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The

COUNCIL OF DEANS
of the
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
presents
a reception and dinner
on Monday, October 30, 1989
at the
NATIONAL PRESS CLUB
Main Lounge and First Amendment
14th and F Streets, N.W.
Washington, D.C.

***

RECEPTION
7:00 p.m.
(Cocktails and Hors d'oeuvres)

DINNER
8:00 p.m.
(See Menu Inside)

Reception/Dinner entertainment provided by
Sidney's Orchestras Inc.

The Reagan-Gorbachev Summit

The National Press Club hosted foreign and American press in December 1987 when the Soviets used the Club as their pre-Summit briefing center. During the historic meeting between U.S. President Ronald Reagan and Soviet Premier Mikhail Gorbachev, the Club was buzzing with excitement and expectation, and display boards were filled with messages and the latest bulletins.

One of the gala events was the State dinner hosted at the White House by the Reagans for the Soviet leader and his wife Raisa. The elegant menu featured the finest of American cuisine with unique Russian touches. Tea, for example, was presented in the nouvelle form as a dessert sorbet, rather than Russian style from a samovar. And caviar was served in a sauce for the fish course. Enjoy the taste of "glasnost."

Council of Deans Dinner Menu
National Press Club
October 30, 1989

Reagan-Gorbachev Summit Menu

December 8, 1987

Columbia River Salmon and Lobster Medallions en Gelée

Caviar Sauce
Fennel Seed Twists

Loin of Veal with Wild Mushrooms

Topped with champagne sauce
Tarragon Tomatoes
Corn Turban

Medley of Garden Greens

Brie Cheese with Crushed Walnuts
Vinegar and Avocado Dressing

Tea Sorbet with Honey Ice Cream

COUNCIL OF DEANS - AAMC

Registration Form

Listed below is a schedule of COD meetings to be held during the AAMC Annual Meeting, October 27-November 2, 1989, Washington, D.C. Meetings will be at the Washington Hilton Hotel. The "COD Annual Dinner" will be at the National Press Club. **Please check appropriate boxes and return this form by October 20, 1989 to: Gladys V. Peters, Association of American Medical Colleges, One Dupont Circle, N.W., Suite 200, Washington, D.C., 20036.**

Day/Time	Meeting Name	Room	Will Attend	Will Not Attend
SUNDAY, Oct 29				
12:00pm- 1:45pm	GPA/Development Lunch	Military	[ ]	[ ]
2:00pm- 4:00pm	COD/AAHC Program	Jefferson West	[ ]	[ ]
MONDAY, Oct 30				
7:00am- 9:00am	Community Based Deans (B)	Map	[ ]	[ ]
7:00am- 9:00am	California Deans (B)	Jackson	[ ]	[ ]
7:00am- 9:00am	Midwest/Great Plains Deans (B)	Caucus	[ ]	[ ]
7:00am- 9:00am	Southern Deans (B)	Military	[ ]	[ ]
11:30am- 1:00pm	COD Ad Board Luncheon **(Members Only)**	Cabinet	[ ]	[ ]
1:30pm- 4:30pm	COD Business Meeting	Jefferson E&W	[ ]	[ ]
7:00pm-10:00pm	COD Reception/Dinner	Nat'l Press Club	[ ]	[ ]
TUESDAY, Oct 31				
7:00am- 8:00am	Private Freestanding Deans (B)	Conservatory	[ ]	[ ]
7:00am- 8:00am	Western Deans (B)	Kalorama	[ ]	[ ]
1:00pm- 4:30pm	VA/COD Joint Session	Ballroom Center	[ ]	[ ]
5:15pm- 8:00pm	David M. Worthen Award Recipient Reception	Jefferson/Lincoln	[ ]	[ ]

(B) = Breakfast Meeting

Name: _____
Spouse/Guest: _____
Institution: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone Number: (___) _____

COUNCIL OF DEANS

ANNUAL MEETING PROGRAM

100th ANNUAL MEETING

October 27-November 2, 1989
Washington Hilton & Capital Hilton Hotels
Washington, D.C.

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(713) 798-4846

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Davis, California 95616
(916) 752-0321

SUNDAY, October 29, 1989

NEW DEANS BREAKFAST HAS BEEN CANCELLED. THERE WILL BE THE USUAL NEW DEANS ORIENTATION AT THE SPRING MEETING.

12:00pm- 1:45 pm — GPA/Development Lunch w/Deans
Washington Hilton
Military

2:00pm- 4:00pm — COD/AAHC Joint Program
Washington Hilton
Jefferson West

"THE FOUR HORSEMEN
ACADEMIC MEDICAL CENTERS REVISITED"

Moderator

William T. Butler, M.D.
Baylor College of Medicine

Keynote Presentation

Clayton Rich, M.D.
University of Oklahoma

An overview of pressures faced by leaders in academic medical centers

Four Perspectives

Medical Center CEO
Donald C. Harrison, M.D.
University of Cincinnati Medical Center

Medical School Dean
George T. Bryan, M.D.
University of Texas Medical School at Galveston

Clinical Department Chairman
John D. Stobo, M.D.
Johns Hopkins University School of Medicine

Teaching Hospital CEO
Raymond G. Schultze, M.D.
University of California, Los Angeles Medical Center

4:00pm- 6:00pm — **AAMC PLENARY SESSION**
Washington Hilton
International Ballroom

MONDAY, October 30, 1989

7:00am- 9:00am	Community Based Deans Breakfast Meeting Washington Hilton Map
7:00am- 9:00am	California Deans Breakfast Meeting Washington Hilton Jackson
7:00am- 9:00am	Midwest/Great Plains Deans Breakfast Meeting Washington Hilton Caucus
7:00am- 9:00am	Southern Deans Breakfast Meeting Washington Hilton Military
11:30am- 1:00pm	COD Administrative Board Luncheon Meeting Washington Hilton Cabinet **(Board Members Only)**
1:30pm- 4:30pm	**COD Business Meeting** Washington Hilton Jefferson East & West
7:00pm-10:00pm	**COD Reception/Dinner** National Press Club

National Press Club
14th and F Streets, N.W.
Washington, D.C.

The National Press Club was founded in 1908. The halls and meeting rooms of the Club are lined with photographs and memorabilia of famous people who have used the Club as a forum. American Presidents have dined at the Club and all of the presidents since President Taft have been on its membership roll.

TUESDAY, October 31, 1989

7:00am- 8:00am	Private Freestanding Deans Breakfast Meeting Washington Hilton Conservatory
7:00am- 8:00am	Western Deans Breakfast Meeting Washington Hilton Kalorama
10:30am-12:00pm	**AAMC Special General Session - Rural Health** **Washington Hilton** **Jefferson East & West**
10:30am-12:00pm	1990 COD Spring Meeting Planning Committee Meeting COD Suite
1:00pm- 4:30pm	VA/COD Joint Session Washington Hilton Ballroom Center

	Topic	Potential Speakers/Panelists
1:00pm- 1:45pm	Welcome Introductory Remarks	Hon. Edward J. Derwinski Secretary, Dept. of Veterans Affairs
1:45pm- 2:30pm	Effecting Change	Nancy K. Austin Co-Authored "A Passion for Excellence" The Leadership Difference" with Tom Peters
2:30pm- 3:00pm	BREAK	
	Change at the Interface Between Academic Medicine and the VA	
3:00pm- 4:30pm	Panel	John A. Gronvall, M.D. (Moderator) Department of Veterans Affairs L. Thompson Bowles, M.D., Ph.D. George Washington University Medical Center Robert G. Petersdorf, M.D. Association of American Medical Colleges Kenneth Shine, M.D. University of California, Los Angeles Thomas Mullon VAMC Minneapolis, MN Thomas Newcomb, M.D. VAMC Durham, NC

5:15pm- 8:00pm	David M. Worthen Award Recipient Reception Washington Hilton Jefferson/Lincoln

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Professor of Anatomy
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Richard A. Cooper, M.D.
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Future Meeting Dates

1989	
October 27-November 2	**AAMC Annual Meeting** **Washington, D.C.**
December 13-15	Officers Retreat Aspen Institute, Maryland
1990	
February 21-22	Executive Council/Administrative Boards Meetings Washington, D.C.
March 14-16	CAS Spring Meeting San Antonio, Texas
April 3-7	**COD Spring Meeting** **Sonesta Sanibel Island Resort** **Fort Myers, Florida**
May 9-11	COTH Spring Meeting Boston, Massachusetts
June 27-28	Executive Council/Administrative Boards Meetings Washington, D.C.
September 26-27	Executive Council/Administrative Boards Meetings Washington, D.C.
October 19-25	**AAMC Annual Meeting** **San Francisco, California**
December	Officers Retreat
1991	
April 13-17	**COD Spring Meeting** **Westcourt in the Buttes** **Tempe, Arizona**
November 9-14	**AAMC Annual Meeting** **Washington, D.C.**

AAMC

AGENDA

for

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

100th
ANNUAL MEETING

Monday, October 30, 1989
1:30 PM - 4:30 PM
Jefferson East & West
Washington Hilton & Tower Hotel
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF DEANS

ANNUAL BUSINESS MEETING

Washington Hilton & Tower Hotel
Washington, D.C.

AGENDA

Monday, October 30, 1989
1:30 PM - 4:30 PM
Jefferson East & West

Discussion Items (Continued)

E. Medical School Application Pool Trends
Richard R. Randlett

F. Veterans Administration Issues: Update
William T. Butler, M.D.

G. "Traffic Rules" for Admission to Medical School: Report on First Year's Implementation Experience
Robert Beran, Ph.D.

IX. Information Items:

A. HEAL Student Loans: Update
Michael Heningburg, Director
Division of Student Assistance, HRSA

B. Charles E. Culpeper Foundation Study: Assessing Change in Medical Education (ACME) in U.S. Medical Schools - Update
Louis J. Kettel, M.D.

C. Legislative Update
Richard M. Knapp, Ph.D.

X. Old Business

XI. New Business

X. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SPRING BUSINESS MEETING OF THE COUNCIL OF DEANS
Fess Parker's Red Lion Resort
Santa Barbara, California

MINUTES

Note: This year the Council of Deans divided it's Spring Business Meeting into three two hour sessions: **Wednesday, April 12, 3:00 pm-5:00pm; Friday, April 14, 10:45 am-12:30pm; and Saturday, April 15, 10:45 am-12:15pm.** Therefore, the Minutes of the three Business Meetings of the Council will be reported in the aforementioned order.

April 12, 1989
First Business Meeting
3:00pm-5:00pm

Presiding: William T. Butler, M.D.

I. CALL TO ORDER

William T. Butler, M.D. called the meeting to order at 3:00 p.m. Dr. Butler welcomed all; recognized the new deans present; and invited the participation of D. Kay Clawson, M.D., Chair, AAMC Executive Council and Ernest R. Jaffe', M.D., Chair, Council of Academic Societies.

II. AAMC PRESIDENT'S REPORT

Robert G. Petersdorf, M.D., recalled the Association's proposed new dues structure was the principle focus of his report at the 1988 spring meeting. The AAMC Assembly approved the dues proposal, November 1988. Invoices will be mailed in May 1989. The increased dues revenue will assure continued aggressive representation to the Washington community and allow the Association to meet a number of objectives in its comprehensive strategic plan. The Strategic Plan was endorsed by the Association at the December 1988 officers' retreat. The Plan is part of the background for this meeting.

Ongoing activities of the Association are reported as part of the implementation of the Strategic Plan. Some activities gestated during 1988 but have recently come into public view. Others remain in development concepts.

Recruiting:

Douglas E. Kelly, Ph.D., Chair, Anatomy and Cell Biology at the University of Southern California, joins the Association as Associate Vice President for Biomedical Research in July 1989. This completes the Association's senior level position recruitment. The added senior level staff enables the Association to address even better basic science, biomedical research and teaching.

Division of Academic Affairs

July 1, 1989, Louis J. Kettel, M.D., becomes Vice President in the Division of Academic Affairs, succeeding August G. Swanson, M.D., who will move to a new position, Vice President, Graduate Medical Education (GME) and International Programs. Dr. Swanson is charged to expand AAMC activities in GME, oversee the operation of the National Residency Matching Program and be responsible for international medical education activities.

Among the wide variety of the Division activities is a grant from the Charles E. Culpeper Foundation, Inc. to review changes in medical student education. The Association wants to document the many curriculum changes extant despite constant cries for more change.

Medical College Admission Test (MCAT):

An Association press conference one month ago reported the proposed changes in MCAT, last revised in 1977. The next exam, scheduled for 1991 introduction, will incorporate changes recommended by two constituency working committees. The new examination configuration includes four tests: biological sciences; physical sciences; verbal reasoning; and writing samples of two thirty minute essays. This new battery will provide a better measure of applicant ability to think and reason critically. This MCAT revision effort will require a substantial AAMC commitment to ensure continued reliability and validity.

MEDLOANS Program:

The Association's MEDLOANS program, initiated in 1986, has met a real need at our medical schools. After a slow year start, student loans processed in the current cycle total more than $5.5 million, representing more than 50% increase over last year at this time. The real contribution of the MEDLOANS Programs, however, has been the competition brought to the marketplace resulting in lower borrowing costs even to students who use other loan programs.

The 1986 Association's Committee on Transition between Medical School and Residency report recommendations have been acted upon, including the November 1 uniform release date for deans letters and the shortening of the National Residency Matching Program timetable. Continued interest in minimizing transition difficulties from medical school to residency led the Association successfully to propose to the NRMP Board of Directors we become the operating agency after Jack Graettinger's spring, 1989 retirement.

Division of Biomedical Research

The Division's recent agenda has been focussed by the intense public scrutiny on issues of scientific misconduct. The Association has been an academic community leader on this issue since its 1982 report on "The Maintenance of High Ethical Standards in the Conduct of Research." Recently, the Association distributed the "Framework for Institutional Policy and Procedures to Deal with the Misconduct of Research" document. An ad hoc committee, chaired by David Cohen, Ph.D., Association Chair-Elect, continues to address misconduct issues, as well as the complex conflict of interest in academic research issues.

Other externally driven Division activities relate to laboratory animals and the use of fetal tissue in research. The Louis W. Sullivan, M.D. confirmation hearings are ample evidence that these issues are not going away. James O. Mason, M.D., new Assistant Secretary for Health, Department of Health and Human Services (DHHS), recently pointed out DHHS is now willing to get involved and asked for the Association's help.

Thomas E. Malone, Ph.D., Vice President, Division of Biomedical Research, has additional plans for the Division which include: industry/academia relationships; research space management; and faculty planning and development, examining the impact of removing age-based mandatory retirement.

Division of Clinical Services

Launching the new Group on Faculty Practice (GFP), now fully operational, has been an important effort of this busy Division. The timely creation of GFP helped the Association focus on issues like: the impact of relative value scales on reimbursement and Congressman Fortney H. Stark's legislative efforts to address conflicts of interest arising from physician ownership of referral facilities.

The Division also provides the data for arguments to continue the indirect medical education adjustment at a level generally higher than that usually recommended in the President's budget. J. Robert Buchanan, M.D., General Director of the Massachusetts General Hospital and Richard M. Knapp, Ph.D. testified before a Congressional Committee on this particular issue on April 11th.

The Division staffs a new AAMC committee relating to teaching physician payment. The first committee on this issue was appointed in 1969. A small committee studying nursing issues in teaching hospitals has also been initiated.

Division of Communications

The Division has implemented a revitalized and redirected Journal of Medical Education, "Academic Medicine." The inaugural issue of Academic Medicine appeared three months ago. The inaugural and subsequent three editions have been very favorably received, showing real promise of becoming an important contributor to policy issue debates affecting our academic medical centers while maintaining a forum where research on medical education can be carefully considered and published.

Dr. Petersdorf reported the Association unveiled its new graphic identity program at its 1988 Annual Meeting and is now working to improve the quality in appearance of the Association's principal publications. A resource notebook on animal rights which should be especially useful in helping medical schools and teaching hospitals educate others about the responsible use of animals in research will soon be issued by the Association.

Division of Institutional Planning and Development

The Division has had the principal responsibility for staffing the Association's Task Force on Physician Supply. The Task Force will report at this meeting and will make its recommendations at a special 1989 AAMC Annual Meeting general session.

The Division staffed Committee on Aids has completed and mailed the second and final report.

The Division continues to expand the activities of the Association's Management Education Program; the newest addition, a program on problem-based learning, was presented twice in 1988 and will be offered twice in 1989. The Division is also the repository of many of the Association's databases--a significant effort is on the way to increase the analytical and resource studies based on these data. As an example, the Howard Hughes Medical Institute has awarded the Association a five year grant to track their medical student fellowship program.

Division of Minority Health, Disease Prevention and Health Promotion

The Division is the newest in the AAMC. It reflects the concern and commitment of our community to improve the participation of minorities in the medical profession. Headed by Herbert

W. Nickens, M.D., formerly Director, Office of Minority Health, Department of Health and Human Services, division activities have been encouraged by initial grants from the Robert Wood Johnson and Josiah Macy Foundations.

Office of Governmental Relations

The Office is presently working on several major governmental initiatives which will involve the Association this year. The Strategic Plan is ambitious in its legislative goals. Of these the most pressing legislative and regulatory issues deserving the Association's attention are:

1. Appropriations, particularly for the Veterans Administration.

2. Indirect medical education adjustment in Medicare.

3. Biomedical research; especially animal welfare, use of fetal tissues, and oversight to prevent scientific misconduct.

Association Awards:

Last year the Association, by extending the deadline and making a special appeal for research award nominations, selected a very worthy awardee, Dr. Gilman from Southwestern. This year the Association has changed to a two stage research award nominating procedure. The first nominations stage requires only a letter. The nominees will be reviewed and the finalists selected from that group. The second stage asks the nominators of the finalists to prepare a more extensive package for review, including reprints of publications. Leon E. Rosenberg, M.D., chaired the committee that recommended this change in procedure in order to reduce the administrative burden on those making nominations for the AAMC's Flexner and Research Awards.

Other Issues:

The Association has expended a good deal to time and effort in finding a new home. Progress is being made, although not without a certain amount of pain and certainly with a lot of hard work. Dr. Petersdorf expressed his gratefulness for the support and cooperation he has received.

III. PHYSICIAN SUPPLY TASK FORCE REPORT FOR ACTION

Daniel C. Tosteson, M.D. purposed to come as close to signing off on the report as possible. The report is divided into the following components: medical education as it bears on physician supply; declining applicant pools; graduate medical education; foreign medical graduates; and research and research training.

Physician Supply: **(See Task Force on Physician Supply Review Draft of 4/8/89, Pages 6-8)**

The Task Force concluded that:

- The number of M.D.'s will approach 700,000 by the year 2000, and by 2020 a physician population ratio of 280 per hundred thousand in contrast to 140 per hundred thousand in 1960. Given the abundance of physicians, the Task Force found little justification to establish additional capacity.

The Task Force agreed the number of physicians probably does not constitute a demonstrable surplus. Because estimating demand for physician services is uncertain, the term abundance was chosen to characterize the number of physicians.

- A valid reason for leaving significant numbers of citizens without adequate medical services is not a "shortage" of physicians.

- Health services research is needed to determine whether the abundance of physicians gives rise to skills atrophy or over-doctoring.

The Task Force recommended that:

1. Adequate access to health services for all should be identified as a high priority of society made more feasible by the abundance of physicians. The AAMC should catalyze an effort with other organizations to develop durable solutions to the problem of access to care for the underserved.

2. Health services research should be undertaken to measure and monitor the relationship between the impact of an abundance of physicians and matters such as the maintenance of physician skills and physician-induced demands for unnecessary services.

DISCUSSION

The questions and comments covered many aspects of physician supply and demand. In response, Dr. Tosteson noted that nothing came to the attention of the Task Force documenting that skills atrophy is occurring. The issue was raised by several members of the Task Force as a potential concern and is often raised in discourse.

Acknowledging Canada's regulatory methods for controlling escalating costs, the Task Force and the several subcommittees discussed the potential impacts if such occurred in the U.S., but no effort was made to quantitate the effect on physician manpower. However, the graduate medical education component of the report does suggest that program directors take into account the demands for services in their specialties in setting the size of their programs.

The Task Force made no projections based on the increasing proportion of physicians who are in full time positions and how the increase effects patients entering the system.

To questions about the choice of the word "abundance" and the suggestion that "ample" might be a better term, Dr. Tosteson reported on the Task Force's efforts to choose an appropriate word: surplus and surfeit were also considered. The Task Force would feel uncomfortable with a word that implied no evidence of an abundance in some specialties and in some places.

Dr. Tosteson reported the Task Force will word the report in such fashion that **surplus, adequate, ample, etc.** is used in qualifying phrases indicating the heterogeneity of the pool geographically and to some extent by specialty.

A commenter suggested that the last part of item II might be read to mean that the maintenance of physician skills implied maintenance of physician-induced demands for unnecessary services. Others raised questions about the national service program suggested. Dr. Tosteson reported the Task Force worded this section recalling the mixed record of the National Health Service Corp. There was a sentiment to explore some form of inducement to give service in underserved areas. It was not more explicitly developed, but implied to be the best way for the underserved areas to be met.

Declining Applicant Pool: **(See Task Force on Physician Supply Review Draft of 4/8/89, Pages 8-10))**

The Task Force concluded that:

- Medical schools should ensure they do not compromise the quality of their graduates by admitting students unprepared to undertake the work involved.

- The persistence of the underrepresentation of certain groups, despite affirmative action admissions policies and vigorous recruiting efforts, suggests that even more far-reaching measures must be taken in order to increase the presence of these students in medical school.

The Task Force recommended that:

1. The quality of their graduates should be the first priority in medical school decisions about the size of their entering class; reducing the size of the entering class should be preferred to compromising quality.

2. The decline in the number of students applying to medical school should be addressed by the AAMC; a campaign should be developed to attract able students to the study of medicine and the biomedical sciences.

3. Increasing the presence of underrepresented minorities in the profession requires aggressive action; the AAMC should advocate the development of a long term comprehensive program ranging from steps to foster and preserve affirmative action gains to imaginative and productive efforts directed toward expanding the number of qualified minority applicants. Health sciences should be vigorously promoted in primary and secondary schools.

DISCUSSION:

To the question of the role of admission selection implicit in **Recommendation 1**, Dr. Tosteson welcomed suggestions for rewording that would capture the point. The Task Force agreed, however, it is the quality of the product that is our social responsibility.

Suggested wording for **Recommendation 1** is:

> "The quality of graduates is the primary concern of the medical school faculty. Quality of the entering class is one factor in the quality of the graduating physician. If too few qualified students are available, schools must reduce the size of their class."

Dr. Tosteson said the Task Force will capture this suggestion. He also acknowledged the distinction between quality and academic qualifications. The present wording does represent an effort to take the distinction into account.

When asked if there is data that tuition has affected the number of applicants, Dr. Tosteson reported the trends are impressive.

H. Paul Jolly, Ph.D. reported it is possible to test whether the rate of decline is similar or different among schools according to the level of tuition. The problem is identifying trends school-by-school and correctly categorizing them.

While schools with very high tuition have seen a sharp applicant pool decline, Dr. Petersdorf noted, the Association would like to avoid publishing data which allows invidious comparisons among schools with complex differences.

Graduate Medical Education **(See Task Force on Physician Supply Review Draft of 4/8/89, Pages 11-13)**

The Task Force conclusions recognize the mix of programs now present may not match national needs and acknowledges that one year of graduate medical education is insufficient preparation for independent practice.

Highlights of the Task Force conclusions are that:

- Graduate medical education emphasizes the development of expertise in essential clinical skills and has become a necessary component of the continuum of medical education.

- Many young physicians are choosing their specialty on the basis of inadequate information and at times prematurely.

The Task Force recommended that:

1. Enhanced data resources and analysis should be brought to bear on the decision-making of medical schools, residency programs, and policy makers on matters affecting physician supply; the AAMC should continue to develop its capabilities in this area. In particular, it should report regularly on estimates of future physician requirements by specialty, geography and on the availability of residency positions and resident preferences.

2. Graduate medical education programs and their sponsoring institutions should take into account data descriptive of national needs as they decide on the character and scope of the training opportunities that they will provide.

3. The completion of an accredited residency program should be required of all medical school graduates, whether domestic or foreign, before an unrestricted license for independent practice is permitted.

DISCUSSION

When questioned on the choice of the word **"may"** in the phrase "the distribution **may** not meet national needs...," rather than **"don't meet,"** Dr. Tosteson said, "this is compromise wording."

Interpreting **Recommendation 3**, Dr. Tosteson said, "foreign medical graduates of English speaking countries and Scandinavia" means they will have to repeat an accredited program in this country. The issue is addressed further under the foreign medical graduate section.

To the comment that it is not practical to expect graduates from an "appropriate" school in an English speaking country to take another training program here, L. Thompson Bowles, M.D., Ph.D. noted regardless of the extent of training and specialty overseas, to be fully licensed in almost any jurisdiction they must complete one or more accredited post-graduate training years.

There were comments that the Task Force is silent on the influence of physician reimbursement. The report also gives the appearance that the AAMC is obligated to provide sufficient residences to accommodate all medical school graduates, whether foreign or domestic. Dr. Tosteson recognized this has enormous implications. As a practical matter, it is not so much an issue of creating additional residency slots, rather it is a need to exert control over which we have no control and

match existing positions and the number of graduates from accredited institutions. The Task Force recognized the roles that specialty boards and RRCs play in controlling the numbers of residency positions for individual specialties.

Dr. Tosteson reported it would be fair to say that the Task Force was not prepared to step up behind Bill Hsiao's relative value scale.

Dr. Bentley reviewed this Task Force committee's rationale and recalled a 1980 AAMC position that recommends there be a change in reimbursement to better compensate the non-procedural services. The Task Force committee felt the Association was well served to continue that policy.

The rationale for focusing on the Association's action is that our constituency includes the Council of Teaching Hospitals and the Council of Academic Societies who, in fact, represent all of the components of the graduate medical education system. Specifically, program directors were viewed as AAMC members and do determine the policies of the boards.
August G. Swanson, M.D. described the roles of the ACGME, the ABMS and the RRCs in the accreditation authority as it relates to control manpower and suggested we look to other mechanisms than accreditation to affect physician supply.

There followed lengthy discussion of the relationship of supply, training and licensure. Dr. Tosteson noted the issue is one of favoring regulation to eliminate the oversupply by specialty, the so-called specialty maldistribution, verses using accreditation and graduate education control to adjust supply. **Recommendation 3** was carefully discussed in the steering committee. The notion of a certain period of graduate medical education time was rejected. Adopting the unrestricted license for independent practice approach was meant to convey that licensing jurisdictions should be encouraged to have intermediary levels of licensure that would allow individuals not fully qualified to practice in their specialty to have a license that would allow them to do some level of practice.

After extensive further discussion, Dr. Tosteson concluded that this was not a very wise recommendation to emerge from the Association of American Medical Colleges.

Some question was raised as to value of AAMC data collection. Dr. Tosteson asked if **Recommendations 1 and 2** should be left out all together leaving no mention of data collection. The comments which followed suggested collecting data is acceptable.

<u>Foreign Medical Graduates</u> **(See Task Force on Physician Supply Review Draft of 4/8/89, Pages 13 and 14)**

Foreign medical graduates come from a variety of institutions and many countries. Their preparedness is uncertain. The assessment measures are generally inadequate. Everyone is cognizant of an important role which this country has played and hopes to continue to play in the education of foreign medical graduates.

The Task Force recommended that:

1. The eligibility of foreign medical graduates to enter accredited graduate medical education programs as qualified residents should be determined by examinations administered by the Educational Commission on Foreign Medical Graduates. The examination sequence should consist of four parts; to the current cognitive examination in the basic science disciplines and cognitive examination in the clinical disciplines should be added an assessment of the ability to communicate effectively in English as a spoken language and an evaluation of clinical skills. The AAMC should support the advancement of the Medical Scholars Program.

Commenters recognized two issues to be addressed by the single recommendation: strengthening the eligibility requirements to enter a residency and the reason for a foreign medical graduate to enter the residency. Some foreign medical graduates intend to practice in this country and some plan to return to their own country to practice medicine. Dr. Tosteson noted the difficulties separating individuals by their intent for training.

Richard Moy, M.D. commented that in the body of the Task Force report these issues are separated as two very different programs and two sets of obligations.

One of the major purposes of the International Medical Scholars Program (IMSP) was reported as a plan to provide educational opportunities. The ECFMG is developing the testing series recommended.

Research and Research Training in the Academic Medical Center **(See Task Force on Physician Supply Review Draft of 4/8/89, Pages 15-18)**

The Recommendation has been revised from the distributed Review Draft. It now bears the four changes recommended by the chair of the subcommittee, David Cohen, Ph.D. The revised Recommendation reads (revised language has been underscored):

> The training of scientists, including physician scientists, in the biomedical, behavioral and related social sciences should be affirmed by the AAMC as a unique function of academic medical centers that is of equally importance to their missions of educating physicians for practice, conducting biomedical research and providing exemplary patient care.

DISCUSSION

Dr. Tosteson agreed that the notion that some schools can exist in the absence of an environment of inquiry is internally inconsistent and an undesirable statement. The notion is supported, however, by language in several parts of the body of the report, both in the medical school portion and in the part of the report which deals with science education. This could easily lead to misinterpretation if left as the worded in the Executive Summary. There was consensus that the last sentence of the conclusions on Page 15 needs to be reconciled with the revised recommendation.

Dr. Petersdorf noted the lack of attention the report gives to the need for primary care physicians. Not mentioning it is very much contrary to what COGME is saying.

Dr. Tosteson stated he would be very happy to entertain directions for reshaping the Recommendations that are more consistent with the President's views.

He then turned to the combined list of ten (10) Recommendations.

Looking at **Recommendation 7: "The completion of an accredited residency program should be required of all medical school graduates, whether domestic or foreign, before an unrestricted license for independent practice is awarded,"** Dr. Tosteson said he inferred from the discussion and the "straw" vote a lack of substantial enthusiasm for including that Recommendation, at least in its present form. Dr. Tosteson asked if a firmer statement about the existence of specialty maldistribution and the need to reorient the number of available residency slots in the direction of educating and graduating more primary care doctors and fewer sub-specialists would be favored?

A commenter said the availability of positions is not the problem. There are insufficient numbers of graduates choosing this career.

Another said the difficulty is that primary care disciplines are less attractive to a large number of graduates. Students don't find the primary care disciplines challenging, exciting, or fun. We ought to look at what it is that we are doing as educators; what it is that the residency programs are doing at their level; and what these factors are that are creating the disattraction.

Another noted the applicants to medical schools need to be reviewed. There are applicants who would like to take care of people and do that every day for the rest of their lives. These applicants may be seen as boring, uninteresting, not necessarily intellectual, and not necessarily the people admission committees want in our medical schools. Others commenters supported this notion.

Several speakers felt the recommendations should emphasize and recognize this national problem and address it, lest the rest of the report lose its value.

A statement supporting pilot or demonstration projects to encourage students to select the primary care field for their residency training programs was suggested.

Dr. Tosteson received support for the idea that the recommendations should include mention of the existence of the tradition to place value on specialty training and the need for a broad attack on that problem, particularly to do all that we can to increase the number of graduates who choose to go into primary care. Specific mention of residency positions will be avoided.

Dr. Tosteson called attention to the gap between the number of graduates from U.S. and Canadian accredited schools and the number of residency positions. This single factor leads to the increase in the number of practicing doctors in the U.S. over which we could have some influence.

Commenters debated the merits of the Canadian approach which controls physician supply through residency positions at the provincial level; legislative approaches; and licensure approaches.

A commenter noted the role hospital service needs in determining the available residency positions.

Another commenter suggested this issue is so complex that a separate new task force needs to be appointed to study it alone.

Dr. Tosteson thanked the Council for its input. The Task Force will come back with the final report in the Fall.

IV. ADJOURNMENT

SPRING BUSINESS MEETING OF THE COUNCIL OF DEANS
Fess Parker's Red Lion Resort
Santa Barbara, California

MINUTES

April 14, 1989
Second Business Meeting
10:45am-12:30pm

Presiding: L. Thompson Bowles, M.D., Ph.D.

I. CALL TO ORDER

L. Thompson Bowles, M.D., Ph.D., chair-elect of the Council, called the meeting to order at 10:55 a.m.

II. REPORT ON THE SINGLE EXAMINATION FOR LICENSURE

Dr. Bowles reviewed the content of his presentation at the November, 1988 meeting in Chicago. The pressures, particularly in New York and California are recent, beginning about three years ago, but the notion of a single examination for licensure goes back several decades. In the early 1980s the National Board of Medical Examiners (NBME), the Federation of State Medical Boards (FSMB), the Association of American Medical Colleges (AAMC), and many associated organizations reviewed with intensity the notion of changing the NBME exam, its purpose, and the licensure exams in this country. Other than a good deal of dialogue, very little actually happened at that time. However, around 1985 the state of New York and quickly thereafter the state of California made it clear at both the legislative level and at their medical licensing board level that equity issues were emerging that were going to mandate that the states offer only one licensing exam. In response to concern by FSMB, NBME and some in academia, the concept of a single examination was resurfaced. Robert Volle, Ph.D., the new president of the National Board of Medical Examiners, was led to convene a task force which included NBME, FSMB, AAMC, AMA, ACGME, ECFMG, the Department of Health and Human Services, the National Board of Osteopathic Medical Examiners (NBOME)and, early on, the American Osteopathic Association (AOA). The Osteopaths ultimately chose not to participate. The Task Force recommendation for a single examination is now before us for discussion. At this point in time NBME has received the report. At the NBME meeting, March 30 and 31, 1989, the Board endorsed, in principle, a single examination system for licensure in the United States and directed its executive board and staff to continue to work with the organizations just identified and to bring back a final proposal that would be ready for implementation by its spring meeting in 1990. Dr. Volle is here to describe the examination system being proposed and to review some of the issues that have come under discussion.

Dr. Volle reviewed the present system of licensure in the U.S. and the history of the Task Force activities. He then presented the scheme of the proposed single examination for medical licensure as distributed in the agenda.

Highlighting, Dr. Volle said it is proposed that:

1. The exam will be available to all medical board jurisdiction for their use to evaluate graduates of LCME medical schools and non LCME schools. The whole question of equity would disappear.

2. The examination would consist of three steps. The present terminology would not be used. Parts I, II, and III; Components I and II; day 1 and day 2 would be replaced by Steps I and II.

3. Graduates of LCME schools, would have to write and pass Steps I and II. After the medical degree one year of graduate medical education is recommended before the individual would be eligible to write Step III. Step III is envisioned as a two day examination based on the practice of medicine. Some of the elements of FLEX would continue: questions would have to do with fundamentals of the biomedical sciences and with mechanism of disease.

4. Graduates from non-LCME schools would have to, as they do today, continue to earn the ECFMG certificate and would have to spend a minimum of one year of graduate medical education to be eligible to write Step III.

5. The standards for these examinations would be set by our LCME accredited school students. We would continue to use the same reference groups; that is students who are in or about the second year medical school who write the examination for the very first time would be the reference group for Step I. Students in or about the fourth year of LCME accredited medical school who write Step II for the first time would set the standards for Step II. A similar approach would be true for Step III.

The management of the single examination would occur under three organizations working through several structures. The proposal calls for the development of a composite committee. The composite committee would be made up of representatives from NBME, FSMB, and ECFMG. It would be the responsibility of the composite committee to overview the test system design and to validate the examination so that we can say to all the jurisdictions this examination, its three components, will meet your needs for examination and licensure. The actual examination preparation would be a division of labor between the NBME and FSMB as is the present practice for FLEX. Step I and Step II would be developed, items written, content determined as done today using the faculty of the United States and Canadian schools of medicine. The National Board would have primary responsibility for those two parts of the examination. The Federation and the National together would have responsibility for the development of Step III. The National Board's staff will develop the examinations, converting questions to the proper editorial form, printing the examination, performing psychometric analysis, developing psychometric score reporting and the like. The National Board's staff would be responsible for this in all three steps.

The National Board, through the U.S. medical schools, would administer Steps I and II. The Educational Commission would administer Steps I and II to all the foreign medical schools. Just as FLEX is administered by the state medical boards, the Federation through its state medical boards would administer Step III.

Dr. Volle then commented on some concerns. There is the possibility of standards erosion with time. The fact that the NBME is an independent, voluntary agency adds flexibility to maintain standards. A single examination system of this type becomes far more restrictive. We have to be prepared as contracts are written and as agreements are written to avoid political pressure to change standards, stated Dr. Volle. The question of students in LCME schools, the question of graduates from LCME setting standards is not negotiable. The NBME will maintain its certificate. One of the reasons NBME wantS to maintain their certificate is that it represents the independence and

the integrity of the National Board. Should there be a time when standards are slipping, each organization in this scheme maintains its independence. There is no organic relationship over and above what we do now. Should political pressure influencing the quality of the exam be perceived, the National Board would be prepared to withdraw.

Dr. Volle addressed the question of an adverse impact on accreditation. If the described system of standards is maintained no examination sequence can have an adverse impact on the very good and needed important work of the Liaison Committee on Medical Education (LCME). The Task Force shared the penultimate draft of the proposal with the LCME and with the ACGME for review before the final drafting. Both organizations, while reserving judgment and reserving the right to change their minds, saw nothing in this proposal that would have an adverse impact on their work. When Dr. Volle spoke to the LCME, the question of a jurisdiction developing a new medical school that would not receive LCME accreditation was posed. Would this examination sequence be offered to students and graduates of that school? According to Dr. Volle, the language in the Task Force proposal states very clearly that this examination sequence would not be offered to those students and to those graduates, but the legal machinery in the United States probably would require this examination be offered to the students and graduates of a non-accredited domestic medical school.

Will a system of this kind drive medical education? Dr. Volle noted that the National Board is already charged with driving medical education in the United States; the NBME is also charged with being an impediment to curricula innovation. However, Dr. Volle noted the faculty is the University; the faculty has responsibility for curriculum; the faculty has responsibility to evaluate its programs and to evaluate its students; and no faculty should surrender that responsibility to the National Board or to any other agency.

Dr. Volle noted today there is not a test of readiness for graduates of LCME accredited schools to enter residency training. There is a test of readiness for graduates of non-LCME schools. It's called the ECFMG certificate. Will an examination sequence of this kind, Step I, Step II, Step III, i.e., a single examination for everyone, become a test of readiness to enter graduate medical education? The Task Force did not intend it. Whether it does in fact turn out to be that way will be determined by constituent use.

Finally, Dr. Volle observed, should this or a proposal similar to this fail, we will see a very much modified National Board, but there will be a single examination in this country! State legislatures and the federal government will demand a single examination; that examination will be FLEX I and FLEX II.

DISCUSSION

Comment: At what point do the non-LCME accredited school students take Step I and Step II? In other words, are they taking it at the same time as the LCME students are taking step I and step II.

Response: In order for the examinations to be secure and in order for them to have meaning, U.S. students and students from foreign medical schools will take it on the same day, at the same time, and the same examination. Just as it is today, Step I and Step II would not be linked. A person would have to have written and passed Step I and Step II to take Step III.

Comment

At what point in their achieving a M.D. degree in a non-LCME school would students be allowed to take either Step I or Step II?

Response: The initial takers will be graduates, but over time the ECFMG will need to determine at what point in the sequence of the M.D. education the candidates would be able to sit for Step I and then subsequently Step II.

Comment from Dr. Bowles: At the present time, the National Board expects and desires to maintain National Board certification as an additional symbol of academic achievement. It is possible that the Board may determine that certification should represent something a little bit different in the future; for example, there might be an increased standard in order to get that certification.

Question: If separate certification by National Boards is additional to this single licensure examination, would the student have to take Step III plus some other equivalent to Part III?

Response: Dr. Bowles noted the Federation's concern that if NBME certification continues as a certain kind of improved acknowledgement of performance, it will be de facto a new kind of second pathway; but for now the certification will continue in its current form. The future is uncertain.

Comment: Is it planned to set a limit on the number of times students from non-LCME accredited schools can take the exam? What kind of security are you going to maintain? Will it be possible to identify students coming in under two separate names?

Response: Dr. Bowles noted the security issue is real and serious. It has been identified as a critical detail to be worked out. Be assured that the organizations involved have given highest priority to make certain the administration is secure.

The ECFMG will be determining the limits on the number of times you can take the exam sequence.

John Chapman, M.D., reported for the NBME committee he chaired on the feasibility and the desirability of the single pathway to licensure. The committee's answer was yes, it is desirable and it is feasible. The committee agreed that a dual system is unacceptable to those with the authority to make the decisions on what system qualifies. Addressing the issue of long-term continuation of standards that are recognizably adequate to the examination process, the fact that the reference group will be first time exam takers from LCME accredited institutions was felt by this committee to be absolute and non-negotiable.

What impact, if any, should or would this system have on the LCME process of accreditation? As Dr. Volle noted, the LCME saw no adverse impact. In fact there were some of us who felt that a single pathway would actually in long run contribute to a better understanding of what performance on these examinations mean. To the point of this exam driving medical education in relationship to student performance medical license exams now drive the curriculum if faculty so chose. The certificate of the National Board was also a topic of the committee's evaluation. The committee recommended that the certification of the National Board be maintained and that the National Board's "integrity" as an organization providing a certification be sustained.

Comments from William Luginbuhl: Dr. Luginbuhl agreed the present system is untenable. He highlighted LCME accreditation, but did not see it as a threat to the accreditation process. He agreed the single exam could strengthen the process.

Comment: Joseph Gonnella, M.D. spoke in support of the recommendations made by the NBME committee, but one concern has been the long-term impact on the standards. Bringing in a respected member of the public sector to the conjoint committee is one way to minimize the political pressures that might be placed on the system in the future. The other is the scoring of the new examination. To minimize the impact on curriculum, he recommended a pass/failure rather

than a number system. He pointed out, however, that pass/fail poses a dilemma for American schools that have a very high failure rate. Differences of student performance scored as 580 verses 500, or 390 verses passing are differences that may be exaggerated by directors of residency programs, especially if letters of evaluation for medical schools are non-specific. While he supported pass/failure reporting, the pass level must be reassessed.

Response: Dr. Bowles reported there is a lot of support for the pass/failure issue, but also concern and opposition to it. The COD has addressed that issue before. Pass/failure may well become more compelling should this sequence become the exam.

Comment: Donald G. Kassebaum, M.D. reaffirmed the LCME action described. He added that one Puerto Rican medical school is matriculating and graduating students that are not LCME accredited. So the circumstance currently exists, but the LCME doesn't see this examination path to licensure linked to that issue. To the point that there is no means to assess graduates of LCME accredited schools readiness to enter graduate medical education, the fact that they are awarded M.D. degrees by schools whose educational content and processes are evaluated by the LCME does constitute such an assessment.

Comment: Dr. Petersdorf noted one year of graduate medical education between Step II and Step III was a low minimalist requirement. A number of states are asking for two years, at least for FMGs, and some have urged three years of graduate medical education. Similarly, AAMC's Physician Supply report is suggesting a completed residency training program before full licensure. Dr. Petersdorf then asked Dr. Volle to comment further on the way NBME intends to score the examination. Specifically, why not set an absolute scoring standard rather than using the reference group?

Response: Dr. Volle reported that the NBME is reviewing its standard setting procedures and probably will move toward the **"Ingulf"** method. However, it isn't the ranking so much that is important as it is where we put the pass/fail line. By 1991 when NBME comes forth with a comprehensive examination, they hope to have made some progress on that whole question.

Robert Tranquada, M.D. commented that the absolute scoring method has a problem too. Sooner or later it is possible for the states to require publishing questions. Then a student could simply learn the minimum necessary to pass the licensing exam as it is possible in West Germany.

August Swanson, M.D. noted that the Federation of State Medical Boards is fifty-four independent jurisdictions. With the FLEX exam each jurisdiction sets its own standards. I think I heard at the National Board meeting that it was anticipated the Federation would try to draw people together within its own constituency to really talk about how this new exam should be used. What about the possibility of fifty-four different levels for the pass/fail level if they reject the national standard?

Dr. Bowles agreed that as things stand now each jurisdiction picks any exam and awards license on completely different bases. This is likely to continue. With respect to the standards setting, right now there seems to be confidence by the Federation that Steps I and II will have a common standard. Dr. Bowles recognized the potential and the need for some "political" discussions with respect to standard setting on Part III.

Dr. Volle agreed the question has not been tested yet with the Federation, but that the Federation will consider this proposal at its April 1989 annual meeting. I gather they will follow the same pattern of the National Board and that is to request endorsement in principle with action to be deferred until April 1990.

Louis J. Kettel, M.D. asked Dr. Volle to comment on the NBME and ECFMG attitudes toward including a clinical skills assessment in the examination system when and if it is available.

Dr. Volle responded that the National Board has agreed that over the next four or five years it will invest considerable resources in the attempt to develop a national examination that involves clinical skills assessment. This is in addition to the computer work that we have done. George Miller, M.D. is chairing the NBME steering committee on this area. We have formed an alliance with the Association of American Medical Colleges, American Medical Association, the Educational Commission on Foreign Medical Graduates, the American Board of Medical Specialties to determine whether or not it is possible to mount a national effort that can lead to the development and implementation of such an examination as a component of this system. We think by January of 1990 we can have the outlines of a prototype examination that would help in the assessment of clinical skills.

Dr. Bowles thanked Dr. Volle and promised to keep the Council informed as the process continues. He invited continued comment and requested understanding on the part of all if this step is to happen.

III. LEGISLATIVE UPDATE

Dr. Knapp reported there are a variety of new people to deal with in Washington. Chief among them is Secretary Sullivan. He then called attention to the Legislative and Regulatory Current Status Report. David Moore, in the AAMC Office of Governmental Relations, puts this out. The Association's legislative objectives are on Page 11 of the Strategic Planning Document. Improved relations with Congressional and committee staff members is a goal. We want them to know AAMC, to look to us for ideas, for information and above all wonder what the AAMC thinks. In addition to the usual efforts to try and accomplish the goal, we are publishing descriptive documents in difficult areas; one such document was on the issue of fetal research and the use of fetal tissue from induced abortions in research. A similar document is being prepared on the medical education adjustment. Another is on research training. Finally there will be a document on the responsible use of animals in research and education. A second approach is to ask congressmen, senators and other influential people to write brief columns for **Academic Medicine**. In January we had Congressman Henry A. Waxman (California); February, Senator Quentin N. Burdick (North Dakota); March, Congressman Fortney H. Stark (California) wrote a column on conflict of interest with respect to patient referrals; April, Congressman John D. Dingell (Michigan) wrote on misconduct and research; May, Senator Alan Cranston (California) wrote on trauma problems; and in June, if all goes well, the Secretary of Education will have an article.

Dr. Knapp then called attention to two regulatory matters. The first is the teaching physician regulations promulgated for comments due on April 10. A committee chaired by Hiram C. Polk, M.D., Chair of Surgery, University of Louisville, and among others three deans (Drs. Wilson, Arkansas; Pardes, Columbia; and Bowles, George Washington), and staffed by Jim Bentley prepared the response letter. The second regulatory matter concerns the Department of Agriculture's regulations concerning the use of live animals in research. As one of the major parts of responding to those regulations, we are trying with NABR to determine the financial impact of those regulations on your respective institutions. A mail survey went out April 3. Please give it your attention when you return home if you have not already.

Among a variety of legislative issues, Dr. Knapp highlighted VA funding; NIH and ADMHA funding; and Medicare. Stepped up efforts to get more attention to the problems of the VA started with Harry Beaty, M.D. appearing in first class fashion before Senator Alan Cranston's committee. Earlier in this year, before the House Veterans Affairs Committee, Kenneth Shine, M.D., UCLA, and L. Thompson Bowles, M.D., Ph.D testified. In the senate, a panel of four deans (Drs. Asbury, Interim Dean at Penn; Corn, Georgetown; Dennis, Maryland; and once again Dr. Shine) testified. On May 18, Dr. Dennis will also appear before Senator Barbara A. Mikulski's (Maryland)

subcommittee. We need to identify a witness for Congressman Bob Traxler's subcommittee when that hearing is scheduled. Additionally, a letter went out over Dr. Butler's signature asking for letters on the problems that those of you who have major affiliations are experiencing. The response was the best we ever got from the collective group of deans. Dr. Knapp has thirty-five really very good letters. They have had their impact. Copies of "The Friends of the VA for Medical Care and Research" were distributed. The document has been put together by AAMC and American Federation for Clinical Research staffs. It has been signed by fifty-three other organizations and circulating widely.

A major concern is the proposed 50% reduction in the indirect medical education adjustment. Dr. Petersdorf's March letter to every member of the House and Senate Budget, Finance, and Ways and Means Committees was copied to each dean. Dr. Knapp visited everybody on the staff of the Finance Committee. AAMC is working hard on Senator Dave Durenburger (Minnesota). The Senator spoke to the Executive Council in February 1989 and through that we actually got to see him. The Association now must work on the House Ways and Means Committee. Robert Buchanan, M.D., General Director of the Massachusetts General Hospital, appeared before Congressman Stark's Health Subcommittee. By memorandum you were asked to please write to members of the Senate Finance Committee and Ways and Means Committee with respect to the importance that this money has to the hospitals of which you are affiliated.

Much of the work in support of NIH and ADMHN is done through the ad hoc group on medical research, a federation of about 100 organizations with a small steering committee chaired by Dr. Sherman and staffed by Dave Moore in our office. The proposed NIH budget, is a 5.3% increase. Without the AIDS money its about a 3.6% increase. The NIH budget over a ten year period has increased on a constant dollar bases. When we talk to Congressmen we do need to understand the money is up.

Particular attention as always needs to be paid to the biomedical research support grant. Some of you have asked about the salary cap. You are aware that in the budget there is a recommended salary cap for research grants not to exceed $125,000. The right thing to do here is to write only to Congressman William H. Natcher Kentucky) or Senator Tom Harkin (Iowa).

In regard to science and research misconduct, there will be hearings again in an oversight way on the Baltimore case. There will be a bill introduced shortly by Congressman Dingell.

Dr. Knapp asked the deans to give attention to: 1) the survey on the impact of the Agriculture regulations with respect to the use of live animals in research; 2) think carefully about the Medicare issue and write on that subject; 3) write to your own Congressman, plus the members of the subcommittees in the Senate and the House with respect to the biomedical research support grant; and 4) keep the mail rolling on the VA. I would like to ask Dr. Shine to make a few observations about the VA that we have learned in our travels on that subject. He has worked very hard on that subject.

Kenneth Shine, M.D. reviewed the present state of affairs which surround the issues of VA funding. Problems of leadership, facility age, administrative change, new laws, a shift of power from the field more centrally and ineffective Veterans service organizations present a difficult situation. People in both the House and the Senate have said they need the medical school deans. The medical schools need to call attention to the hospital system's problem, to comment on quality in addition to emphasizing the importance of the affiliations and the impact on such things as the ability to recruit residents, and to recruit physicians. Congress is asking our help. Dr. Shine suggested some areas to address:

1. When your faculty announces programs, research results, or activities that involve the VA, make sure the VA is credited. Congress needs to see up in the front of the article the

connection to the VA if they are to use this information with their colleagues to get support.

2. The COD needs to make themselves available to come to Washington to speak on these issues. Only so much can be done by the deans in and around D.C. It is absolutely critical Congress hear from deans from states where there are key people on committees.
3. Invite one of the subcommittee chairs or one of the representatives or senators in your area to visit your VA facility. Show them the way in which funding, research budget, infrastructure, lack of facility upkeep, and absence of equipment influence your work.

4. If you are considering a break in affiliations, limitation of programs, or find your programs in jeopardy as a result of any of these funding problems, let Dr. Knapp or myself know. Documenting these threats are important because they represent changes in the quality of the VA program. It also impacts on the research productive of the VA about which there is considerable concern.

5. In the next two or three months a delegation of deans from selected places around the country should meet with Secretary Derwinski and discuss our concern, the intensity of the concern, and how it affects particular institutions. At the same time we should help, consult and emphasize the importance of the affiliations to the VA.

Comment on the Legislative Update

Nancy Gary, M.D. asked in regard to Mr. Dingel's misconduct proposed legislation, whether it would be important to know the level of reporting of misconduct within the medical schools? She also suggested we be clear on when federal reporting becomes necessary and supported keeping the handling of misconduct within the University as much as possible.

Dr. Knapp said we are working on the balance between institution and federal roles.

Thomas Kennedy, M.D. said the content of legislation is not known. In the draft bill the institutions will be required to report twice a year on all allegations and how they are pursued.

Dr. Kettel thanked the deans for their positive response about visits to the VA by their staff and Representatives from Congress. When Representative Traxler met with the COD Administrative Board, he emphasized the importance of regional congressional understanding and support for the VA.

Dr. Bowles spoke of the added task for deans to respond to requests to write letters and to appear at Congress. But as somebody who resides in Washington, D.C., he emphasized the importance of this issue at this time.

Robert Tranquada, M.D. asked that AAMC "pink action memoranda" always have a succinct statement of the issues up front. Secondly, always clearly indicate whether deans should be sending letters just to their delegation on a particular committee or more generally to others as well.

IV. PROGRESS REPORT ON THE CHARLES E. CULPEPER FOUNDATION, INC. FUNDED PROJECT TO ASSESS CHANGES IN MEDICAL EDUCATION (ACME)

Dr. Kettel made two points about the project. First, it will regularly be on the agenda because it is the educational institutions' project--they have ownership. Secondly, his recent visits to some schools to talk about curriculum changes revealed that medical education is on the right track. Some of the recommendations for change of the past few years are just not implementable or at

least not rapidly. We are going to have to develop recommendations all can get behind.

The project staff is now complete. Data collection has begun. The Advisory Group has its first meeting May 2, 1989. Dr. Beaty chairs the group. The staff looks forward to the Groups advice.

Finally, one interesting observation. Ambulatory care teaching we have heard so much about is tracked in the annual curriculum survey. This year's analysis revealed some four schools have dropped their required primary care ambulatory clerkships. Something interesting is happening. The time is right for this study.

V. ADJOURNMENT

SPRING BUSINESS MEETING OF THE COUNCIL OF DEANS
Fess Parker's Red Lion Resort
Santa Barbara, California

MINUTES

April 15, 1989
Third Business Meeting
10:45am-12:15pm

Presiding: William T. Butler, M.D.

I. CALL TO ORDER

William T. Butler, M.D. called the meeting to order at 10:45 a.m.

II. APPROVAL OF MINUTES

The Minutes of the Council of Deans Annual Business Meeting of Monday, November 14, 1988 were approved.

III. SMALL GROUP DISCUSSIONS REPORTS

Drs. George T. Bryan; Phillip M. Russe; and Henry P. Russe presented the following feedback on the contents of the small group discussions.

Student Recruitment, Issues of Lower Class Size: The Impact on Funding -George T. Bryan, M.D.

Dr. Bryan thanked Dr. B. Lyn Behrens for presenting the issues and providing the focus for discussion.

The conclusions represented are:

1. It is not and should not become the position of the Association of American Medical Colleges that schools should be closed or that class size should be reduced.

2. Individually and collectively, attention should be given to the issue of qualities. Deans and schools must assure the quality of the M.D.s graduated regardless of the applicant pool size and regardless of average MCAT and GPAs.

3. Reduction in class size will have some financial impact, but it is not and should not be insurmountable.

4. The current unwritten guideline for the transfer of students between medical schools for hardship cases only should be formalized and disseminated. As a correlator to that, although the LCME does not formally define class size, the process of accreditation does examine resources and the relationship of those resources to the number of students that matriculate and pass on through school.

5. The Association should sponsor a program to increase recruitment into medicine.

Issues in Hospital Affiliations - **Henry P. Russe, M.D.**

Dr. Russe noted the diversity of opinion among the various discussion groups. Observations on specific topics were:

1. Written documents. A number of schools are reviewing their affiliation agreements, some more than a decade or two old.

2. Goals. Affiliations have diverse goals. These include: increased prestige of the affiliated hospital and attempts to influence competition.

3. Governance. Aspects of governance related to who does it, how it gets done and how the affiliation relates to different situations.

4. Expense, Cost or Financing. Discussants noted financial benefits to some affiliations while in others they were a cost to the medical school.

The role of hospital competition in affiliations was discussed, as well as the potential of linking graduates of hospital training programs to the hospital.

The concept of affiliations between medical schools was also considered.
No specific recommendations for action were made by the discussion groups.

Issues in Graduate Medical Education - **Phillip M. Forman, M.D.**

Dr. Forman reported the issue of control or administrative leadership of programs was a common theme. Control was related to financing and the extent to which medical schools fund programs. The role of the ACGME was considered in some groups. One group reflected the frustration of many that organized and academic medicine have been unable to develop strategies to deal with issues of control over the number of residents and the number of programs in certain specialties. One group felt the AAMC needed to take a strong leadership role in this matter.

One group suggested a series of specific actions for the AAMC as follows. **The AAMC should:** determine the reasons for the decrease interest in primary care; support an increase in salaries for primary care residents; introduce formal programs to teach residents how to be teachers; develop positions on the ACGME's general requirements for graduate medical education to guide AAMC representatives to the ACGME; and evaluate the status of moonlighting and its impact.

One group identified definitional problems, finding conceptual agreement on what primary care was, but could not agree on who primary care doctors were and which doctors ought to be providing or did provide primary care.

IV. DISCUSSION OF "STRATEGIC PLANNING FOR THE AAMC" and LIBRARY OF MEDICINE PANEL ACTIVITY

Strategic Plan

John F. Sherman, Ph.D. noted that the Strategic Planning document distributed is the product of staff effort, discussion with the Association's officers at the December 1988 retreat and discussion with the Executive Council in February 1989. With one exception, it received general acceptance. The exception was the legislative proposals. Because of timing and the need for precise decision, that portion was endorsed as policy to give the staff and the governance the authority to proceed on current legislative issues.

The process by which the document was prepared was in response to John Colloton, then Chair of the Assembly, and Bob Petersdorf, in his first period as president, both of whom wished to formalize arrangements for reviewing programs and other activities of the Association. In particular, they wished to match in an integrated or comprehensive fashion the resources available to the Association to that which is required for ongoing or proposed activities. The effort was undertaken by the senior staff throughout calendar year 1988, using the mechanism of retreats, i.e. a series of meetings described as "advances" by Dr. Petersdorf. Three elements are contained in each proposed activity.

- **First**, an identification of those activities most closely allied with the objectives, roles, capabilities and needs of the Association and its constituents.

- **Second**, an appraisal of the feasibility for effective intervention.

- **Third**, a convergence of proposed activities with predictable resources. Those resources being identified as: financial, intellectual, and physical.

The several iterations during the twelve month period resulted in the present document. These components are somewhat predictable. The first effort was a review by the staff of the Association's Mission Statement which was substantially revised and adopted by the Executive Council, September 1988. From the Mission Statement derived the content of the Plan document. First is a series of strategic goals and a series of environmental assumption, followed by the legislative proposal and details on activities either underway or proposed for the foreseeable future and final incorporation into the document itself.

At the officers' retreat the elected leadership with the executive staff established the priorities for those activities identified earlier in the process which are included in the document.

The final part of the Plan is a series of major proposed initiatives listed on the last page of the document. That list is not in any priority order.

Comments on the Strategic Plan

1. Dr. Petersdorf reported on the process and its follow up. Quarterly meetings of the executive staff are planned to follow the various initiatives, charting progress the Association is making and where courses ought to be altered. Dr. Petersdorf emphasized that ultimately what we do is a responsibility of the people elected to govern the Association. It's not a "wild" Plan where the staff can march off in any direction it assumes. Rather, everything that involves money and almost everything does, or the raising of money, or the changing of priorities within the Association, does require approval by the Executive Council. We deal constantly with the Executive Committee and with the Executive Council so that new initiatives undertaken will be approved and modified by you.

Finally, as to the issue of graduate medical education and the discussion group's recommendation this morning, the staff is aware of those desires and needs. Dr. Swanson is going to concentrate specifically on the area of graduate medical education; it is the least accountable part of the medical education system. The AAMC has minor membership, along with AMA, AHA and other traditional parents in the American Board of Medical Specialties (ABMS); however, the ultimate controlling authority in the ABMS are the Boards themselves. The deans, vice presidents, hospital directors, and many other people are very concerned about the constant changing of requirements for board certification--not only changing but escalating. The changes are put forth under the rubric of improving and maintaining quality. Who can argue with quality? However, the changes are all expensive and the people who are proposing the changes are not paying the bill.

Dr. Petersdorf explained that the ACGME and its accreditation process is more accountable to the parents of the ACGME, i.e. AAMC, AMA and AHA. The Association has some degree of control. While the challenge from the deans discussion group to deal with graduate medical education is accepted, it is a very difficult area in which to affect change.

2. Dr. Petersdorf recognized that the legislative objectives are to a large extent reactions to what other people have initiated. However, there are a number of initiatives, e.g. getting some construction money back into the NIH budget. Let us know if any of these issues need special sustaining effort, special reaction to somebody else's effort, or in which we ought to be doing some rather elaborate planning, collaboration and other efforts to initiate activities that are good for the Association.

National Library of Medicine

Dr. Sherman reported when Medical Library Assistance Act revision of 1987 called for a special effort to publicize both the availability of services and the methods of access to them. The Library took the call very seriously and established a panel--Outreach Planning Panel--which met over a period of some months in 1988 and early 1989. It will publish a report shortly that goes beyond listing of services and describing the access to them. The panel is to examine the quality and nature of the services; make suggestions to the Library's Board of Regents for either expansion or modification of those services; and proceed with finding ways to make those services much more available than presently. The Board of Regents will issue a report about this effort. The Association will seek enough copies to distribute widely within its constituency. A better edition of **Grateful Med** developed for both students and faculty and the strengthening of regional medical library resources in information management, both locally and nationally, would seem good objectives for action. Dr. Sherman suggested the deans watch for the report and be prepared to react to its recommendations.

V. REPORT AND REQUEST FOR ACTION ON ISSUES IN SCIENCE MISCONDUCT, FRAUD AND CONFLICT OF INTEREST

Thomas E. Malone, Ph.D. reported the activities of the Division of Biomedical Research in this area.

- Legislative activities in the area of misconduct are under surveillance with Richard Knapp, Ph.D.

- The new organization proposed by the Department of Health and Human Services, the Office of Integrity at NIH, and the Office of Scientific Integrity Surveillance in the Public Health service are being monitored.

- The framework document approved by the Executive Council last June has been distributed. It represented an effort done conjointly with many other higher educational organizations in Washington, although much of the writing was done by the AAMC staff.

- Pink memos responding to the proposed rule making that codified the NIH interim policy of handling allegations of misconduct were sent out this past Fall.

Dr. Malone stated it is clear there will now be attention to the area of conflict of interest. The Wise hearings of this past September were summarized by Thomas J. Kennedy, Jr., M.D. and sent to you. Even before the Wise hearings, Dr. Sherman gave the AAMC ad hoc Committee on Misconduct instruction to look at conflict of interest. The increased concern over conflict of interest prompted extending the Committee's title to the "ad hoc Committee on Misconduct and Conflict of Interest." The committee is chaired by David Cohen, Ph.D., of Northwestern. Other members are: William T. Butler, M.D.; Joe D. Coulter, Ph.D; Ernst R. Jaffe', M.D.; Michael J. Jackson, Ph.D.; Douglas E. Kelly, Ph.D.; Max Poll; Spencer Foreman, M.D.; Robert E. Tranquada, M.D. The two committee hearings this year were both devoted to conflict of interest. The following are Division activities in this area:

- Conflict of interest policies in AAMC constituent institutions are being reviewed. Eighty-five institutions have responded; about a dozen are teaching hospitals. Of that number 64% have policies in place; 27% reported they have no such policies; and 9% of the responses were not decipherable. The policies are being analyzed according to a number of perimeters; are prevention and education activities included?; are disclosure forms used by the medical school?; how are issues of equity, consulting with industry, and research agreements handled?

- Drs. Eleanor Shore and Steven Atkinson from Harvard attended the February 1989 committee meeting. As a result of the Sane case, Harvard is re-examining its policy on conflict of interest because, clearly, it did not prevent the case. Some of the things Harvard will take into consideration in revising the policy are: consistency in policies among the medical school and affiliated hospitals--Sane obviously had multiple responsibilities; policy statements on permitted or not permitted activities; specificity of language. The new Harvard policy language will use **"must"** and **"will"** statements as opposed to **"should, or would"** statements.

- The Division plans to catalogue examples of procedures in this area. For example, at Baylor the "letter of appointment" is accompanied by the "conflict of interest policy." The new appointee attests through signature that they understand and have read that policy. Baylor also requires completion of a disclosure form. If there are problems, that information is sent to the department chairman or unit head. If there are indications of conflict of interest, the information goes to a committee which recommends action. At Baylor, industrial sponsors are required to disclose in writing any ongoing relationships that they have with faculty.

- The Committee, with the help of Drs. Shore and Atkinson identified some of the things such a catalogue may surface which will lead to a guidance document very much like the "framework document." Some of the elements in such a document include: how to handle the considerable educational and preventive measures; faculty responsibilities; policy implementation; the development and form of research agreements with industry; the nature, frequency and form of disclosures of financial holdings; conflict of interest that may exist

in the procurement process; use of graduate students in proprietary research; outside professional activities--consulting with industry; possibly the treatment of conflicts of commitment; applicable state and federal laws and procedures; and administrative arrangements that are in place or should be in place for handling conflict of interest; and the role of responsible officers or any type of committee structure.

At the moment a directive has been received from the committee to expand the analysis. The committee is not certain that a guidance document should be developed.

VI. OLD BUSINESS

None

VII. NEW BUSINESS

None

VIII. ADJOURNMENT

Dr. Butler thanked the Division of Academic Affairs staff for putting on an outstanding session in a fine hotel. Dr. Butler also thanked the participants and members of the Council for their active participation in a very productive meeting for all.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Future Meeting Dates

1989

October 27-November 2	AAMC Annual Meeting Washington, D.C.
December 13-15	AAMC Officers Retreat Aspen Institute, MD

1990

February 21-22	Executive Council/Administrative Boards Meetings Washington, D.C.
March 14-16	CAS Spring Meeting San Antonio, TX
April 3-7	COD Spring Meeting Sonesta Sanibel Island Resort Fort Myers, Florida
May 9-11	COTH Spring Meeting Boston, MA
June 27-28	Executive Council/Administrative Boards Meetings Washington, D.C.
September 26-27	Executive Council/Administrative Boards Meetings Washington, D.C.
October 19-25	AAMC Annual Meeting San Francisco, CA
December	AAMC Officers Retreat

1991

April 13-17	COD Spring Meeting Westcourt in the Buttes Tempe, AZ
November 9-14	AAMC Annual Meeting Washington, D.C.