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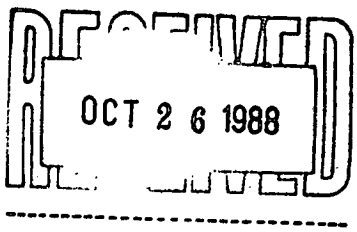
REMARKS TO THE COUNCIL OF DEANS

ROBERT G. PETERSDORF, M.D.

PRESIDENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

PRESENTED TO THE COUNCIL OF DEANS AT THE AAMC ANNUAL MEETING, CHICAGO, ILLINOIS, NOVEMBER 14, 1988.



REMARKS TO THE COUNCIL OF DEANS

I AM VERY GLAD TO BE WITH YOU THIS AFTERNOON TO PROVIDE A REPORT ON THE ASSOCIATION AND ITS ACTIVITIES DURING THE LAST YEAR. THIS REPORT WILL BE BRIEF SINCE MUCH OF THE INFORMATION IS AVAILABLE TO YOU IN OTHER SOURCES SUCH AS THE ANNUAL REPORT. NEVERTHELESS, I DO WANT TO HIGHLIGHT A FEW OF THE IMPORTANT THINGS THAT THE ASSOCIATION IS WORKING ON.

FIRST, I AM DELIGHTED TO REPORT THAT WITH THE ARRIVAL NEXT MONTH OF DR. HERBERT NICKENS AS VICE PRESIDENT FOR MINORITY HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION, THE ASSOCIATION'S EXECUTIVE STAFF RECRUITMENT WILL BE COMPLETE. OF THE TWELVE MEMBERS OF THE STAFF, SIX HAVE BEEN AT THE ASSOCIATION FOR 12 YEARS OR MORE AND SIX HAVE JOINED

THE STAFF SINCE MY ARRIVAL TWO YEARS AGO. THIS GIVES US A USEFUL MIX OF INSTITUTIONAL MEMORY AND LONG-TERM CONSTITUENT RELATIONSHIPS COMBINED WITH PEOPLE BRINGING NEW IDEAS AND EXPERIENCES TO THE ASSOCIATION. I THINK THAT THE SENIOR STAFF YOU HAVE WORKING FOR YOU AT THE AAMC IS QUITE TALENTED, AND I HOPE YOU DRAW ON THIS TALENT FOR YOUR NEEDS.

DURING THE PAST SIX MONTHS THE EXECUTIVE STAFF HAS BEEN WORKING ON THE DEVELOPMENT OF A FORMAL STRATEGIC PLAN FOR THE ASSOCIATION. PART OF THIS PROCESS HAS BEEN THE DEVELOPMENT OF A NEW MISSION STATEMENT WHICH WAS APPROVED BY THE EXECUTIVE COUNCIL IN JUNE AND A SET OF SEVEN STRATEGIC GOALS WHICH HAVE BEEN DEBATED BY EACH OF OUR ADMINISTRATIVE BOARDS. THE PLAN ITSELF WILL BE THE SUBJECT OF DISCUSSION AT OUR OFFICER'S RETREAT NEXT

MONTH. THIS PROCESS HAS BEEN AN EXTREMELY USEFUL EXERCISE FOR US AS IT HAS ALLOWED A COMPREHENSIVE REVIEW OF OUR CURRENT ACTIVITIES TO BE COMBINED WITH SOME FORWARD LOOKING AT NEW PROGRAM INITIATIVES.

ONE OF THE THINGS THAT HAS BEEN A PRIORITY OF MINE DURING THE LAST YEAR HAS BEEN AN EFFORT TO INCREASE THE LEVEL OF OUTSIDE SUPPORT FOR PROGRAM ACTIVITIES. I BELIEVE WE HAVE BEEN RELATIVELY SUCCESSFUL IN THE PAST SEVERAL MONTHS. BOTH THE MACY AND ROBERT WOOD JOHNSON FOUNDATIONS HAVE MADE AWARDS TO SUPPORT EXPANDED ACTIVITIES IN MINORITY PARTICIPATION IN MEDICAL EDUCATION. THESE INITIATIVES WILL BE LOCATED IN THE NEW DIVISION OF MINORITY HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION. THE DECISION THAT AAMC ACTIVITIES IN THIS ARENA MUST BE MORE AGGRESSIVE IS CONGRUENT WITH

YOUR WISHES AS EXPRESSED DURING DISCUSSIONS AT YOUR SPRING MEETING.

THE ASSOCIATION'S OTHER MAJOR GRANT HAS COME FROM THE CULPEPER FOUNDATION AND WILL SUPPORT AN IN-DEPTH EXAMINATION OF CURRICULAR CHANGES BEING UNDERTAKEN AT OUR MEDICAL SCHOOLS. THE ASSOCIATION'S RANGE OF ACTIVITIES IS VERY BROAD TO REFLECT THE MULTITUDE OF PROGRAMS AT OUR MEMBER ACADEMIC MEDICAL CENTERS. BUT, WE MUST NOT LOSE SIGHT OF THE CENTRALITY OF THE MEDICAL EDUCATION MISSION TO ACADEMIC MEDICINE. THIS NEW PROGRAM IS THE ASSOCIATION'S FIRST MAJOR EDUCATIONAL STUDY SINCE THE GPEP REPORT, AND WILL BE DIRECTED BY LOU KETTEL.

AFTER NEARLY A YEAR OF PLANNING, IN JUST TWO MONTHS TIME, OUR NEWLY REVISED JOURNAL, ACADEMIC MEDICINE, WILL APPEAR. FOR A LONG TIME I HAD HEARD THE JOURNAL OF MEDICAL EDUCATION REFERRED TO AS THE "MOST CITED AND LEAST READ" JOURNAL. WE WANT TO CHANGE THAT QUOTE--OR AT THE MINIMUM THE PART ABOUT BEING LEAST READ, AND I THINK ACADEMIC MEDICINE WILL DO THIS. I THINK THE PUBLICATION WILL BE A HANDSOME ONE, BUT ONE THAT IS ALSO INTERESTING, LIVELY, AND WIDE-RANGING IN CONTENT AND SCOPE. IN SHORT, WE WANT IT TO BE JUST LIKE THE COMMUNITY IT SERVES. I HOPE YOU WILL SUPPORT YOUR NEW JOURNAL WITH YOUR READERSHIP, YOUR IDEAS, AND YOUR ARTICLES.

I PARTICULARLY WANT TO THANK THIS COUNCIL FOR ITS SUPPORT OF THE SCHOOL VISIT PROGRAM. I THINK IT IS VERY USEFUL FOR OUR STAFF TO GET OUT TO MEET YOU

ON YOUR OWN TURF SO THAT YOU HAVE AN OPPORTUNITY TO DEMONSTRATE THE UNIQUE AND INTERESTING ASPECTS OF YOUR SCHOOLS. WHENEVER LEGISLATION OR REGULATION TRIES TO STRAIGHT-JACKET PROGRAMS INTO A RIGID MOLD, THE ASSOCIATION TESTIFIES THAT THE STRENGTH OF AMERICAN MEDICAL EDUCATION LIES IN ITS DIVERSITY. THESE SCHOOL VISITS ARE ENFORCING THAT VIEW AND ARE GIVING US A CHANCE TO EXPOSE SOME OF OUR MID-LEVEL STAFF TO YOUR ACTIVITIES. SO FAR THIS YEAR WE HAVE VISITED MINNESOTA, NEW JERSEY MEDICAL, LOMA LINDA, ROCHESTER, CREIGHTON, NEBRASKA, JEFFERSON, AND WITHIN THE NEXT MONTH WE WILL BE AT THE MEDICAL COLLEGE OF OHIO AND NORTHEAST OHIO. YOU ARE BEING VERY GENEROUS WITH YOUR TIME AND I BELIEVE YOU WILL BE REPAID WITH A MORE INFORMED STAFF WHO IS BETTER EQUIPPED TO SERVE YOU.

DURING THE NEXT YEAR WE WILL SEE THE COMPLETION OF THE WORK OF AAMC'S COMMITTEE ON AIDS AND THE ACADEMIC MEDICAL CENTER AND THE MCAT REVIEW COMMITTEE AS WELL AS THE TASK FORCE ON PHYSICIAN SUPPLY. WE WILL HAVE A NEW COMMITTEE ON THE EFFECT OF THE NURSING SHORTAGE ON TEACHING HOSPITAL ACTIVITIES (AS WELL AS A TASK FORCE TO EXAMINE CERTAIN GOVERNANCE ISSUES). WE EXPECT TO HAVE A NEW DOCUMENT ON ETHICAL BEHAVIOR BY RESEARCHERS, AND AN ANALYTICAL PAPER ON TRENDS IN HOSPITAL PROFITS WITH PARTICULAR EMPHASIS ON RECENT TEACHING HOSPITAL DATA. WE CAN ALSO EXPECT TO BE WORKING ON ISSUES RAISED BY THE HSIAO STUDY.

BE ASSURED THAT YOUR ASSOCIATION WILL CONTINUE ITS ADVOCACY FOR ALL ACTIVITIES OF ACADEMIC MEDICAL CENTERS. WE DO THIS IN SUPPORT OF YOUR

INSTITUTIONS, BUT WE CANNOT DO THIS WITHOUT YOUR PERSONAL SUPPORT. WE GREATLY NEED AND VALUE YOUR PARTICIPATION IN THE ASSOCIATION--THROUGH THIS MEETING AND YOUR MANY OTHER CONTRIBUTIONS TO OUR ORGANIZATION.

I WILL BE GLAD TO TAKE QUESTIONS.

AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AGENDA

FOR

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

MONDAY, NOVEMBER 14, 1988
2:00 PM - 5:00 PM
SALON II

CHICAGO MARRIOTT HOTEL
CHICAGO, ILLINOIS

COUNCIL OF DEANS

Sessions Schedule

CHICAGO MARRIOTT

CHICAGO, ILLNOIS

Sunday
November 13, 1988

	Sessions	*Room*
9:00 AM - Noon	*Community Based Medical School Deans*	*Michigan*
1:00 PM - 3:30 PM	*CAS/COD/COTH Joint Session*	*Salon D*

Monday
November 14, 1988

	Sessions	*Room*
7:00 AM - 9:00 AM	*Midwest/Great Plains Deans Breakfast*	*Northwestern*
7:00 AM - 9:00 AM	*California Deans Breakfast*	*Minnesota*
7:30 AM - 9:00 AM	*New Deans Breakfast*	*Purdue*
12 Noon - 1:30 PM	*COD Administrative Board*	*Indiana*
2:00 PM - 5:00 PM	*COD Business Meeting*	*Salon II*
7:00 PM - 11:00 PM	*COD Reception/Dinner*	*The Art Institute of Chicago*

AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Tuesday
November 15, 1988

	Sessions	Room
7:00 AM - 8:15 AM	*Southern Deans Breakfast*	*Midway*
7:00 AM - 9:00 AM	*Western Deans Breakfast*	*Ontario*
10:30 AM - 12 Noon	*COD 1989 Spring Meeting Program Planning Committee*	*Parlor, Butler/Kettel Suites*
11:45 AM - 2:30 PM	*Associated Medical Schools of New York*	*Lincoln Shire II*
12 Noon - 3:00 PM	*Private Freestanding Medical School Deans Luncheon*	*Ontario*
1:00 PM - 5:00 PM	*VA/COD Joint Session*	*Salon I*

Wednesday
November 16, 1988

	Sessions	Room
8:30 AM - 11:00 AM	*Rural Health Interest Group**	*Monroe*

* *This session will take place at the Palmer House. Shuttle bus service will be available between the Marriott and the Palmer House.*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

Chicago Marriott
Chicago, Illinois

AGENDA

Monday, November 14, 1988

2:00 PM - 5:00 PM

Salon II

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SPRING BUSINESS MEETING OF THE COUNCIL OF DEANS

MINUTES

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

The Hotel Inter-Continental
Hilton Head, South Carolina

I. CALL TO ORDER AND QUORUM CALL

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

II. APPROVAL OF THE MINUTES

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

III. REPORT OF THE PRESIDENT

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

Dr. Petersdorf then reported as follows:

- Strategic Planning:

  The Association's executive staff has been working to develop a strategic plan. This plan will identify major programmatic priority areas and new activities for a five (5) year period. The plan will be presented at the December 1988 officers retreat; be taken to each Council for discussion; and to the Executive Council for approval in February 1989. Dr. Petersdorf invited the deans to send ideas to the Vice Presidents, or to him directly.

- Housestaff Hours:

  The AAMC is not alone among professional societies taking up this issue. As an umbrella organization for medical education, it is essential to address the issues arising from the public debate. The

AAMC final document was adopted by the Executive Council on February 25th. Attention on graduate medical education was prompted by a 1984 case in which a young woman was admitted to a major New York City teaching hospital where she died in less then twenty-four (24) hours. A Grand Jury investigation returned no indictments, but did make several recommendations concerning emergency room staffing, the supervision of residents in training, and the hours assigned to residents. In response, the New York State Commissioner of Health, David Axelrod, M.D., appointed an ad hoc advisory committee on emergency services to analyze the Grand Jury's recommendations. Dr. Petersdorf noted that the Association meticulously debated the content of its position paper at three Executive Council meetings, at the Annual Meetings of the three constituent councils and at the officers retreat. Dr. Petersdorf emphasized the importance to the medical education community of the public's perception of how we conduct our professional education. It is essential for the AAMC to make a public statement concerning these important issues of supervision and training. To summarize, Dr. Petersdorf stated the Association's consensus on the following points:

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

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

- The AAMC wants to be certain that whatever changes are made, the educational services and fiscal implications of these changes are considered.

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

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

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

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

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

- Minority Affairs

Dr. Petersdorf continued by noting a more vigorous program is needed to increase participation in medicine by underrepresented minorities. Previous efforts by the Association and its members have been effective, but much remains to be accomplished. Demographers report minority segments of the population are the fastest growing. Underrepresented minorities in medicine will soon comprise about one-third of our future population, and potentially one-third of our applicant pool. The Association is planning to upgrade its own minority affairs activities through a new office headed by a vice president to be recruited shortly. Programmatic activities for this office are already under discussion with various foundations. Dr. Petersdorf is confident we will be able to undertake this effort immediately without waiting for a dues increase or for funds to support the new office and its work.

- Awards

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

- **Association Dues**

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

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

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

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

- o $1.3 million to compensate for the deficit in the 1988-89 budget. The 1988-89 budget with its deficit has already been approved by the Executive Committee and the Executive Council.

- o $700,000 dollars this year was taken out of designated reserve funds and set aside by the Executive Council for various programmatic activities, mainly for updating of the MCATs. This expenditure is now part of the permanent operating budget.

- o $1.2 million is interest income now annualized for operations. We need to be able to get along without using interest income as part of our operating budget.

- o $1.4 million is for new programs, plus inflation. This is about ten percent (10%) of next year's $14 million operating budget.

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

- o The Association's space is both inadequate in quantity and in functional quality. Further, we are in two locations. Student services are located at 1776 Massachusetts Avenue where we'll

rent an additional 10,000 square feet in November 1988. We need more space, need better space and need to bring the operations together. The issue of safety is also important. And finally, the image of the AAMC space should be commensurate with our image.

The proposed dues increase will not go to build new space. The dues increase will save the $1.2 million interest income for space efforts. It works in the following way. If the dues increase is approved and becomes effective in the summer of 1989, which is the earliest that it can, for the first several years the interest income will be put aside for a down payment probably on a new building. After considerable study with several consultants, we have determined that long-term leasing is not the best option for us. We spend over a million dollars annually for rent now; however, we ought to be able to leave our successors a building in which the AAMC has equity. The lease at 1 Dupont Circle ends January 1, 1992. At that point we want to be prepared to move into new quarters housing the entire organization. Should we move into the suburbs as other organizations have? It's our feeling, firstly, that Bethesda, the most desirable suburb, is as expensive as central Washington.

- Central Washington is an address we feel we should have and not bury ourselves among the condominiums of Alexandria and Arlington. We think we will be able to purchase a D.C. building in 1992.

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

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

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

There have been concerns about the size of the dues increase. Could it be phased in over a longer period of time? This would not meet our immediate needs. We already have an operating deficit of

$1.3 million, plus the $700,000 from the designated accounts and this will have to be continued. The time is limited to build the capital funds for new quarters before the expiration of our lease in December 1991.

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

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

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

John Colloton, as a member of the Finance Committee, assured the Council of three things:

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

IV. LEGISLATIVE UPDATE

Dr. Richard Knapp presented a legislative update. He first called attention to the AAMC's published comprehensive legislative and

regulatory update. Specific items were then updated. First, the National Institute of Health's reauthorization process concerns. There are five issues: Fetal research; the proposed deafness institute; the proposed center for rehabilitation research; health research facilities construction; and the use of animals in research.

Concerning construction, there is some optimism. Drs. Richard Janeway and Louis Kettel made a presentation before a special advisory panel at NIH on February 9th. We worked with and endorsed the Association of American Universities and the National Association of State Universities and Land Grant Colleges testimony before Congressman Waxman on March 4th. We and others have been working with Senator Kennedy's staff. Currently in the NIH reauthorization bill there is a health facilities research construction provision with an initial authorization for $150 million. This is an area in support in dealings with dean's congressional delegations.

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

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

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

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

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

The Veterans Administration as a cabinet department is being held up over the matter of judicial review of disputes about coverage. Dr. Butler, as Chairman of the Special Medical Advisory Group, and Dr. Petersdorf

have been very active on the issue of eliminating politics from the appointment of the Chief Medical Director.

The National Academy of Sciences was to do a study on age discrimination through required retirement. It has not been funded yet, although there is a million dollars in the President's budget for it. You are aware that Universities may require retirement at a specified age through 1993. Dr. Robert Jones on Joe Keyes' staff has communicated with those of you who are in states who have similar statues.

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

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

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

V. DISCUSSION ITEMS

A. Small Group Discussions

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

   - The AAMC should work to increase federal, other public and private support of:

     - improvement of general education in primary and secondary school systems;
     - minority students enrolled in professional schools.

   - The AAMC should:

     - develop public relations and communications programs directed to the several levels of recruiting needed, i.e. elementary, secondary, and premedical schools, especially the largest contributors to the pool. Such programs should include faculties and parents;
     - regularize data collection and distribution directed to realistic targets of accomplishment;
     - identify successful recruitment programs, and through workshops and other means bring them to the attention of the constituency;
     - develop communication links and coalitions among

communities, families, and premedical educators and advisors and the schools such as magnet programs working in this area.

- Education institutions should:

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

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

   - The AAMC should:

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

   - Medical schools should review institutional policies and practices regarding:

     - promotion and tenure results and the time frame of actions;
     - involvement of women and minority faculty in search and P&T processes;
     - salary equity;
     - facility equity;
     - mentoring systems for these faculty;
     - existing basic science doctoral and MD/PhD programs for their potential of attracting women and underrepresented groups to future academic positions.

3. Dr. Henry Russe presented the report and recommendations from the groups attending the sessions on "Graduate Medical Education: How Should It Be Supported in the Future?" by first noting that the proposal that postgraduate trainees be paid in the form of a loan which would be forgiven for various forms of service including service to medical schools as well as hospitals was received with low enthusiasm. All groups recognized the present burden for the cost of GME is largely borne by hospitals including large amounts covered federally through Medicare and the VA. This may well change in the future. The recommendations were that the AAMC:

- study the possibility and ramifications of classifying house officers as students; and
- continue to support the present system of funding as long as possible.

4. Dr. Robert Friedlander presented the report and recommendations from the groups attending the sessions on "International Medical Education: What are the U.S. Roles and Responsibilities?" as follows:

- The AAMC should:
  - provide models which resolve regulatory problems, including: the scope of activities; licensure and various forms of residency accreditation;
  - with the International Medical Scholars Program (IMSP) and its parent organizations:
    - develop a way of coordinating/ centralizing funding for programs;
    - embark on a public awareness program;
    - define categories of institutions in addition to medical schools who would be eligible to receive international medical scholars; and
    - define the terms 'fellow'/'scholars' and the length of such experiences.
  - systematically gather and distribute information on needs and how these might be fulfilled by international scholars on our campuses.
- The IMSP should:
  - develop a communication system, perhaps in the form of a newsletter and/or conference, on the experiences and methods developed;
  - serve as a facilitator for foreign governments, schools and agencies who wish to become involved;
  - serve as a match maker for resources and needs.

- Programs and institutions should:

  - focus on primary care offerings and limit the use of tertiary care education since few third world and underdeveloped countries are unable to provide these high technology. When tertiary care education is offered there should be an effort to provide or assure that the resources for implementation are available upon return of the trainee to the country of referral;
  - develop a certificate or other type of recognition award to signify completion of the program.

5. Dr. Robert Tranquada presented the report and recommendations of the groups that attended the sessions on "Continuing Medical Education: Who is responsible for its Quality?" as follows:

   - The AAMC, recognizing 1) that the continuum of education is within its prerogative, 2) knowing that there is great diversify of activity and 3) noting that relicensing and recertification are realities and provide both an opportunity and a need for medical school involvement, should:

     - convene a Task Force to review the role of medical schools in CME, the role of the AAMC, the ACCME and the medical schools in the issue of recertification and relicensure;
     - reexamine earlier decisions regarding relationships with the Society of Directors of Continuing Medical Education.

6. Dr. Phillip Forman after commending Dr. John Gronvall on his openness and candor reported and made recommendations from the groups attending the sessions on "Strengthening the VA-Medical School Relationship" as follows:

   - The AAMC and the deans should:

     - support increased funding of VA research;
     - advocate language in the legislation proposing VA cabinet status that will buffer the VA from politicization.

   - The COD should:

     - consider meeting with VA administrators at each AAMC Annual Meeting;
     - consider a special orientation program for new deans from schools with VA affiliations.

- The individual school deans are encouraged:
  - to invite VA Central Office professional staff to help and advise on issues and problems in the VA-Medical School relationship;
  - to involve veteran's service organizations at the local level in VA-medical school affairs;
  - to become familiar with the VA conflict of interest policies (available on request from the VACO or Amy Eldridge at the AAMC).

B. The MEDLOANS program was reviewed by Dr. Robert Beran. The AAMC originated a student loan program about two years ago. The first full academic year of the program occurs in June. The AAMC loan program allows a student to apply to the four available student loans through one single application. They write one check for payback payments. It is a privately insured loan not requiring the student to have a co-signer. The interest rate today is about six tenths of a percent above prime. The bank has been extraordinarily receptive and has consented to allow students or residents to refinance their last loans to take advantage of some new options. Others such as AMSA have similar loan programs. A number of the states have changed their terms and conditions also. This new market has made the student the benefactor.

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

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

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

D. Individual School Applicant/Matriculant Analyses

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

VI. NEW BUSINESS

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

VII. ADJOURNMENT

Report of the COD Nominating Committee

The COD Nominating Committee met in conjunction with the COD Spring Meeting in Hilton Head, South Carolina on March 21, 1988 and again by conference call on August 10, 1988. The Committee proposes the following slate:

Chairman-elect of the Council of Deans

L. Thompson Bowles, M.D., Ph.D.
Acting Vice President for Medical Affairs and
Dean for Academic Affairs
George Washington University Medical Center

Members-at-Large of the Council of Deans

David S. Greer, M.D.
Dean and Professor of Community Health
Brown University
Program in Medicine

Leon E. Rosenberg, M.D.
CNH Long Professor of Human Genetics and
Dean
Yale University School of Medicine

Hibbard E. Williams, M.D.
Professor of Internal Medicine and Dean
University of California - Davis
School of Medicine

Council of Deans Representatives to the Executive Council

George T. Bryan, M.D.
Vice President for Academic Affairs
Dean
University of Texas
Medical School at Galveston

Phillip M. Forman, M.D.
Vice Chancellor for Health Services and
Dean
University of Illinois
College of Medicine

W. Donald Weston, M.D.*
Dean
Michigan State University
College of Human Medicine

*To complete two years of Dr. Bowles' unexpired term as a representative to the Executive Council.

Experiences of Medical Students in Obtaining Residencies:

Comparison of 1987 with 1988 Graduates

The transition from medical school to residency largely involves the senior year of medical school and the experiences of medical students in obtaining a residency. Beginning in 1986, sixteen questions were added to the AAMC's medical student Graduation Questionnaire to obtain information about the residency application process and its effect on students' senior year. The analysis of the experiences of 1986 graduates were provided to those who attended the Association's annual meeting in November of 1986. It served to focus the discussion at a special session entitled Graduate Medical Education and the Transition from Medical School to Residency.

In the discussions about how to make the transition from medical school to residency less disruptive, the following actions were particularly stressed:

- Move the deadline for submission of rank order lists to the National Resident Matching Program later in the year. The NRMP later announced that the date for 1988 graduates would be shifted from early January to February 19.

- Establish a date for the release of deans' letters to programs. The Council of Deans established November 1, 1987 as the date for the release of deans' letters for the 1988 class to programs.

- Move program application deadlines to later in the year.

- Restrain programs from asking candidates to do "audition" electives to be considered for selection to a program.

- Inform program directors of the limitations of using National Board of Medical Examiners examination scores in making selection decisions. The National Board sent a bulletin detailing the limitations of National Board scores to all program directors.

The dialogue about the transition began too late in the selection process to have an effect on the experiences of the 1987 class. This was confirmed when the data from the class of 1987 survey were compared with the 1986 results. There was essentially no difference in the experiences reported. This year the survey of the class of 1988 shows definite changes, generally in the direction of improving the selection process and smoothing the transition. Because the policies and actions of programs in each specialty differ, the experiences of candidates for one specialty can be quite different from those of another. The legends under each table highlight the changes in experiences of the 1988 class as compared to 1987.

TABLE 1
Percentage of Respondents Who Reported on When They Decided on the Specialty or Subspecialty They Desire to Practice*

Specialty	Before Medical School		During Years 1 & 2		During Year 3		During Year 4		Still Undecided		No. of Respondents	
(Change from 1987 in Parentheses)												
Anesthesiology	7.2	(+2.3)	7.6	(-1.1)	51.1	(-10.1)	33.3	(-8.2)	0.0	(-.2)	499	(-11)
Dermatology	6.3	(-2.6)	10.1	(-1.7)	52.5	(-2.3)	28.5	(+4.8)	0.0	(0.0)	158	(+23)
Emergency Medicine	20.2	(+2.2)	10.1	(-.8)	44.6	(-1.9)	23.3	(+.8)	.7	(-.4)	287	(+3)
Family Practice	31.0	(+1.2)	10.9	(+.1)	36.1	(-4.6)	20.9	(+3.1)	.5	(0.0)	1007	(-418)
Internal Medicine	11.5	(-.2)	9.0	(0.0)	52.1	(-2.8)	25.8	(+3.3)	1.0	(-.2)	1021	(+78)
Neurology	12.1	(-1.2)	14.3	(+2.3)	42.9	(-10.4)	29.1	(+7.8)	.5	(+.5)	182	(+32)
Neurosurgery	20.8	(+3.8)	18.9	(+.7)	43.4	(-8.9)	14.2	(+2.8)	0.0	(0.0)	106	(+18)
Obstetrics/Gyn	10.5	(-1.0)	4.3	(-4.3)	65.7	(+3.1)	18.5	(+3.4)	.2	(-.4)	531	(+7)
Ophthalmology	16.7	(+6.6)	21.5	(-1.6)	50.0	(-5.7)	10.1	(0.0)	0.0	(-.3)	288	(-28)
Orthopedic Surgery	26.1	(+1.1)	14.7	(-3.5)	47.1	(+1.7)	11.0	(+.7)	0.0	(-.7)	456	(01
Otolaryngology	4.9	(+.6)	12.6	(-3.6)	66.1	(-2.0)	14.8	(+4.5)	.5	(0.0)	183	(-2)
Pathology	15.0	(+4.0)	10.2	(-.3)	45.6	(-14.1)	28.6	(+10.4)	0.0	(0.0)	147	(-34)
Pediatrics	28.1	(+8.1)	4.6	(-1.3)	49.9	(-8.1)	15.7	(+.4)	.6	(0.0)	477	(-47)
Psychiatry	16.3	(-4.2)	6.0	(-1.7)	54.3	(+1.8)	21.6	(+3.7)	.8	(+.2)	514	(+7)
Radiology	6.3	(+.7)	9.1	(-1.5)	54.7	(-7.8)	28.7	(+8.6)	0.0	(-.9)	574	(+36)
Surgery	21.6	(-1.4)	9.5	(+.9)	53.8	(-3.3)	13.9	(+3.2)	.3	(+.1)	582	(-83)
Urology	0.0	(-3.4)	5.0	(+1.0)	73.0	(+1.2)	20.6	(-.1)	.7	(+.7)	141	(-33)
All Respondents	14.3	(-.6)	8.1	(-1.2)	46.6	(-6.7)	20.6	(+1.9)	1.9	(-1.2)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The junior year remains the principle year for choosing a specialty, but for the class of 1988, there was a definite increase in the percentage making their decision in the fourth year, and an accompanying decrease in the proportion making their specialty choices in year three. The shift toward a larger proportion in the fourth year could be related to the extension of the deadline for submission of rank order lists to the National Resident Matching Program from early-January to mid-February and the movement of application deadlines from summer/early fall to fall/early winter.

TABLE 2
Percentage of Respondents Reporting When One or More Programs Required Completed Application (Including DL&T)*

Specialty	Prior to July	During July	Aug	Sep	Oct	Nov	Dec	No. of Respondents
(Change from 1987 in Parentheses)								
Anesthesiology	.2 (-1.9)	.4 (-4.5)	1.2 (-14.2)	2.0 (-23.8)	6.2 (-30.6)	32.7 (-2.5)	48.3 (+15.4)	499 (-11)
Dermatology	1.3 (+.6)	1.3 (+.6)	0.0 (-1.4)	4.4 (-4.4)	8.9 (-2.2)	15.8 (-19.0)	54.4 (-3.3)	158 (+23)
Emergency Medicine	1.4 (+.4)	.7 (-.7)	2.4 (-6.4)	2.4 (24.3)	6.6 (-31.7)	34.8 (-4.2)	40.1 (+.4)	287 (+3)
Family Practice	.3 (-.2)	.9 (-1.0)	2.7 (-2.2)	2.7 (-10.8)	4.6 (-17.3)	20.6 (-17.3)	60.1 (+6.6)	1007 (-418)
Internal Medicine	1.0 (+.4)	.7 (-.3)	2.0 (-1.0)	1.3 (-6.1)	3.4 (16.6)	16.3 (-28.2)	65.5 (+9.1)	1021 (+78)
Neurology	.5 (+.5)	.5 (-3.5)	2.7 (-3.3)	1.6 (-20.4)	11.5 (-11.1)	30.2 (-10.4)	41.2 (+20.6)	182 (+32)
Neurosurgery	0.0 (-1.1)	.9 (-2.5)	3.8 (-33.7)	17.9 (-46.8)	24.5 (-11.8)	34.9 (+25.9)	5.7 (+3.5)	106 (+18)
Obstetrics/Gynecology	.4 (+.3)	.6 (-.7)	1.1 (-5.1)	3.6 (-23.4)	7.3 (-35.2)	36.0 (-20.4)	40.3 (+4.3)	531 (+7)
Ophthalmology	.7 (-4.9)	.3 (-18.3)	3.1 (-45.6)	8.3 (-31.5)	20.1 (+13.5)	36.1 (+18.7)	22.6 (-9.3)	288 (-28)
Orthopedics	.4 (-2.2)	.9 (-5.4)	2.4 (-47.8)	4.8 (-78.5)	9.4 (-63.4)	42.8 (+7.3)	30.5 (+16.1)	456 (0)

(Continued)

There has been a definite shift of application deadlines toward November/December. Most programs have accommodated to the November 1st dean's letter release date and the change in the NRMP rank order list submission deadline.

TABLE 2 (Continued)
Percentage of Respondents Reporting When One or More Programs Required Completed Application (Including DL&T)*

Specialty	Prior to July	During July	Aug	Sep	Oct	Nov	Dec	No. of Respondents
(Change from 1987 in Parentheses)								
Otolaryngology	1.1 (-5.3)	1.1 (-22.6)	5.5 (-72.8)	16.9 (-56.0)	31.1 (-2.9)	29.5 (+19.3)	6.0 (+.1)	183 (2)
Pathology	.7 (+.2)	.7 (+.7)	1.4 (-4.6)	1.4 (-19.0)	6.1 (-25.3)	28.6 (-13.3)	55.1 (+7.1)	147 (-34)
Pediatrics	.2 (-.7)	.4 (-.9)	3.1 (-.9)	1.9 (-6.6)	3.4 (-9.9)	22.4 (-15.0)	59.5 (+2.3)	477 (-47)
Psychiatry	1.0 (+.5)	.8 (-1.7)	1.2 (-16.1)	4.5 (-23.9)	8.9 (-21.0)	28.4 (+1.0)	41.8 (+8.5)	514 (+7)
Radiology	.2 (-1.1)	1.2 (-3.6)	1.4 (-16.2)	6.6 (-38.3)	9.9 (-36.3)	40.1 (+4.6)	30.3 (+2.7)	574 (+36)
Surgery	.3 (-1.0)	.9 (-.6)	2.6 (-8.0)	3.3 (-26.7)	6.4 (-33.1)	29.2 (-19.6)	48.1 (+1.5)	582 (-83)
Urology	0.0 (-.5)	.7 (-5.0)	6.4 (-25.2)	15.6 (-45.3)	27.0 (-9.2)	36.9 (+17.4)	7.1 (+3.7)	141 (-33)
All Respondents	.5 (-.7)	.7 (-2.6)	2.2 (10.5)	3.6 (-20.7)	7.5 (-21.8)	26.7 (-12.3)	48.6 (+5.4)	10082 (-906)

*Percentages do not add to 100 because each cell excludes the percentage of nonresponses and the percentage of students reporting that programs did not require letters and transcripts in that time period.
SOURCE: 1988 AAMC Graduation Questionnaire

TABLE 3

Percentage of Respondents Reporting that One or More Programs Required National Board of Medical Examiners Scores*

Specialty	Part I		Part II		No. of Respondents	
(Change from 1987 in Parentheses)						
Anesthesiology	52.1	(-34.0)	30.1	(+3.4)	499	(-11)
Dermatology	41.1	(-29.3)	38.0	(+8.4)	158	(+23)
Emergency Medicine	51.6	(-34.3)	31.0	(+6.0)	287	(+3)
Family Practice	45.6	(-27.2)	27.5	(+2.5)	1007	(-418)
Internal Medicine	43.2	(-31.8)	32.8	(+5.3)	1021	(+78)
Neurology	47.8	(-24.2)	29.7	(+9.0)	182	(+32)
Neurosurgery	48.1	(-40.5)	36.8	(+10.7)	106	(+18)
Obstetrics/Gynecology	42.9	(-41.8)	34.5	(-5.2)	531	(+7)
Ophthalmology	57.3	(-20.5)	20.1	(-.5)	288	(-28)
Orthopedic Surgery	55.0	(-33.8)	29.2	(+.3)	456	(0)
Otolaryngology	54.1	(-34.5)	35.5	(+5.8)	183	(-2)
Pathology	42.9	(-21.2)	21.8	(+1.9)	147	(-34)
Pediatrics	37.9	(-27.4)	29.6	(+8.2)	477	(-47)
Psychiatry	37.5	(-27.8)	18.3	(-3.1)	514	(-10)
Radiology	46.5	(-37.3)	34.3	(+3.6)	574	(+36)
Surgery	45.4	(-37.0)	35.9	(-.3)	582	(-83)
Urology	53.9	(-30.6)	27.7	(+4.7)	141	(-33)
All Respondents	45.1	(-31.0)	30.3	(+3.5)	10082	(-906)

*Percentages do not add to 100 percent because each cell excludes the percentage of nonresponses and the percentage of students who reported that programs did not require this type of NBME score.
SOURCE: 1988 AAMC Graduation Questionnaire

There was a remarkable drop in the frequency of 1988 graduates reporting that one or more programs required NBME Part I scores. This was accompanied by a slight increase in the proportion of respondents reporting that Part II scores were required.

TABLE 4

Percentage of Respondents Who Were Told by One or More Programs that They Were More Likely to be Selected if They Took an Elective in the Specialty at that Institution*

Specialty	Percent		No. of Respondents	
(Change from 1987 in Parentheses)				
Anesthesiology	31.7	(-3.2)	499	(-11)
Dermatology	32.3	(+9.4)	158	(+23)
Emergency Medicine	61.3	(-7.0)	287	(+3)
Family Practice	34.7	(-3.8)	1007	(-418)
Internal Medicine	30.0	(-3.1)	1021	(+78)
Neurology	28.0	(+11.7)	182	(+32)
Neurosurgery	76.4	(-7.7)	106	(+18)
Obstetrics/Gynecology	51.2	(-8.9)	531	(+7)
Ophthalmology	27.4	(+2.1)	288	(-28)
Orthopedic Surgery	84.9	(-2.6)	456	(0)
Otolaryngology	62.8	(-8.6)	183	(-2)
Pathology	15.0	(-3.8)	147	(-34)
Pediatrics	32.1	(-3.0)	477	(-47)
Psychiatry	24.3	(-10.6)	514	(+7)
Radiology	30.5	(-3.8)	574	(+36)
Surgery	47.9	(-3.5	582	(-83)
Urology	67.4	(+2.5)	141	(-33)
All Respondents	38.5	(-4.2)	10082	(-906)

*The percentage of nonresponses and the percentage of students reporting that no programs made this suggestion are excluded.
SOURCE: 1988 AAMC Graduation Questionnaire

Overall, there was a decrease in programs recommending that students take "audition" electives at their institutions. However, in excess of 60 percent of students applying to programs in emergency medicine, neurosurgery, orthopedics, otolaryngology and urology were asked to consider taking an "audition" elective.

TABLE 5

Percentage of Respondents Who Took Two or More Electives in the Specialty in Which They Planned to Take a Residency*

Specialty	At Own Institution		At Other Institution		No. of Respondents	
(Change from 1987 in Parentheses)						
Anesthesiology	24.0	(-1.5)	8.6	(-2.6)	499	(-11)
Dermatology	33.5	(+.1)	15.2	(+4.1)	158	(+23)
Emergency Medicine	15.0	(-4.0)	22.0	(+.2)	287	(+3)
Family Practice	16.2	(-.4)	10.6	(+1.6)	1007	(-418)
Internal Medicine	55.9	(-14.8)	23.0	(+.1)	1021	(+78)
Neurology	29.7	(+1.0)	8.8	(-.5)	182	(+32)
Neurosurgery	8.5	(-6.3)	30.2	(-.5)	106	(-18)
Obstetrics/Gynecology	20.9	(-5.6)	21.1	(-.7)	531	(+7)
Ophthalmology	27.8	(-5.0)	17.7	(-1.4)	288	(-28)
Orthopedic Surgery	19.7	(-3.5)	38.8	(+1.8)	456	(0)
Otolaryngology	18.0	(+1.8)	16.4	(-10.6)	183	(-2)
Pathology	42.2	(+7.4)	8.8	(+1.6)	147	(-34)
Pediatrics	55.3	(-8.4)	23.9	(-2.2)	477	(-47)
Psychiatry	26.3	(-1.1)	16.3	(+.5)	514	(+7)
Radiology	26.7	(-1.7)	11.8	(-1.1)	574	(+36)
Surgery	31.6	(-4.2)	21.0	(-3.1)	582	(-83)
Urology	14.2	(-6.5)	17.7	(-.7)	141	(-33)
All Respondents	33.5	(-5.7)	19.0	(-.2)	10082	(-906)

*Percentages do not add to 100 percent because the percentage of nonresponses, the percentage of students reporting one or no electives, and the percentage for whom the number was unclear are excluded.

SOURCES: 1988 AAMC Graduation Questionnaire

The proportion of respondents who took two or more electives in the specialty planned for graduate medical education at their own institution dropped from 39.2 percent to 33.5 percent. Overall, there was essentially no change in the proportion taking two or more electives at other institutions. Neurosurgery and orthopedic candidates reported the highest frequency of two or more electives at other institutions.

TABLE 6

Percentage of Respondents Reporting That One or More Programs Asked Them to Make a Commitment Before the Match*

Specialty	Percent		No. of Respondents	
(Change from 1987 in Parentheses)				
Anesthesiology	20.2	(+1.8)	499	(-11)
Dermatology	6.3	(-2.6)	158	(+23)
Emergency Medicine	6.3	(+2.5)	287	(+3)
Family Practice	7.6	(+1.0)	1007	(-418)
Internal Medicine	8.8	(+1.0)	1021	(+78)
Neurology	11.5	(+.1)	182	(+32)
Neurosurgery	11.3	(+3.4)	106	(+18)
Obstetrics/Gynecology	14.1	(-.8)	531	(+6)
Ophthalmology	10.1	(-.4)	288	(-28)
Orthopedic Surgery	16.4	(-12.3)	456	(0)
Otolaryngology	8.7	(-.6)	183	(-2)
Pathology	32.0	(-11.1)	147	(-34)
Pediatrics	9.9	(+3.2)	477	(-47)
Psychiatry	14.4	(-38.8)	514	(+7)
Radiology	18.8	(-17.7)	574	(+36)
Surgery	7.9	(+.7)	582	(-83)
Urology	9.2	(-5.2)	141	(-33)
All Respondents	11.5	(-2.8)	10082	(-906)

*The percentage of nonresponses and the percentage of students reporting that no programs asked for a commitment before the match are excluded.
SOURCE: 1988 AAMC Graduation Questionnaire

There was a slight overall decrease in the frequency of respondents reporting they were asked to make a commitment before the match. The most dramatic change was a drop for psychiatry candidates, from 53.2 percent to 14.4 percent.

TABLE 7
Number of Days Spent Away from Medical School Applying and Interviewing for a Residency Position*

Specialty	Percentage of Respondents Who Spent 0-7 Days		8-14 Days		15-21 Days		Over 21 Days		Average Days Spent		No. of Respondents	
(Change from 1987 in Parentheses)												
Anesthesiology	22.8	(+2.6)	25.1	(-2.4)	23.2	(-.5)	27.7	(-2.1)	18	(0)	499	(-11)
Dermatology	36.1	(+2.7)	32.3	(+1.9)	16.5	(+2.4)	10.8	(-3.3)	12	(-2)	158	(+23)
Emergency Medicine	15.0	(-1.9)	23.0	(-.6)	29.3	(+3.6)	30.0	(-.7)	19	(0)	287	(+3)
Family Practice	30.5	(+2.6)	30.0	(-1.4)	18.2	(-1.0)	17.4	(+1.0)	14	(-1)	1007	(-418)
Internal Medicine	27.3	(+2.0)	28.0	(+.9)	21.5	(+1.3)	20.4	(-.9)	15	(-2)	1021	(+78)
Neurology	20.3	(+.3)	23.6	(-5.1)	24.2	(+4.2)	28.6	(-.1)	18	(0)	182	(+32)
Neurosurgery	6.6	(-4.8)	19.8	(+.5)	19.8	(-7.5)	46.2	(+12.1)	23	(+1)	106	(+18)
Obstetrics/Gynecology	19.2	(+.7)	26.0	(+1.8)	23.9	(+.4)	28.2	(+.7)	19	(0)	531	(+7)
Ophthalmology	22.9	(+3.9)	24.0	(-.4)	25.3	(-1.6)	24.3	(-3.5)	17	(-1)	288	(-28)
Orthopedic Surgery	19.5	(+3.1)	21.3	(+2.7)	27.4	(-3.3)	27.4	(-1.8)	18	(-2)	456	(0)
Otolaryngology	17.5	(+1.8)	23.5	(+2.4)	29.5	(+2.5)	26.8	(-4.5)	18	(-2)	183	(-2)
Pathology	34.0	(+2.5)	29.9	(-2.7)	19.0	(+4.6)	12.9	(-3.7)	13	(0)	147	(-34)
Pediatrics	27.7	(+2.5)	26.4	(-3.2)	23.5	(+1.2)	19.5	(+1.2)	15	(-1)	477	(-47)
Psychiatry	32.9	(+1.8	28.2	(-.6)	18.5	(+.6)	16.5	(-.3)	14	(0)	514	(+7)
Radiology	13.6	(-4.3)	21.6	(-1.8)	28.2	(+5.0)	33.6	(+1.0)	20	(+1)	574	(+36)
Surgery	12.7	(+1.4)	19.6	(+.4)	29.4	(+1.9)	35.1	(-3.4)	21	(-1)	582	(-83)
Urology	7.8	(-3.1)	21.3	(+5.8)	22.7	(+3.7)	44.0	(+.3)	23	(0)	141	(-33)
All Respondents	23.4	(+1.3)	25.9	(-.2)	22.9	(+.1)	24.1	(-.5)	17	(-1)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The average number of days spent applying and interviewing for a residency dropped by one day. Candidates for neurosurgery and urology reported the highest number, with an average of 23 days for each. Pathology candidates again had the lowest average at 13 days.

TABLE 8
Number of Dollars Spent Applying and Interviewing for a Residency Position*

Specialty	Respondents Who Spent $0-499		$500-999		$1,000-1,499		$1,500 or more		Average Dollars Spent		Number Responded	
(Change from 1987 in Parentheses)												
Anesthesiology	27.3	(+3.6)	18.4	(-4.5)	15.2	(-2.3)	35.7	(+2.4)	1174	(+26)	499	(-11)
Dermatology	40.5	(-2.5)	20.3	(+3.3)	13.3	(-4.5)	17.1	(+3.0)	796	(+41)	158	(+23)
Emergency Medicine	16.4	(-2.3)	17.8	(-1.6)	17.1	(+.2)	44.6	(+2.3)	1459	(+147)	287	(+3)
Family Practice	47.4	(-3.5)	21.1	(-.9)	12.2	(-1.0)	14.0	(+3.4)	651	(+17)	1007	(-418)
Internal Medicine	33.9	(-2.9)	21.7	(-1.6)	16.6	(-.9)	23.4	(+3.3)	898	(-5)	1021	(+78)
Neurology	22.0	(-4.6)	16.5	(-9.5)	20.9	(+7.6)	37.9	(+6.5)	1340	(+196)	182	(+32)
Neurosurgery	6.6	(+3.2)	6.6	(-4.8)	15.1	(+2.6)	64.2	(-2.9)	2306	(+351)	106	(+18)
Obstetrics/Gynecology	23.0	(+4.1)	23.0	(+.5)	17.7	(+1.1)	32.0	(+2.2)	1186	(-3)	531	(+7)
Ophthalmology	19.1	(+4.3)	14.6	(-6.6)	13.2	(-2.6)	49.0	(+2.5)	1536	(-11)	288	(-28)
Orthopedic Surgery	16.9	(+3.7)	14.3	(-5.4)	20.0	(+.9)	44.7	(-.9)	1537	(+59)	456	(0)
Otolaryngology	13.1	(+2.9)	15.3	(-1.5)	13.1	(-4.2)	55.2	(+3.3)	1798	(+149)	183	(-2)
Pathology	30.6	(-5.3)	23.1	(-.7)	12.2	(0.0)	27.9	(+5.3)	1038	(+114)	147	(-34)
Pediatrics	35.6	(-.5)	21.2	(-4.0)	17.0	(+2.5)	22.2	(+1.8)	869	(-3)	477	(-47)
Psychiatry	30.7	(-2.5)	24.3	(0.0)	14.8	(-2.0)	24.1	(+3.2)	979	(+12)	514	(+7)
Radiology	18.8	(-5.7)	18.8	(+.4)	16.7	(+.2)	41.5	(+3.3)	1406	(+172)	574	(+36)
Surgery	14.6	(-2.2)	18.7	(+.2)	17.9	(-2.4)	45.5	(+3.1)	1515	(+47)	582	(-83)
Urology	7.1	(-2.0)	14.9	(-4.6)	13.5	(-7.8)	61.0	(+12.8)	1796	(+160)	141	(-33)
All Respondents	28.4	(-2.3)	20.3	(-1.8)	16.1	(-.5)	30.4	(+3.2)	1114	(+50)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

The average amount spent by all respondents increased by 4.7 percent. There was an 18 percent increase in expenditures by candidates for neurosurgery programs.

TABLE 9

Extent to Which Pursuit of a Residency Influenced Choice of Electives and Organization of Clinical Education*

Specialty	Primary or Major Influence		Minor or No Influence		No. of Respondents	
(Change from 1987 in Parentheses)						
Anesthesiology	77.2	(+.6)	21.2	(-1.1)	499	(-11)
Dermatology	70.9	(+.5)	25.9	(-3.7)	158	(+23)
Emergency Medicine	83.6	(+.5)	15.0	(+1.2)	287	(+3)
Family Practice	58.8	(-1.9)	37.8	(+.6)	1007	(-418)
Internal Medicine	66.5	(+1.6)	30.8	(-2.7)	1021	(+78)
Neurology	69.2	(+9.8)	28.6	(-10.7)	182	(+32)
Neurosurgery	76.4	(-4.3)	16.0	(-1.1)	106	(+18)
Obstetrics/Gynecology	72.9	(-1.7)	25.0	(-.8)	531	(+7)
Ophthalmology	85.4	(+1.2)	12.2	(-2.3)	288	(-28)
Orthopedic Surgery	88.6	(+.4)	9.6	(-.5)	456	(0)
Otolaryngology	80.3	(-5.1)	17.5	(+6.1)	183	(-2)
Pathology	65.3	(+4.0)	32.0	(-3.9)	147	(-34)
Pediatrics	65.0	(-.9)	33.3	(+.1)	477	(-47)
Psychiatry	62.5	(+2.3)	34.8	(-2.1)	514	(+7)
Radiology	76.3	(-1.0)	21.3	(+.1)	574	(+36)
Surgery	74.1	(-3.6)	24.2	(+3.1)	582	(-838)
Urology	79.4	(-5.7)	17.7	(+4.0)	141	(-33)
All Respondents	69.8	(-.3)	27.5	(-.3)	10082	(-906)

*Percentages add across rows and may not equal 100 percent due to rounding and the exclusion of the no response category.
SOURCE: 1988 AAMC Graduation Questionnaire

There was essentially no change in the extent to which the pursuit of a residency influenced the choice of respondents' electives and the organization of their clinical education.

AAMC Recommendations Concerning
Medical School Acceptance Procedures ("Traffic Rules")

The Executive Council, at its June, 1988 meeting, approved a revised set of recommendations concerning medical school acceptance procedures, commonly referred to as the "traffic rules." The new version of the traffic rules was recommended by the Group on Student Affairs Committee on Admissions after two years of study.

The medical student selection process has become extremely competitive due primarily to the decline in the number of applicants. During the last several years, schools have experienced increased difficulty in filling their entering classes in a timely manner. The selection process now extends well into the summer months resulting in increased operating costs for the schools. The indecision or "holding out" on the part of applicants is causing the months of July and August to be frustrating and chaotic for admissions officers.

For example:

- For the 1988 entering class, **1,386 applicants** were holding more than one acceptance on July 13, 1988. This represents an increase of 285 in just one year.
- For this same class, **705 applicants** were holding more than one acceptance on August 16, 1988.
- During the last two years, the number of cases reported where a student was offered a position at one school **after they had already matriculated** at another school has increased.

The approved revision of the traffic rules includes procedures for notifying applicants of acceptance, the amount and refundability of acceptance deposits, procedures for accepted applicants to notify the school of their choice, and ground rules regarding the processing of applicants holding multiple acceptances.

In order to restore order to our system of student selection, the cooperation and resolve to observe these rules by all schools will be necessary. The AAMC's Section for Student and Educational Programs and the GSA will assist in obtaining the cooperation of the schools.

The Council of Deans is requested to provide active and full support for the revised set of recommendations. Observance of these recommendations by all schools will result in an earlier and more orderly system of selecting students.

Recommended for the 1989 Entering Class

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

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

1. Each school of medicine should prepare and distribute to applicants and college advisors a detailed schedule of its application and acceptance procedures and should adhere to this schedule unless it is publicly amended.

2. Each school of medicine should agree not to notify its applicants (except for those applying via Early Decision Program (EDP)) of acceptance prior to October 15 of each admission cycle.

3. By March 15 of the year of matriculation, each school of medicine should have issued a number of acceptances at least equal to the size of its first year entering class.

4. Only after April 15 are schools free to apply appropriate rules for dealing with accepted applicants who, without adequate explanation, hold one or more places in other schools. These rules should recognize the problems of the applicant who has multiple offers and also of those applicants who have not yet been accepted.

5. By May 15 of the year of matriculation, an applicant who has received offers of admission from more than one school should choose the one school that he or she prefers and withdraw from all other schools to which he or she has been accepted.

6. Prior to May 15 of the year of matriculation, an applicant should be given at least two weeks to reply to an offer of admission. After May 15, schools may require applicants to respond to acceptance offers in less than two weeks. An applicant may be required to file a statement of intent, or a deposit or both. The statement of intent should provide freedom to withdraw if the applicant is later accepted by a school that he or she prefers.

7. It is recommended that the acceptance deposit not exceed $100 and be refundable until May 15. After that date, a school may retain the deposit as a late withdrawal fee. If the applicant matriculates at the school, the school is encouraged to credit the deposit toward tuition.

8. Subsequent to June 1, a school of medicine seeking to admit an applicant already known to be accepted by another school for that entering class should advise that school of its intent. Because of the administrative problems involved in filling a place vacated just prior to the commencement of the academic year, schools should communicate fully with each other with respect to anticipated late roster changes in order to keep misunderstandings at a minimum.

9. After an applicant has enrolled in a U.S. school of medicine or begun a brief orientation program contiguous to enrollment, no further acceptances should be offered to that individual. Once enrolled in a school, students have an obligation to withdraw their applications promptly from all other schools. Enrollment is defined as being officially registered as a member of the first year entering class at a school.

Report of the ad hoc Committee on the Dean's Letter

The ad hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency examined the effect of the selection process for residency positions on medical students' education and made recommendations on what should be done to lessen any disruptive effects on students' general professional education. Included in the recommendations that were widely accepted was one to improve deans' letters. Specifically, the committee recommended that the AAMC appoint an ad hoc committee composed of deans for student affairs and program directors from several specialties to develop guidelines on the evaluative information desired by program directors and to explore the feasibility of providing a model format for deans' letters.

The ad hoc Committee on the Dean's Letter met twice to address the issues raised in the preceding recommendation. Committee discussions focused on the following concerns:

- o Is the dean's letter primarily a document of faculty evaluation or a document of recommendation?
- o Should the name of the letter be changed?
- o How do program directors view and use the dean's letter?
- o What information should be included in the dean's letter?
- o What information can be included to distinguish one student from another?
- o What documents should accompany the dean's letter?

A preliminary report summarizing committee discussions was prepared and distributed to all committee members and the deans for student affairs at U.S. medical schools for their comments and suggestions. At their final meeting on September 22, 1988, committee members approved the revised preliminary report, drafted an outline for the content of the dean's letter and made the following recommendations.

- o The dean's letter is a letter of evaluation.
- o Specific content areas should be included in each student's letter. (The content areas are specified in a separate outline).
- o The letter should follow a specified chronology of the student's academic career.
- o The letter should include institutional group data regarding grade distribution and the preformance of graduates of the institution.
- o The following groups must be educated regarding the use and interpretation of the dean's letter:
  - a. program directors
  - b. deans for student affairs
  - c. faculty
  - d. students

- Schools should establish a monitoring process and request feedback from program directors regarding the usefulness of the letters.
- The letter should include a statement that it is written in compliance with the recommendations of the AAMC ad hoc committee.
- The name of the letter should be changed to "Dean's Letter of Evaluation".
- The committee recommends the use of the Universal Application Form.

MISSION STATEMENT

The Association of American Medical Colleges has as its purpose the improvement of the nation's health through the advancement of academic medicine. As an association of medical schools, teaching hospitals, and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research and health care, and assists its members by providing services at the national level that facilitate the accomplishment of their missions. In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance the search for biomedical knowledge, to advance health services research, and to integrate education and research into the provision of effective health care.

August 30, 1988

STRATEGIC GOALS

TO PROMOTE excellence in medical education and research in an environment providing high quality patient care.

TO ATTRACT the most talented and broadly representative persons into medicine.

TO PROMOTE an environment in which research can flourish.

TO PROMOTE the intellectual, organizational and financial vitality of medical schools and teaching hospitals.

TO PROMOTE a community of interest in academic medicine.

TO PROVIDE representation about the Association's purposes, capabilities, positions to its constituents, the public and their elected and appointed representatives.

TO MAINTAIN the Association's intellectual and financial resources needed to achieve these goals.

October 19, 1988
(DRAFT)

DRAFT/DRAFT/DRAFT

Date: 10/3/88

TO: Research Faculty in Biological and Medical Sciences

From: Medical School Deans

Re: The Need to Participate in Public Education About Animal Research

The Deans of medical schools in the United States are united in support of the humane use of animals for biomedical research. This research is essential to improving the health and well-being of the American people, and we actively oppose any legislation, regulation or social action that would limit such research.

Opposition to animal research is a growing phenomenon, but it is not new. More than a century ago, as experimental physiology became key to modern biological and medical science, antivivisection as a social and political movement appeared in England and shortly thereafter in the United States. It was a small but vigorous movement which attempted to impede or outlaw the use of animals in research on grounds that such research was immoral and unnecessary. The achievements of biomedical science coupled with vigorous political action by the research community sent the early antivivisection movement into decline, but within the last 10 years, a strikingly similar movement has re-emerged worldwide under the banner of animal rights.

The modern animal activists, using techniques similar to those of their predecessors, are attempting to vilify the research scientist, o discredit essential research methods, and to restrict the use of animals by well organized and well financed political campaigns at the local, state and national level. The animal rights movement is persistent, and activists are quite consciously attempting to increase the cost of research through cumbersome regulation, in order to reduce the amount that can be done. There is substantial pressure to eliminate the use of dogs, cats and primates in research. Campaigns to arouse public fear and opposition are increasing the cost of new research facilities. Unless the research community mobilizes to inform the public and legislators about its humane practices and the critical role animals play in understanding life processes and in treating and curing disease, scientists may experience serious difficulties in continuing vital research which requires the use of animals.

Most Americans support research with animals, but they want assurance that animals are treated humanely and used only when necessary. Animal rights activists have exploited this concern for animal welfare to limit or stop research with animals, and, as a result, some Americans mistakenly believe that the abuse of laboratory animals is common. National and state programs to reassure political leaders and the public with the facts about the humane use of animals in research do exist, but they cannot be effective without the support and assistance of individual researchers.

We urge research scientists who use animals in research to participate in a concerted public education effort. Become familiar with the allegations made by animal activists, and be prepared to speak out publicly about the humane care and treatment laboratory animals receive and the important role animals play in basic and medical science. There are numerous effective ways to be involved: contact local or national research support groups and offer your help; work with your research institution to promote public awareness programs; join letter writing campaigns to local and national elected representatives and the press when animal research is challenged; offer to talk about animal research to local community groups and at elementary, high school, college and university forums; accept inquiries from the media about your research and participate in media and public affairs programs.

The research community as a whole has been careful, responsible and supportive of appropriate and humane care and treatment of laboratory animals. The public is being told otherwise, and researchers must let people know they are being mislead. Continuation of critical research and the health of America depends upon a truly informed citizenry.

Student Loan Default Study

The Division of Academic Affairs, Section for Student and Educational Programs in conjunction with a subcommittee of the GSA Committee on Student Financial Assistance, is initiating a study of student loan defaults on federally issued loans by graduates of U.S. medical schools. The purpose of the study is to gain a better understanding of the reasons for student loan defaults and the possible identification of any predisposing factors to the incidence of default. The documentation of any predisposing factors could serve as a basis for intervention during the student's in-school borrowing years.

Most of the studies that have been undertaken on this subject concentrate on loans procured during undergraduate study with subsequent default during the post-baccalaureate period. The issues associated with loan defaults of graduate and professional students has received little attention.

The Division of Student Assistance, Health and Human Services, has informed us that while the default rate for allopathic students in the HEAL program is still quite low, the amount of the withdrawal from the SLIF for those allopathic students who default has doubled each of the last two years.

The study of the issues associated with medical graduate loan defaults will address both Title IV and Title VII loan programs and will include the identification of factors causing borrowers to default and the demographic characteristics of medical students who cannot or do not repay their loans.

In addition to gaining a better understanding of the circumstances that precipitate the borrowers' inability to meet their payment obligations, the study is targeted to the development of strategies to prevent medical student borrowers from defaulting on their loan obligations.

As a part of this study, the AAMC will also seek to identify the factors unique to the situation faced by graduate and professional student borrowers. The majority of the student loan legislation is directed to the undergraduate student borrower and therefore, overlooks the unique education and training requirements of graduate and professional students. As part of this study, consultation with the leadership of the other graduate and professional schools, the federal government, and representatives of the major needs analysis systems will be undertaken to identify factors common to all their borrowers.

The student loan default subcommittee is chaired by Norma Wagoner, Ph.D. (Chicago-Pritzker). Other members of the committee include Leon Johnson (National Medical Fellowships), Michael S. Katz (UMDNJ), John F. Walters (Washington University), and Mary B. Walton (St. Louis University).

The committee is presently delineating its research plan. Preliminary proposed activities include a survey of HEAL and GSL borrowers who have defaulted, and a survey of the medical schools in which financial aid officers will be given a listing of their institution's HEAL defaulters and asked to assess why these particular students defaulted.

A summary of the research plan will be distributed in early December.

AAMC FUTURE MEETING DATES

1988

November 11-17	Annual Meeting Chicago, Illinois
December 11-13	Officers & Staff Retreat

1989

February 22-23	Executive Council/COD Admin. Board Washington, D.C.
April 11-16	COD Spring Meeting Fess Parker's Red Lion Resort Santa Barbara, California
June 14-15	Executive Council/COD Admin. Board Washington, D.C.
September 27-28	Executive Council/COD Admin. Board Washington, D.C.
October 27-Nov. 2	AAMC Annual Meeting Washington, D.C.
December 13-15	Officers Retreat Wye Woods Conference Center

1990

April 7-11	COD Spring Meeting Sonesta Sanibel Harbour Resort Florida