedures <sup>for selection of residents</sup> for all of its pro-  
grams; and
- o That each institution establish a ~~central-administrative-sys-~~  
<sup>system of academic</sup>  
~~tem-for-the-receipt-of-applications-and-the-announcement-of~~  
<sup>governance for graduate medical education that will</sup>  
~~selection-decisions---~~ ~~This-system~~ should ensure that all pro-  
grams adhere to ~~institutional-policies-and~~ <sup>national</sup> procedures.

## Institutional Accreditation

In its deliberations about the need for an academic governance structure for graduate medical education, the committee reviewed the General Requirements Section of the Essentials of Accredited Residencies that was adopted by the Accreditation Council for Graduate Medical Education and ratified by its five sponsors in 1981. The committee believes that the General Requirements provide a foundation upon which an institution can build an academic governance structure for graduate medical

*Such a governance structure would enhance the implementation of the General Requirements and assist the residency review committees*

~~General Requirements are rarely, if ever, applied in accreditation decisions by residency review committees is strong evidence that graduate medical education remains fragmented and specialty specific.~~

Compliance by an institution with the General Requirements should be a first order accreditation determination. Lack of compliance should jeopardize the accreditation of all of an institution's programs. The committee does not believe that each residency review committee can be expected to make a uniform decision about whether an institution is in compliance with the General Requirements. The committee recommends:

- o That the ACGME establish an institutional review committee empowered to determine institutional compliance with the General Requirements;
- o That the committee be composed of program directors, <sup>representatives of basic and clinical faculty,</sup> medical school deans, and teaching hospital directors, <sup>and representatives of the housestaff;</sup>
- o That a system be established to survey institutions periodically and independently of program surveys;
- o That for institutions accredited by the Liaison Committee on Medical Education (LCME), these surveys be coordinated with LCME surveys; and
- o That the accreditation decisions of the institutional review committee be communicated to, and be binding upon, each residency review committee.

## 2. Institutional Accreditation

The CAS Board believes that adherence to the ACGME General Requirements Section of the Essentials of Accredited Residencies can only strengthen institutional quality and buttress the accreditation standards of the residency review committees (RRCs). An institutional mechanism for academic governance will assure an institutional overview of the degree of adherence to the General Requirements, which the specialties collectively identified as essential to graduate medical education programs.

The prerogatives of selection of individual residency candidates by individual programs and development of specialty residency requirements by the individual disciplines are not at issue. The Board does not believe that institutional responsibility for graduate medical education should abrogate the authority of the RRCs to establish and enforce individual specialty standards for residency training programs. The RRCs will continue to make the judgements as to whether individual training programs meet the standards of the specialty. Identifying the resources necessary to improve programs that do not meet these standards should be a collective institutional responsibility.

The CAS Board agrees with the concept of accreditation of institutions by the ACGME for compliance with the General Requirements. The Board believes that an ACGME accreditation process would be complementary with the acknowledged role of the RRCs in establishing the special residency requirements. An ACGME institutional accreditation committee should have a broader representation of basic and clinical faculty and housestaff than is proposed.

### Specific Problems and Recommendations

Specific problems must be solved to ameliorate educational disruption at the transition. Some of these are largely within the control of the medical schools and should concern the Liaison Committee on Medical Education, which is responsible for determining the quality of medical student programs. Others are problems that must be solved by the mutual efforts of both medical school and graduate medical education authorities.

#### Medical School Problems:

Medical schools deans and their faculties have the ethical responsibility to ensure that graduates have attained a general professional education that imparts the knowledge, skills, values, and attitudes expected of all physicians. The intrusion of external forces that impair the accomplishment of this responsibility must not be permitted.

Some students, intent on making themselves competitive for selection in certain specialties and programs, have sought to interrupt their junior year's required sequence of clerkships to take electives, either at their own or other institutions. The

committee recommends:

- o That all students take the clerkships required by the Liaison Committee on Medical Education (internal medicine, surgery, pediatrics, obstetrics/gynecology, psychiatry, and, in some schools, family practice), only in the institution in which they are matriculated; and
- o That the satisfactory completion of an institution's required clerkship sequence precede the privilege of taking clinical electives elsewhere.

Many students increasingly devote their electives in the

senior year to the pursuit of a residency position. <sup>while</sup> The commit-

tee does not believe that a uniformly structured senior year

should be imposed upon all students. But, it strongly recommends that students' elective programs should be tailored to their completion of a general professional education that is consonant with their specialty choices and career plans. The committee recommends:

- o That each school establish an authoritative system to review *in the clinical years* and approve each student's elective sequence; and
- o That the Liaison Committee on Medical Education adopt accreditation policies to encourage the implementation of these recommendations.

### 3. Medical School Problems

The CAS Board concurs with these recommendations and believes it is the responsibility of each medical school and its faculty to scrutinize closely the clinical curriculum of its students and to take these steps to insure the quality and educational sequence of clinical clerkships and electives.

Selection Criteria Problems:

Program directors are intent upon selecting the most qualified graduates that they can. Their selection criteria are based upon students' knowledge, skills, and personal qualities. Medical school faculties responsible for evaluating students' achievement in these areas communicate their evaluations through

*faculty letters,*  
deans' letters and transcripts. Some programs evidence a low

regard for these evaluations; ~~even doubting their candor.~~ As a result, a large number of programs require students to submit National Board of Medical Examiners scores, and some are even requesting Medical College Admission Test scores. To obtain what are perceived to be more reliable evaluations, informal networks of communication between clinical departments and program directors about candidates have evolved within disciplines. To observe candidates' performance, it is often suggested that they take an elective in a specialty at the institutions to which they are applying. This practice has led some students to take multiple electives in the specialty that they hope to pursue in their residencies.

The committee believes that these selection criteria problems can be solved and recommends:

- o That every medical school faculty inform their students at matriculation that their ultimate evaluation will consist of a balanced appraisal of *the students' strengths and weaknesses* ~~their weaknesses and their~~ strengths;
- o That those responsible for assembling evaluations and communicating them to graduate medical education programs adopt the principle that their responsibility is to provide a candid appraisal of students' weaknesses as well as their strengths; *and*
- ~~o That programs only require the submission of standardized test scores that have been demonstrated to have a significant correlation with clinical performance; and~~
- o That ~~all~~ programs abandon the practice of suggesting that candidates take an elective at an institution for the *sole* purpose of improving their chances for selection.

4. Selection Criteria Problems

The CAS Board agrees that written evaluations of medical students should be strengthened. Both Deans and faculty letters should accurately portray the student's characteristics and abilities. Such letters should be informative enough to permit residency candidates to be evaluated without on-site performance.

The Board disagrees with the implication that preclinical performance of students is not relevant to residency selection. It also feels that standardized test scores should not be categorically withheld from the residency selection process.

The Board feels that there may be legitimate reasons for a student to take a clinical elective at another institution, and is reluctant to prohibit all such electives.

#### Procedural Problems:

The procedural problems at the transition are largely related to timing. They are complicated by the large number of applications that must be processed both by the medical schools and by graduate medical education institutions and their programs. The committee believes that changes in the timing of the application and selection process and institutional systems to assist programs to process large numbers of applications can ameliorate the procedural problems.

The National Resident Matching Program (NRMP) is governed by all the parties concerned with medical students' and residents' education. Since its establishment, the NRMP has sought to adapt its policies and procedures to serve the needs of both students and graduate medical education programs. All graduate medical education programs should select senior students only through the matching program. The committee is convinced that further modifications to improve the program can be accomplished. A high priority for change is the schedule for submitting rank order lists and releasing match results.

The crucial dates in the NRMP schedule are in the second week in January, when students and programs must submit their rank order lists, and in the second week in March, when the match results are released. NRMP uses the two month period between these dates to computer code rank order lists and to obtain confirmation of their accuracy from both students and programs. The committee recommends:

- o That medical schools, teaching hospitals, and programs work together to ensure that senior medical students are selected for residency positions only through the NRMP;
- o That the NRMP explore every possible way to shorten the time between the submission of rank order lists and the release of the match results to one month;
- o That, if this shortening is accomplished, the rank order list deadline be moved to March 1; and
- o That the match results be released on April 1.

The lengthening of the period before rank order lists must be submitted from the present two weeks to two months after the December holidays will provide significantly more time for decisions by both candidates and programs. This schedule will also permit medical schools to incorporate evaluation of a portion of students' senior year performance into their communications to programs. The committee recommends:

- o That, if a March 1 rank order deadline is achieved, all medical schools and programs mutually agree on November 1 as the earliest date evaluations will be released by the schools.

The establishment of separate matching programs that occur in advance of the NRMP schedule by five specialties has contributed to the time pressures on both schools and students. The committee believes that these early matches, which were conceived before NRMP had adapted its programs to the needs of students applying to these specialties, are no longer necessary. The Committee therefore recommends:

- o That negotiations be undertaken to incorporate early matching specialties into the NRMP.

#### 5. Procedural Problems

The CAS Board separates the issue of whether all specialties participate in a single national match for resident selection from when resident selection should take place.

Residents should be selected as late as possible in the senior year of medical school to avoid educational disruption, permit maximal input about medical school performance, and provide more time for the student to consider career choice seriously. The Board believes that beginning the resident selection process later in the year will "return" much of the fourth year to the medical schools and improve the students' clinical education.

The Board recognizes the unique and varying characteristics of residency programs in different specialties. However, it believes that a more integrated and coordinated approach to resident selection is desirable. All specialties selecting residents from the senior class should join in an effort to design an integrated selection system which will balance the needs of individual disciplines, medical schools, students, and the fourth year educational program. The resultant selection/matching process should be simplified and coordinated to reduce stress on students, deans' offices, and residency program directors. The NRMP should be structured to meet these needs.

The Administrative Board believes that a universal application form would significantly reduce the paperwork burden on students. At the same time, a centralized application process at each institution would not relieve and might possibly exacerbate paperwork for the institution because each discipline would still review its own applicants.

The committee considered the proposition that a national centralized application service be established to permit candidates to file only one application for distribution to all the programs to which they are applying. Such a service is not considered feasible. However, the committee believes that both the burden of filing applications by candidates and processing them by programs must be reduced as much as possible.

For candidates, the burden of filing applications can be reduced by the general acceptance of the universal application form developed by the AAMC and distributed by the NRMP. This four-page form has two pages for academic and demographic information that all programs require. It can be filled out once and reproduced. The other two pages are for information that is specific for a particular program or specialty and are completed for each program to which a student applies.

*The Committee recommends:*

~~The burden of processing a large number of applications can be alleviated by central institutional systems for this purpose. While selection decisions must reside with the programs, they can be relieved of much of the paperwork and record-keeping involved in the application process. At academic medical centers, the experience of the medical school admissions office in processing a large number of applications can be applied. The committee recommends:~~

- o That medical schools promote their graduates' use of the universal application form for graduate medical education;
- o That all graduate medical education institutions and their programs accept the universal application form as at least the first step in the application process; and

~~o That institutions develop central systems for handling the~~

~~paperwork and record-keeping for applications.~~

### Facilitating Changes in the Selection Process

The committee recognizes that to some the problems at the transition appear intractable. In part, this perception is due to a lack of opportunity for a mutual search for solutions through discussions among medical school deans, teaching hospital executives, and program directors. The committee senses that all parties are now concerned and are prepared to seek solutions. To facilitate both national and local deliberations, the committee recommends:

- o That institutional executives convene meetings of the program <sup>residents</sup> directors of <sup>their</sup> teaching hospitals to discuss their resident selection policies and procedures;
- o That the AAMC convene a meeting of the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals at its 1986 Annual Meeting to discuss this report;
- o That an ad hoc committee composed of representatives from <sup>CAS, COL, and COT:</sup> ~~specialty organizations most directly involved in graduate medical education~~ be convened by the AAMC, at least annually, for the next several years to review the progress towards solving problems at the transition between medical school and residency, and to discuss further measures to be taken; and
- o That analyses of the addendum to the AAMC's Graduation Questionnaire, which provides quantitative data on the effect of the selection process on students, be provided to guide discussions.

### 6. Implementation

The Administrative Board advocates formation of an ad hoc group to monitor the progress on the various issues identified in this report. Such a group should be expanded to include all parties involved with these transition issues.



## AAMC PROJECTS ON TEACHING IN THE AMBULATORY SETTING

The AAMC is planning two projects designed to assist its members in adapting clinical education to the revolutionary changes taking place in the health care delivery system. The first is a small group invitational symposium on "Adapting Clinical Education to New Forms and Sites of Health Care Delivery," to be held in Annapolis, Maryland, December 8-9, 1986. Approximately 25-30 participants will meet and discuss prepared papers on the topic from the perspectives of medicine, surgery, neurology, and ophthalmology. Separate papers will focus on the health care team approach to ambulatory care and its implications for clinical education and the cost and financing of ambulatory care education. A symposium proceedings is planned for the late spring of 1987.

The AAMC has also been awarded a contract from the Health Resources Services Administration to conduct a study and comparison of transitions of medical education programs from hospital inpatient to ambulatory training programs. The study will examine four issues related to these transitions: organization of the educational system, curriculum and educational methodology, faculty interest and participation in the ambulatory setting, and cost and funding sources. It will first identify the perceived and anticipated problems of shifting education into ambulatory clinics, and then explain how those problems have manifested themselves and what solutions have been devised for five selected specialties in nine academic health centers. The project is expected to be completed by the end of 1987.

The symposium is being staffed by the AAMC's Department of Institutional Development, Joseph A. Keyes, Jr., director, while the study will be conducted by the AAMC's Department of Teaching Hospitals, Richard M. Knapp, Ph.D., director.

## MODEL FEDERAL POLICY FOR PROTECTION OF HUMAN SUBJECTS

On June 3, 1986, the Office of Science and Technology Policy (OSTP) published in the Federal Register a proposed model federal policy for the protection of human research subjects. The policy is expected to be adopted by all federal agencies involved in the support, conduct or regulation of research involving human subjects. The model policy's development was stimulated by the First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research released in December 1981. The adoption of a single model policy for all federal agencies was the most important of the nine Commission recommendations.

The model policy was based on existing DHHS regulations governing research involving humans. The DHHS regulations have been successfully implemented and shown to be workable in a variety of local conditions. By using these existing procedures, the reservoir of experience was tapped and at the same time, the administrative burden of complying with the sometimes conflicting regulations of several agencies was addressed. There were several modifications and rephrasing changes made to the HHS regulations to make them appropriate for the model policy, which did not seem to substantially alter current NIH policy.

The AAMC in its response to the Federal Register notice commented on two concerns with the proposed model policy. The first was the deletion of the current 60-day grace period between the time an institution with an approved assurance submits a grant application to an agency and the institutional review board (IRB) certifies approval of the project. The loss of this grace period would impose unnecessary burdens on the IRB review and might delay submission of promising research projects. Secondly, the proposed policy would allow the FDA to continue to use an inspection system to monitor IRB and investigator compliance, rather than the highly successful NIH assurance system. This is not in keeping with the spirit of uniformity across government agencies and it creates an unnecessary burden for institutions.

Comments were sent to Dr. Joan Porter at NIH, who serves as staff director for the Interagency Committee for the Protection of Human Subjects. More than 24 commentators generally endorsed the government-wide policy, but many protested the loss of the 60-day grace period. The Interagency Committee will now draft a final model policy subject to OSTP approval. Publication of the final policy in the Federal Register is expected in 1987; hopefully, implementing regulations for each agency will be published simultaneously.

## BIOMEDICAL ETHICS BOARD

Last year's NIH reauthorization act created a congressional Biomedical Ethics Board to "study and report to the Congress on a continuing basis on the ethical issues arising from the delivery of health care and biomedical and behavioral research...." The Board consists of 12 members, six from the Senate and six from the House of Representatives, equally divided between Democrats and Republicans. Members of the Board are:

### Senate

Lowell Weicker (R-CT)  
Chairman  
David Durenberger (R-MN)  
Gordon Humphrey (R-NH)  
Dale Bumpers (D-AR)  
Albert Gore (D-TN)  
Edward Kennedy (D-MA)

### House

Willis Gradison (R-OH)  
Vice Chairman  
Thomas Bliley (R-VA)  
Thomas Tauke (R-IA)  
Thomas Luken (D-OH)  
J. Roy Rowland (D-GA)  
Henry Waxman (D-CA)

The Board will appoint a 14-member Biomedical Ethics Advisory Committee to conduct the studies and prepare the actual reports. The membership of the Advisory Committee will be as follows:

- o four individuals "distinguished in biomedical or behavioral research";
- o three individuals "distinguished in the practice of medicine or otherwise distinguished in the provision of health care";
- o five individuals "distinguished in one or more of the fields of ethics, theology, law, the natural sciences (other than the biomedical or behavioral sciences), the social sciences, the humanities, health administration, government, and public affairs"; and
- o two individuals "who are representatives of citizens with an interest in biomedical ethics but who possess no specific expertise."

The Board and Advisory Committee will concentrate initially on two specific issues: (1) an examination of the "nature, advisability, and biomedical and ethical implications of exercising any waiver of existing federal protections of human fetuses in research" and (2) a study of the ethical implications of human genetic engineering.

## COUNCIL ON HEALTH CARE TECHNOLOGY

The Health Promotion and Disease Prevention Amendments of 1984 (Public Law 98-551) mandated the formation of a Council on Health Care Technology. The purposes of this Council are to promote the development and application of appropriate health care technology assessments and to review existing health care technologies to identify obsolete or inappropriately used technologies. The establishment of this Council is consistent with recommendations made by a 1983 Institute of Medicine (IOM) report entitled "A Consortium for Assessing Medical Technology." This report cited the lack of a suitable entity to coordinate existing efforts in medical technology assessment.

One of the primary functions of the Council is to serve as a clearinghouse on health care technologies and assessment. Other mandated responsibilities are to:

- o collect and analyze data concerning specific health care technologies;
- o identify needs in assessment and research on methods;
- o develop and evaluate assessment criteria and methods;
- o promote education, training, and technical assistance in the use of assessment methods and results; and
- o stimulate, coordinate, and commission assessments.

One of the early activities of the Council will be to identify and track technologies in transition. This information will be used to monitor the development, diffusion, and acceptability of technologies.

The Council is seeking financial self-sufficiency through support from both the public and private sectors, and will study the feasibility of providing various revenue-generating services. Initial federal funding for the Council through the National Center for Health Services Research and Health Care Technology Assessment was approved in December 1985. Federal funding for the Council must be matched 2:1 by funds from private sources. The Council is seeking funds from health insurers, medical professional organizations, health product makers, hospitals, health maintenance organizations, and business and labor groups.

The IOM appointed the initial members to the Council in the spring of 1986. These members are:

William N. Hubbard, Jr., M.D., former president of The Upjohn Company, chairman

Jeremiah A. Barondess, M.D., professor of clinical medicine, Cornell University Medical College, co-chairman

Herbert L. Abrams, M.D., professor of radiology, Stanford University School of Medicine

Richard E. Behrman, M.D., J.D., dean, Case Western Reserve University School of Medicine

Paul A. Ebert, M.D., chairman of surgery, University of California-San Francisco

Paul S. Entmacher, M.D., vice president and chief medical director, Metropolitan Life Insurance Company

Melvin A. Glasser, director, Health Security Action Council

Gerald D. Laubach, Ph.D., president, Pfizer, Inc.

Walter B. Maher, director, employee benefits and health services, Chrysler Corporation

Lawrence C. Morris, Jr., senior vice president, health benefits management, Blue Cross and Blue Shield Association

C. Frederick Mosteller, Ph.D., chairman of health policy and management, Harvard School of Public Health

Mary O. Munding, D.P.H., dean, School of Nursing, Columbia University

Anne A. Scitovsky, chief, health economics department, Research Institute, Palo Alto Medical Foundation

C. Thomas Smith, president, Yale-New Haven Hospital

Gail L. Warden, chief executive officer, Group Health Cooperative of Puget Sound

## PHYSICIAN PAYMENT REVIEW COMMISSION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) mandated the formation of a Physician Payment Review Commission. This 11-member Commission will make recommendations to the Congress by March 1 of each year regarding adjustments to the reasonable charge levels for certain physician services (essentially those under Medicare) and changes in the methods for determining the rates of payments for such services. The Commission also will advise and make recommendations to the Secretary of Health and Human Services regarding a relative value scale, which the Secretary is required to develop. Members of the Commission, who are appointed by the Director of the Office of Technology Assessment, include:

Philip R. Lee, M.D., director of the Institute for Health Policy Studies, School of Medicine, UC-San Francisco (chairman)

Oliver H. Beahrs, M.D., professor of surgery emeritus, Mayo Medical School

Robert N. Butler, M.D., professor and chairman of geriatrics and adult development, Mount Sinai School of Medicine

Karen Davis, Ph.D., chairman of health policy and management, Johns Hopkins School of Hygiene and Public Health

John Eisenberg, M.D., M.B.A., associate professor of general medicine, University of Pennsylvania School of Medicine

Jack Guildroy, member of the National Legislative Council of the American Association of Retired Persons

Mark C. Hornbrook, Ph.D., senior investigator and senior economist, Center for Health Research, Kaiser Permanente, Portland, Oregon

Carol Ann Lockhart, M.S., R.N., executive director, Greater Phoenix Affordable Health Care Foundation, Phoenix, Arizona

Walter McNerney, professor of hospital and health services management, J. L. Kellogg Graduate School of Management, Northwestern University

Thomas R. Reardon, M.D., private practitioner, Portland, Oregon

Uwe E. Reinhardt, Ph.D., professor of economics and public affairs, Princeton University

## COUNCIL ON GRADUATE MEDICAL EDUCATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended the Public Health Service Act to create a Council on Graduate Medical Education. Prior to July 1, 1988, and every 3 years thereafter, this Council will make recommendations to the Secretary of Health and Human Services, the Committee on Labor and Human Resources and Committee on Finance in the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means in the House. These recommendations will relate to:

- 1) the supply and distribution of physicians;
- 2) current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties;
- 3) issues relation to foreign medical graduates;
- 4) appropriate federal policies with respect to the above, including policies concerning changes in the financing of undergraduate and graduate medical education programs, and changes in the types of medical education training in graduate medical education programs;
- 5) appropriate efforts by hospitals, medical schools, schools of osteopathy, and accrediting bodies with respect to the above, including efforts for changes in undergraduate and graduate medical education programs; and
- 6) deficiencies in existing databases concerning the supply and distribution of, and post-graduate training programs for, physicians in the United States, and steps that should be taken to eliminate those deficiencies.

The issues to be considered by this Council are unquestionably among the most significant to confront academic medicine, and the Association will continue to track federal efforts to address these questions. Although Public Law 99-272 instructed the Secretary of Health and Human Services to appoint the members of the Council by June 7, 1986, the Department unexplainedly has not yet done so.

DEANS OF U.S. MEDICAL SCHOOL

ALABAMA

Stanley E. Crawford, M.D.  
Dean  
Professor, Dept of Pediatrics  
University of South Alabama  
College of Medicine  
307 University Boulevard  
Mobile, AL 36688

James A. Pittman, Jr., M.D.  
Dean, Professor of Physiology  
and Professor of Medicine  
University of Alabama  
School of Medicine  
Birmingham, AL 35294

ARIZONA

Louis J. Kettel, M.D.  
Dean and Professor,  
Internal Medicine  
University of Arizona  
College of Medicine  
Arizona Health Science Center  
Tucson, AZ 85724

ARKANSAS

I. Dodd Wilson, MD  
Dean  
University of Arkansas  
College of Medicine  
4301 West Markham Street  
Little Rock, AR 72205

CALIFORNIA

Wayne Akeson, MD  
Acting Dean  
UC - San Diego  
School of Medicine  
La Jolla, CA 92093

B. Lyn Behrens, MB, BS  
Dean  
Loma Linda University  
School of Medicine  
Loma Linda, CA 92350

David Korn, M.D.  
Vice President and Dean  
Stanford University  
School of Medicine  
Stanford, CA 94305

Rudi Schmid, M.D.  
Dean  
Professor of Medicine  
UC - San Francisco  
School of Medicine  
513 Parnassus Avenue  
San Francisco, CA 94143



Kenneth I. Shine, MD  
Dean  
UC - Los Angeles  
UCLA School of Medicine  
Los Angeles, CA 90024

Joseph W. St. Geme, Jr., M.D.  
Dean  
University of Colorado  
School of Medicine  
4200 East Ninth Avenue  
Denver, CO 80262

Robert E. Tranquada, MD  
Dean  
Univ of Southern California  
School of Medicine  
2025 Zonal Avenue  
Los Angeles, CA 90033

CONNECTICUT

Leon E. Rosenberg, M.D.  
Dean  
Professor of Human Genetics  
Yale University  
School of Medicine  
333 Cedar Street  
New Haven, CT 06510

Gerald D. Weinstein, MD  
Acting Dean  
UC - Irvine  
California College of Medicine  
Irvine, CA 92717

Eugene M. Sigman, M.D.  
Dean  
University of Connecticut  
School of Medicine  
Box G  
Farmington, CT 06032

Hibbard E. Williams, M.D.  
Dean  
UC - Davis  
School of Medicine  
Davis, CA 95616

FLORIDA

William B. Deal, M.D.  
Dean and Associate Vice  
President for Clinical Affairs  
University of Florida  
College of Medicine  
Box J-215  
Gainesville, FL 32610

COLORADO

Joseph W. St. Geme, Jr., M.D.  
Dean  
University of Colorado  
School of Medicine  
4200 East Ninth Avenue  
Denver, CO 80262

Bernard J. Fogel, M.D.  
Vice President for Med Affairs  
Dean  
University of Miami  
School of Medicine  
PO Box 016099  
Miami, FL 33101

Andor Szentivanyi, M.D.  
Dean  
University of South Florida  
College of Medicine  
12901 North 30th Street  
Tampa, FL 33612

GEORGIA

Richard M. Krause, M.D.  
Dean  
Emory University  
School of Medicine  
1440 Clifton Road, NE  
Atlanta, GA 30322

Stanley W. Olson, M.D.  
Dean  
Morehouse School of Medicine  
720 Westview Drive, Sw  
Atlanta, GA 30310

W. Douglas Skelton, M.D.  
Provost for Medical Affairs  
Dean, School of Medicine  
Mercer University  
School of Medicine  
Macon, GA 31207

Francis J. Tedesco, MD  
Interim Dean  
Medical College of Georgia  
School of Medicine  
1200 Fifteenth Street  
Augusta, GA 30912

HAWAII

Terence A. Rogers, M.D.  
Dean  
Professor, Dept of Physiology  
University of Hawaii  
John A. Burns Sch of Medicine  
1960 East-West Road  
Honolulu, HI 96822

ILLINOIS

Harry N. Beaty, M.D.  
Dean  
Professor of Medicine  
Northwestern University  
Medical School  
303 East Chicago Avenue  
Chicago, IL 60611

Marshall A. Falk, M.D.  
Executive Vice President  
Dean  
University of Health Sciences  
Chicago Medical School  
333 Green Bay Road  
North Chicago, IL 60064

Phillip M. Forman, M.D.  
Dean and Professor,  
Clin Pediatrics & Neurology  
University of Illinois  
College of Medicine  
1853 West Polk Street  
Chicago, IL 60612

Donald W. King, M.D.  
Dean  
University of Chicago  
Pritzker School of Medicine  
950 East 59th Street  
Chicago, IL 60637

Richard H. Moy, M.D.  
Dean and Provost  
Professor of Medicine  
Southern Illinois University  
School of Medicine  
801 North Rutledge  
Springfield, IL 62708

Henry P. Russe, M.D.  
Vice Pres for Medical Affairs  
Dean  
Rush Medical College  
of Rush University  
600 South Paulina Street  
Chicago, IL 60612

John R. Tobin, Jr., M.D.  
Dean  
Professor of Medicine  
Loyola University of Chicago  
Stritch School of Medicine  
2160 South First Avenue  
Maywood, IL 60153

#### INDIANA

Walter J. Daly, M.D.  
Dean  
Professor of Medicine  
Indiana University  
School of Medicine  
1100 West Michigan Street  
Indianapolis, IN 46223

#### IOWA

John W. Eckstein, M.D.  
Dean  
Professor of Internal Medicine  
University of Iowa  
College of Medicine  
100 College of Med Admin Bldg.  
Iowa City, IA 52242

#### KANSAS

D. Kay Clawson, M.D.  
Executive Vice Chancellor  
Professor of Surgery  
University of Kansas  
School of Medicine  
39th and Rainbow Boulevard  
Kansas City, KS 66103

#### KENTUCKY

Donald R. Kmetz, M.D.  
Dean  
University of Louisville  
School of Medicine  
Health Sciences Center  
Louisville, KY 40292

Robin D. Powell, M.D.  
Dean  
University of Kentucky  
College of Medicine  
800 Rose Street  
Lexington, KY 40536

Richard S. Ross, M.D.  
Vice Pres for Medicine  
Dean of the Medical Faculty  
Johns Hopkins University  
School of Medicine  
20 Rutland Avenue  
Baltimore, MD 21205

LOUISIANA

Robert Daniels, MD  
Dean  
Louisiana State University  
Sch of Medicine in New Orleans  
1542 Tulane Avenue  
New Orleans, LA 70112

Jay P. Sanford, M.D.  
President, USUHS  
Dean  
Unif Serv Univ of Hlth Sci  
F. Edward Hebert Sch of Med  
4301 Jones Bridge Road  
Bethesda, MD 20814

James T. Hamlin, III, M.D.  
Dean  
Tulane University  
School of Medicine  
1430 Tulane Avenue  
New Orleans, LA 70112

MASSACHUSETTS

Henry H. Banks, M.D.  
Dean  
Tufts University  
School of Medicine  
136 Harrison Avenue  
Boston, MA 02111

Darryl M. Williams, MD  
Acting Dean & Associate Dean  
for Academic Affairs  
LSU - Shreveport  
School of Medicine  
PO Box 33932  
Shreveport, LA 71130

J. Barry Hanshaw, MD  
Provost  
Dean  
University of Massachusetts  
Medical School  
56 Lake Avenue North  
Worcester, MA 01605

MARYLAND

John M. Dennis, M.D.  
Vice Chancellor for Acad Affrs  
Dean  
University of Maryland  
School of Medicine  
655 West Baltimore Street  
Baltimore, MD 21201

John I. Sandson, M.D.  
Dean  
Boston University  
School of Medicine  
30 East Concord Street  
Boston, MA 02118

Daniel C. Tosteson, M.D.  
President, Harvard Medical Ctr  
Dean, Faculty of Medicine  
Harvard Medical School  
80 East Concord Street  
Boston, MA 02115

#### MICHIGAN

Joseph E. Johnson, III, M.D.  
Dean  
University of Michigan  
Medical School  
1335 Catherine Street  
Ann Arbor, MI 48109

Henry L. Nadler, M.D.  
Dean and Professor of  
Pediatrics and Obstetrics  
Wayne State University  
School of Medicine  
540 East Canfield Avenue  
Detroit, MI 48201

W. Donald Weston, M.D.  
Dean  
Michigan State University  
College of Human Medicine  
East Lansing, MI 48824

#### MINNESOTA

David M. Brown, M.D.  
Dean  
University of Minnesota  
Medical School - Minneapolis  
421 Delaware Street, NE  
Minneapolis, MN 55455

Franklyn G. Knox, M.D.  
Dean  
Mayo Medical School  
200 First Street, SW  
Rochester, MN 55905

Paul C. Royce, M.D.  
Dean and Professor of  
Clinical Sciences & Physiology  
University of Minnesota-Duluth  
School of Medicine  
2400 Oakland Avenue  
Duluth, MN 55812

#### MISSISSIPPI

Norman C. Nelson, M.D.  
Dean  
University of Mississippi  
School of Medicine  
2500 North State Street  
Jackson, MS 39216

#### MISSOURI

Harry S. Jonas, M.D.  
Dean  
Univ of Missouri - Kansas City  
School of Medicine  
2411 Holmes Street  
Kansas City, MO 64108

M. Kenton King, M.D.  
 Dean and Professor,  
 Medicine & Preventive Medicine  
 Washington University  
 School of Medicine  
 660 South Euclid Avenue  
 Saint Louis, MO 63110

William Stoneman, III, M.D.  
 Associate Vice President  
 Dean  
 Saint Louis University  
 School of Medicine  
 1402 South Grand Boulevard  
 Saint Louis, MO 63104

Michael E. Whitcomb, MD  
 Dean  
 Univ of Missouri - Columbia  
 School of Medicine  
 807 Stadium Road  
 Columbia, MO 65212

#### NEBRASKA

Richard L. O'Brien, M.D.  
 Dean, VP-Health Sciences, Prof  
 Medicine & Med Microbiology  
 Creighton University  
 School of Medicine  
 42nd Street & Dewey Avenue  
 Omaha, NE 68178

Robert H. Waldman, M.D.  
 Dean  
 Professor, Dept. of Int. Med.  
 University of Nebraska  
 College of Medicine  
 42nd Street and Dewey Avenue  
 Omaha, NE 68105

#### NEVADA

Robert M. Daugherty, Jr., M.D.  
 Dean  
 University of Nevada  
 School of Medicine  
 Manville Med Sciences Building  
 Reno, NV 89557

#### NEW HAMPSHIRE

Robert W. McCollum, M.D.  
 Dean  
 Dartmouth Medical School  
 College Street  
 Hanover, NH 03756

#### NEW JERSEY

Vincent Lanzoni, M.D.  
 Dean  
 Univ of Medicine & Dentistry  
 New Jersey Medical School  
 100 Bergen Street  
 Newark, NJ 07103

Richard C. Reynolds, M.D.  
 Senior VP Academic Affairs  
 Dean  
 Univ of Medicine & Dentistry  
 Rutgers Medical School  
 PO Box 101  
 Piscataway, NJ 08854

NEW MEXICO

Leonard M. Napolitano, Ph.D.  
Dean  
Director of the Medical Center  
University of New Mexico  
School of Medicine  
Medical Center  
Albuquerque, NM 87131

NEW YORK

Karl P. Adler, MD  
Acting Dean  
New York Medical College  
Elmwood Hall  
Valhalla, NY 10595

Henrik H. Bendixen, M.D.  
Vice President Health Sciences  
Dean, Faculty of Medicine  
Columbia University  
Coll of Physicians & Surgeons  
630 West 168th Street  
New York, NY 10032

Saul J. Farber, M.D.  
Acting Provost and Dean  
Dean for Academic Affairs  
New York University  
School of Medicine  
550 First Avenue  
New York, NY 10016

Robert L. Friedlander, M.D.  
President and Dean  
Albany Medical College  
of Union University  
47 New Scotland Avenue  
Albany, NY 12208

John B. Henry, M.D.  
President  
Acting Dean  
SUNY Health Science Center at  
Syracuse, College of Medicine  
766 Irving Avenue  
Syracuse, NY 13210

Robert J. Joynt, M.D., Ph.D.  
Dean and Vice Provost  
University of Rochester  
Sch of Medicine and Dentistry  
601 Elmwood Avenue  
Rochester, NY 14642

Nathan G. Kase, M.D.  
Dean  
Mount Sinai School of Medicine  
of the City Univ of New York  
1 Gustave L. Levy Place  
New York, NY 10029

Marvin Kushner, M.D.  
Dean  
SUNY at Stony Brook Health  
Sciences Ctr Sch of Medicine  
Stony Brook, NY 11794

Thomas H. Meikle, Jr., M.D.  
 Dean and Provost  
 Professor of Anatomy  
 Cornell University  
 Medical College  
 1300 York Avenue  
 New York, NY 10021

John Naughton, M.D.  
 Dean  
 Professor of Medicine  
 SUNY at Buffalo  
 School of Medicine  
 3435 Main Street  
 Buffalo, NY 14214

Dominick P. Purpura, M.D.  
 Dean  
 Albert Einstein Coll of Med  
 of Yeshiva University  
 1300 Morris Park Avenue  
 Bronx, NY 10461

Richard H. Schwarz, M.D.  
 Dean  
 SUNY Health Science Center at  
 Brooklyn, College of Medicine  
 450 Clarkson Avenue  
 Brooklyn, NY 11203

#### NORTH CAROLINA

Stuart Bondurant, M.D.  
 Dean  
 University of North Carolina  
 School of Medicine  
 Chapel Hill, NC 27514

Richard Janeway, M.D.  
 Vice President, Health Affairs  
 Executive Dean  
 Bowman Gray School of Medicine  
 of Wake Forest University  
 300 South Hawthorne Road  
 Winston Salem, NC 27103

William E. Laupus, M.D.  
 Vice Chancellor and Dean  
 East Carolina University  
 School of Medicine  
 PO Box 2701  
 Greenville, NC 27834

Charles E. Putman, MD  
 Vice Provost for Res. & Devlp  
 Dean  
 Duke University  
 School of Medicine  
 PO Box 3005, Duke Med Center  
 Durham, NC 27710

#### NORTH DAKOTA

Tom M. Johnson, M.D.  
 Executive Director  
 Dean  
 University of North Dakota  
 School of Medicine  
 Grand Forks, ND 58202

#### OHIO

Richard E. Behrman, M.D.  
 Dean  
 Case Western Reserve Univ  
 School of Medicine  
 2119 Abington Road  
 Cleveland, OH 44106



Colin Campbell, M.D.  
Dean  
Northeastern Ohio Universities  
College of Medicine  
4209 State Rt. 44, PO Box 95  
Rootstown, OH 44272

Kenneth W. Rowe, Jr., MD  
Interim Dean & Vice Dean for  
Clinical & House Staff Affairs  
University of Cincinnati  
College of Medicine  
231 Bethesda Avenue  
Cincinnati, OH 45267

William D. Sawyer, M.D.  
Dean  
Professor of Medicine  
Wright State University  
School of Medicine  
PO Box 927  
Dayton, OH 45401

Frank G. Standaert, MD  
Dean  
Medical College of Ohio  
Caller Service No. 10008  
Toledo, OH 43699

Manuel Tzagournis, M.D.  
VP for Health Services  
Dean  
Ohio State University  
College of Medicine  
370 West Ninth Avenue  
Columbus, OH 43210

OKLAHOMA

Larry D. Edwards, M.D.  
Dean  
Oral Roberts University  
School of Medicine  
7777 South Lewis  
Tulsa, OK 74171

Donald G. Kassebaum, MD  
Executive Dean  
University of Oklahoma  
College of Medicine  
PO Box 26901  
Oklahoma City, OK 73190

OREGON

John W. Kendall, Jr., M.D.  
Dean  
Professor of Medicine  
Oregon Health Sciences Univ  
School of Medicine  
3181 SW Sam Jackson Park Road  
Portland, OR 97201

PENNSYLVANIA

Thomas Detre, M.D.  
Dean  
University of Pittsburgh  
School of Medicine  
Alan Magee Scaife Hall  
Pittsburgh, PA 15261

Martin Goldberg, MD  
Dean  
Temple University  
School of Medicine  
3400 North Broad Street  
Philadelphia, PA 19140

Joseph S. Gonnella, M.D.  
Dean and Vice President  
Professor of Medicine  
Jefferson Medical College of  
Thomas Jefferson University  
1025 Walnut Street  
Philadelphia, PA 19107

Harry Prystowsky, M.D.  
Dean  
Pennsylvania State University  
College of Medicine  
500 University Drive  
Hershey, PA 17033

Edward J. Stemmler, M.D.  
Dean  
Dunlop Professor of Medicine  
University of Pennsylvania  
School of Medicine  
36th and Hamilton Walk  
Philadelphia, PA 19104

Alton I. Sutnick, M.D.  
Senior VP for Health Affairs  
and Dean  
Medical Coll of Pennsylvania  
3300 Henry Avenue  
Philadelphia, PA 19129

Israel Zwerling, M.D., Ph.D.  
Sr. Vice Pres. for Academic  
Affairs and Dean, Sch of Med  
Hahnemann Medical College  
235 North 15th Street  
Philadelphia, PA 19102

PUERTO RICO

Raul A. Marcial-Rojas, M.D.  
President and Dean  
Univ Central del Caribe  
School of Medicine  
Cayey, PR 00633

Enrique Mendez, Jr., M.D.  
Dean  
Ponce School of Medicine  
PO Box 7004, University Street  
Ponce, PR 00732

Nydia R. de Jesus, MD  
Dean  
University of Puerto Rico  
School of Medicine  
GPO Box 5067  
San Juan, PR 00936

RHODE ISLAND

David S. Greer, M.D.  
Dean and Professor,  
Community Health  
Brown University  
Program in Medicine  
97 Waterman Street  
Providence, RI 02912

SOUTH CAROLINA

G. William Bates, MD  
Dean  
Med Univ of South Carolina  
College of Medicine  
171 Ashley Avenue  
Charleston, SC 29425

J. O'Neal Humphries, M.D.  
Dean  
Professor of Medicine  
University of South Carolina  
Medical School  
Columbia, SC 29208

SOUTH DAKOTA

Robert H. Quinn, M.D.  
Vice President  
Dean  
University of South Dakota  
School of Medicine  
Dakota and Clark Streets  
Sioux Falls,, SD 57105

TENNESSEE

John E. Chapman, M.D.  
Dean  
Professor of Pharmacology  
Vanderbilt University  
School of Medicine  
21st Avenue South at Garland  
Nashville, TN 37232

Herschel L. Douglas, M.D.  
Dean of Medicine and Vice  
President for Health Affairs  
East Tennessee State Univ  
Quillen-Dishner Coll of Med  
PO Box 23320A  
Johnson City, TN 37614

Walter F. Leavell, M.D.  
Dean  
Meharry Medical College  
1005 18th Avenue, North  
Nashville, TN 37208

Robert L. Summitt, M.D.  
Dean and Professor,  
Pediatrics, Anatomy  
University of Tennessee  
College of Medicine  
800 Madison Avenue  
Memphis, TN 38163

TEXAS

George T. Bryan, M.D.  
Vice Pres for Academic Affairs  
and Dean  
University of Texas  
Medical School at Galveston  
Galveston, TX 77550

William T. Butler, M.D.  
President  
Baylor College of Medicine  
1200 Moursund Avenue  
Houston, TX 77030

J. Ted Hartman, M.D.  
Dean and Professor,  
Orthopaedic Surgery  
Texas Tech University  
School of Medicine  
PO Box 4569  
Lubbock, TX 79430

Peter O. Kohler, MD  
Dean  
University of Texas Medical  
School at San Antonio  
PO Box 20708  
San Antonio, TX 78284

John C. Ribble, MD  
Dean  
University of Texas  
Medical School at Houston  
PO Box 20708  
Houston, TX 77225

Robert S. Stone, M.D.  
Dean  
Texas A&M University  
College of Medicine  
Teague Building  
College Station, TX 77843

C. Kern Wildenthal, M.D.  
President  
Acting Dean  
Univ of Texas Southwestern  
Medical School at Dallas  
5323 Harry Hines Boulevard  
Dallas, TX 75235

UTAH

Cecil O. Samuelson, Jr., M.D.  
Dean  
Professor of Medicine  
University of Utah  
College of Medicine  
50 North Medical Drive  
Salt Lake City, UT 84132

VERMONT

William H. Luginbuhl, M.D.  
Dean  
Professor of Pathology  
University of Vermont  
School of Medicine  
Given Building  
Burlington, VT 05405

VIRGINIA

Stephen M. Ayres, MD  
Dean  
VCU Medical Coll of Virginia  
School of Medicine  
110 East Marshall Street  
Richmond, VA 23298

Robert M. Carey, M.D.  
Dean  
University of Virginia  
School of Medicine  
Charlottesville, VA 22908

Richard G. Lester, M.D.  
Dean  
Eastern VA Medical School  
700 Olney Rd., PO Box 1980  
Norfolk, VA 23501

WASHINGTON, DC

L. Thompson Bowles, M.D.  
Dean  
Professor of Surgery  
George Washington University  
School of Medicine  
2300 Eye Street, NW  
Washington, DC 20037

Milton Corn, MD  
Dean  
Georgetown University  
School of Medicine  
3900 Reservoir Road, NW  
Washington, DC 20007

Russell L. Miller, Jr., M.D.  
Dean  
Professor  
Howard University  
College of Medicine  
520 "W" Street, NW  
Washington, DC 20059

WASHINGTON

Theodore J. Phillips, M.D.  
Acting Dean  
Assoc. Dean, Academic Affairs

University of Washington  
School of Medicine  
Seattle, WA 98195

WEST VIRGINIA

Lester R. Bryant, M.D., Sc.D.  
Vice President for Health  
Sciences and Dean  
Marshall University  
School of Medicine  
Huntington, WV 25701

Richard DeVaul, M.D.  
Dean  
West Virginia University  
School of Medicine  
Morgantown, WV 26506

WISCONSIN

Arnold L. Brown, M.D.  
Dean and Professor,  
Pathology & Lab Medicine  
University of Wisconsin  
Medical School  
610 Walnut St., WARF Building  
Madison, WI 53706

Richard A. Cooper, M.D.  
Academic Vice President and  
Dean  
Medical College of Wisconsin  
8701 Watertown Plank Road  
Milwaukee, WI 53226

FUTURE MEETING DATES

1987 Meeting Dates:

*Executive Council/COD Admin. Board -*

January 21-22  
April 15-16  
June 17-18  
September 9-10

*AAMC Annual Meeting -*

November 7-12  
Washington Hilton Hotel  
Washington, DC

*COD Spring Meeting -*

April 4-8  
Stouffer Wailea Beach Resort  
Maui, Hawaii