



**association of american
medical colleges**

ISSUES FOR CONSIDERATION

**by the
Council of Deans**

A DISCUSSION PAPER

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Dear Colleague:

On the following pages you will find a brief description of the issues identified by the members of the Council of Deans as deserving consideration by the AAMC. This document represents the culmination of an iterative process involving the COD Administrative Board, the Council sitting as a body, and individual members of the Council who provided both written and oral contributions.

As the next step in this process, the Council of Deans' Administrative Board will be convened for a special session on the morning of September 12 for a discussion of these topics.

The COD issue identification and priority setting is being paralleled by similar processes underway in the Council of Academic Societies and the Council of Teaching Hospitals. It is my hope that the Association can fully exploit the potential that this extensive expenditure of energy represents to forge a consensus on its priorities as it prepares for the future it faces. Dr. Cooper's recent announcement of his intended retirement in 1986 adds a new dimension of the importance to this enterprise. I, therefore, call upon each of you to reflect on the matters contained herein, seek appropriate consultation and provide the Association with your best advice as we embark on the next stage of this process.

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Chairman, COD
August, 1984

COUNCIL OF DEANS - ISSUES IDENTIFICATION

Background

The past twenty years have been a period of remarkable growth for medical schools: the number of institutions has grown by 50%, medical school enrollments by 100%, and number of full-time faculty by 300%. Financial support of U.S. medical schools (1960-61 through 1981-82) has grown nearly 500 percent, from \$436 million to \$2,351 million. The proportion from tuition and fees has remained constant at six percent, while state and local support has risen from 17 percent to 22 percent. The most dramatic shift has been a rise in medical service income, from six percent to over thirty percent. Federal research support has dropped from 31 to 22 percent of the medical school budgets, while other Federal support has dropped from 10 to 6 percent.

The Graduate Medical Education National Advisory Committee (GMENAC) predicted that there would be a significant surplus of physicians in the U.S. by 1990 if current product rates were maintained. Under such assumptions, the physician to population ratio is expected to exceed 220 per 100,000 by that year, and to reach 247 per 100,000 by the year 2000. Levels in 1960 and 1978 were 141 and 171 per 100,000 respectively. While there is no universally agreed upon calculus by which need can be determined, it does appear that the large number of physicians being prepared is having an impact on the economics of medical practice and on both the geographic and specialty distribution of physicians.

Notwithstanding this dramatic growth of the U.S. capacity for providing medical education, ever larger numbers of U.S. citizens are enrolling in foreign

schools. While no direct figures on foreign matriculants are available, several indirect measures give some assessment of the magnitude:

- of the number of U.S. citizens who have graduated from foreign schools, those seeking certification through NRMP to enter graduate medical education in the U.S. rose from 860 in 1974 to 2,793 in 1982;
- In 1982, 1826 U.S. nationals then enrolled in foreign medical schools sought advanced placement in U.S. schools (1,337 of these came from seven proprietary schools located in Mexico and the Caribbean);
- The 1980 GAO Report estimated a foreign school enrollment of American nationals between 8,000 and 11,000.

The United States is now in a period of cost consciousness. Efforts are being made to restrain governmental outlays by statutes or regulations, by encouragement of competition or by straightforward budget cutbacks. Most notable, perhaps, is the effort to constrain the growth of Medicare expenditures through prospective pricing of hospital care for Medicare beneficiaries on the basis of statistically generated norms. This shift from retrospective cost reimbursement places new management imperatives on the hospitals and their medical staffs which, in turn, may place new constraints on the ability and/or motivation of the hospital to continue historic and traditional missions related to education, research, and provision of care to the indigent. The NIH's support does not appear as robust and dependable as in times past; programs for institutional support of medical schools have disappeared; and financial assistance for medical students has shifted sharply from scholarships and subsidized loans to government guaranteed loans at "market plus" interest rates.

The Issues

The issues facing deans and thus, the Council of Deans, in large measure, mirror these developments; the size, cost, and quality of the enterprise are uppermost on everyone's mind. In times of plentiful resources, objectives related to effectiveness predominate; in times of scarcity, efficiency considerations are in the ascendency. Thus, efficiency now appears to have gained the upper hand. But efficiency in service of trivial objectives is of no service to society nor does it contribute to the traditional missions of academic medicine. Thus, the first questions to be asked should be mission oriented. The one mission which characterizes all medical schools and academic medicine centers is undergraduate medical education.

Undergraduate Medical Education

The quality of undergraduate medical education was the subject of an entire day's discussion at the 1984 Spring Meeting; its enhancement is the objective of the GPEP project; its preservation is the principal object of the LCME (now considering a revised set of minimum standards).

Chief among the criticisms of medical education is the charge of information overload and the lack of an organized attack on the problem:

- Are we devoting sufficient attention to limiting the burden of unproductive short-term, fact memorization?
- Are we preparing students for independent learning to handle the accelerating growth knowledge from biomedical research?
- Are we developing appropriate conceptual tools and problem solving skills?

- Are we fostering high ethical standards and humanistic values?
- Is the faculty devoting adequate time to its academic responsibilities, particularly with respect to medical students?

Recruitment and Admissions

Some observers, focusing on the decline of the applicant pool, (from a peak of 42,624 in 1974-75 to 36,730 in 1982-83), anticipate a problem of recruitment to the medical profession. They cite a number of factors:

- perceptions of a loss of status of the profession;
- difficulty in financing an education;
- concern that a physician surplus will constrain practice opportunities and limit ability to repay sizable debts;
- fear that physician numbers will require a competitive life style, highly entrepreneurial and marketing oriented;
- observation that specialty choice may be constrained;
- alternate career paths that are competitively attractive and fulfilling.

Questions of sociologic and economic diversity of those entering the study of medicine persist. Many minority students have experienced both personal and financial difficulties in attempting this career and fewer students from under-represented backgrounds are selecting it, probably because of pragmatic considerations.

Are appropriate criteria and assessment instruments being used for admission decisions?

Size

How is it best to respond to perceptions that the academic medical enterprise is too large? too costly?

- What are the implications of reducing class size?
- How can program reconfigurations strengthen rather than weaken institutions?
- Are faculties larger than necessary or appropriate?
- Are faculty salaries simply a marketplace phenomena or is there merit to the notion that they should be examined and possibly adjusted up or down?

Financing

What are the implications of contemporary medical school financing being so heavily dependent on income derived from professional medical services?

Are hospitals and clinical faculty members overly preoccupied with financial matters at the expense of academic considerations?

Are faculty practice plans organized and operated in a way which best serves the academic mission of the institution?

Organization

Is the medical center organized in a way that both permits appropriate differentiation of responsibilities for patient care, research and education yet fosters adequate integration of these tasks to so that they can be accomplished effectively and efficiently?

Should school officials be evaluating new models of organization which reflect more explicitly the interdisciplinary nature of contemporary science?

Should an exploration of the larger task of the dean be undertaken: pulling together the pieces--finance, clinical practice, research and the health services organizations--to accomplish the institution's mission?

Graduate Medical Education

What kind of a process or mechanism or system can be developed to that assure all medical school graduates have an opportunity for graduate medical education?

Is the process of specialty selection and GME placement sound?

Has adequate account been taken of the threats to the current system of funding GME and the implications of alternatives being proposed?

To what extent is the experience of novel and experimental approaches to the organization and financing of GME programs being tracked and communicated?

Foreign Medical Graduates

Are there adequate screening mechanisms to prevent unqualified graduates of foreign medical schools from undermining the quality of medical care in this country? Of graduate medical education programs for which member institutions are responsible?

Has adequate consideration been given to the contending positions of those favoring relatively free access and those advocating tighter regulations and restrictions?

Licensure

Does the impending replacement of the National Board of Medical Examiners Examination by FLEX I and II pose the threat of unacceptable control of medical education by state licensing boards?

Quality of Care

With the current concentration on cost cutting strategies, is the adequacy of quality of medical care likely to become a major future issue?

- Are we appropriately positioned to assess quality?
- What indicators should be developed and monitored?
- What resources should be devoted to such tasks? How directed?

Research

Competition for research dollars is producing stresses which manifest themselves in various ways:

- Proposals for radical modification of the award system (e.g., the sliding scale proposal),
 - Invidious comparisons between the funding of intramural and extramural NIH,
 - Fissures between faculty and administration, government, academia and over indirect costs, and
 - Restricted availability of operating funds for research has reduced capital investments and compromised maintenance of the infrastructure.
- Are we adequately attending to the capital needs of the research enterprise?

Aside from funding, ethical issues related to the conduct of research are among the most prominent. Are the institutions appropriately positioned to deal with questions regarding:

- The probity of investigators?
- The treatment of human subjects of research?
- Of animal subjects?

With the prospect of increasing interconnections between industry and academic medicine, is there in place an appropriate culture, infrastructure or ethic to assure that the involvement assists, rather than detracts from, the ability of the medical centers to carry out fundamental missions? fundamental missions?

Proprietary Hospitals

Fourteen member medical schools have affiliation (or close) relationships with for-profit or investor-owned hospitals. In at least one case (University of Louisville), such a hospital is the school's primary teaching hospital; Creighton University has reached agreement in principle to sell its primary teaching hospital to an investor-owned corporation. Under current AAMC rules, these hospitals are ineligible for COTH membership. Should a mechanism be found for including such hospitals in the AAMC?

ROLE OF AAMC

With respect to each of the issues identified, the role of the AAMC needs to be assessed. Is there a role and of what should it consist? The COTH paper sets out the following framework for analysis:

"Associations of autonomous service and business entities, generally focus their activities on one or more of five goals.

Advocacy--the association works to advantage its members by obtaining favorable or avoiding unfavorable treatment from the environment in which it operates. Advocacy activities may be directed at the political process (legislative and executive) or at the private sector environment.

Economic--the association works to develop programs and member services designed to improve the efficiency and profitability of its members. Examples of such programs include group purchasing, standardized operating procedures, and multi-firm benefit and personnel programs.

Information--the association provides its members with a convenient and reliable network designed to furnish members with significant information on developments in the environment. To the extent that members are willing to share internal information with each other, the association provides a means of facilitating the exchange of "within member developments."

Education--the association develops educational programs specifically designed to meet the specialized needs of its members.

Research--the association develops an organized program to monitor the performance of its members, to develop methods or techniques which can be used by all members, and/or to identify early developments likely to affect the environment in which a member operates.

In most associations, each of these goals is present. Differences in associations seem to reflect differences in the emphasis given a particular goal and in the balance of activity across the five goals."

Governance of the AAMC and the COD

As a result of the Coggeshall Report, Planning for Medical Progress Through Education, completed in April of 1965, the AAMC was reorganized to formally involve teaching hospitals and academic societies in its governance. Thereupon, the old "deans club" was rapidly transformed into an organization with the specific objective of initiating continuous interaction between the leadership of all components of the modern medical center. This has led to the addition of two new Councils. One included over 400 chief executives from a diverse group of hospitals importantly involved in medical education, the other consists of representatives of over 70 academic societies--organizations involved in teaching, patient care and biomedical research--designed to provide a channel of communications for faculty members through their specialty perspectives. While much has been achieved as a result of this transformation, there have been costs as well. Perhaps chief among these has been that the deans' sense of personal involvement with their organization has been attenuated. Though the AAMC retained its name, and recognized the primacy of its medical school constituency by preserving a plurality of deans as voting members of the Executive Council, the increased number of interests and perspectives involved in policy making for the organization has led to a diminution of the sense of immediacy previous felt by the deans.

The 50 percent increase in the number of schools greatly added to the difficulty of the deans personally, and the AAMC as an organization in maintaining effective communications. But numbers alone were not the problem; increasing diversity added to the complexity as well. New schools consciously adopted non-traditional approaches to teaching, faculty, and relationships to hospitals. New interest groups were formed, as deans and others sought to discover colleagues who shared similar problems and to solicit help from others whose situation resembled their own.

The diversity of interests represented and the complexity of the issues required new integrating mechanisms, more bureaucratic procedures and sometimes intricate decision making processes. The multitude of environmental factors impinging on medical education, biomedical research and patient care, together with the rapidity with which developments occur required a full-time professional staff not otherwise occupied by responsibilities for managing institutions. Staff played an increasingly prominent role not only in coordinating the processes, but in identifying issues, analyzing their implications and proposing responses as well. On urgent matters, such as legislative developments requiring rapid response, the process often directly engaged only the Council's officers, some of the most directly affected members and/or those with possible legislative influence. The membership at large sometimes was unaware of the deliberations until after the decisions had been made, or they were asked to respond only after directions had been well established and there appeared little possibility of exerting significant influence.

Several specific strategies have been designed to advance the objective of assuring that the Council of Deans serves as the deans' professional society:

- The COD Spring Meeting with its mix of program, business and unscheduled time designed to facilitate maximum interchange among the deans.
- The establishment of the AAMC's Management Education Programs recently recast to emphasize the continuing education function of the program.
- The new deans "package" and orientation program.

Suggested approaches to enhance this objective are:

- A proposed new session at the annual meeting emphasizing dialogue and deliberation in contrast to routine business and reports.
- A new level of responsibility and accountability on the part of the Board members for communication with the membership as a whole.
- Acceptance of a greater level of responsibility on the part of Board members for the initiation of new Council members into the society.
- The strategy that more deans be invited to participate in the AAMC through task forces and committees and that there be increased interaction between AAMC staff and member deans.
- The Council of Deans Roster developed at the suggestion of the nominating committee as a means of assisting the membership in making informed decisions about the selection of the Council's leadership, should be expanded for use in the selection of task forces and committees and as a means of creating greater familiarity and communications among Council members. It was suggested that the roster include:

- the dean's specialty or discipline,
- outside organizations or activities, and
- areas of experience or expertise.

The deans should also be queried regarding AAMC activities in which they would like to become more deeply involved.

- The AAMC should explore the potential of modern information and communication technology to create more immediate and accessible channels of communication between the AAMC and its members and among deans themselves.

Issues:

- Are the affairs of the Council of Deans conducted so as to realize the goal of the Council serving as the deans' professional organization?
 - Are appropriate meeting sites chosen, issues identified, speakers selected, opportunities for effective dialogues offered?
 - Do appropriate mechanisms exist for involving the deans in AAMC issue selection and analysis? Policy setting deliberations?
 - Are the deans adequately informed of AAMC activities?
 - Are the deans adequately staffed and given support for their involvement in AAMC programs?
- Are there adequate mechanisms for each council to consider and evaluate the views of the other councils? To communicate its own views to the other councils?
- Are there ways to create a broader sense of participation in the policy setting activities of the AAMC?

- Is the CAS, which represents academicians in their specialty perspective, the best mechanism for involving medical school faculties in the AAMC deliberations? Is the perception that the CAS structure inevitably leads to a focus on faculty as clinicians or faculty as investigators, rather than faculty as educators, accurate?
- Should the AAMC have a more systematic approach to examining the horizon within which it is working? Should it consider educational programs for its members devoted to horizon scanning and interchange of perceptions regarding impending forces which will shape their futures?

AAMC Programs

- Are there new or expanded programmatic initiatives which the AAMC should undertake?
 - Would it be appropriate and feasible for the AAMC to engage in efforts to enhance faculty career development, such as providing traveling fellowships akin to those offered by the American College of Physicians and the American College of Surgeons?
 - Similarly, should the AAMC concern itself with career development for current or prospective deans or hospital administrators by offering programs similar to the Administrative Fellowships offered by the American Council on Education?
- Are there subjects which would lend themselves to exploration by membership task forces or committees? Examples might be follow-up activity related to the GPEP project, further consideration of the dimensions of the problems and issues related to foreign medical

graduates, or more focused topics such as the emerging role of computers in academic medicine.

- Are there issues which require that the AAMC develop new or different relationships with other organizations such as the AMA, the AAHC, or the Association of Professors of Medicine, for example?
- Are there issues or problems which call for the AAMC to engage in new or expanded data collection, analysis, projection or modeling activities?
It has been suggested, for example, that the development of a more realistic method of projecting future physician incomes would be of great service to members in counseling on student debt levels.
- Can the AAMC play a more active role in assisting its members to track local, state or regional issues?
- With respect to the AAMC as a whole, is there a proper balance between its various programs and activities?