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COUNCIL OF DEANS ACTIONS  
ON  
DISCUSSION GROUP REPORTS

APRIL 5, 1986

I. ATTRACTIVENESS OF MEDICINE AS A PROFESSION

A consensus of the reports of the discussion groups as distilled by the Administrative Board resulted in seven recommendations for Council action:

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

career and an academic endeavor. Our objective should be to better identify the problems, issues and the target populations to which attention should be directed.

5. The Medical School Admissions Requirement handbook should be revised, based on the insight gained from additional data analysis and surveys. Emphasis should be given to the chapter which describes the profession and opportunities in medicine. This material should be reprinted as a brochure to give to high school advisors and others who counsel students regarding the selection of medicine as a career.
6. All medical schools should analyze individual applicant pool data seeking negative factors that can be corrected and positive factors that can be emphasized in their local areas.
7. The AAMC as a national policy and schools individually, should emphasize the historic role of medicine as a socially responsible profession. Especially to be noted are opportunities to act as patients' advocates and the key role physicians can play in seeking to correct defects in the delivery system which allow inadequate health care for large segments of our population. As some groups put it, we should "seek the high road and accept as opportunity the challenges being made available in this changing health care world." Implicit is the development of appropriate sensitivity to the needs of underrepresented minorities in the profession and their role in the delivery of care.

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

- o On motion, seconded and carried, the COD requested each school to analyze its class size in reference to the size and quality of its applicant pool, and in reference to its ability to maintain high internal standards of education with the changing scene of the health care field. The COD declined to endorse the development of any Association position regarding physician manpower issues at this time.
  
- o On motion, seconded and carried, the COD unanimously requested that the Ad Board put in a prominent place on its agenda the issue of U.S. medical school faculties participating in, and thereby giving credibility to, foreign medical schools.

## II. INSTITUTIONAL RESPONSIBILITY FOR MEDICAL EDUCATION

The conclusions derived from the group discussions on this topic resulted in five points that could be labeled advice or recommendations and one recommended action item.

1. The dean is felt to be a key person in the implementation of institutional responsibility. As the chief executive officer, the personal priority and advocacy of the dean for medical education can have a strong positive influence on the school. It was suggested that the dean should establish out of his office a central resource unit to provide technical support for education and that there be some central funds available to encourage drive and reward the educational system. It was pointed out that the dean is able to express the high priority for education in the evaluation of the departmental chairmen, budget priorities, the many occasions he has to express his own attitudes and values, his charge to search committees, his own interviews with candidates for administrative and faculty positions, and his interaction with students.
2. It was felt that the call for more self-directed, problem-based learning in the medical curriculum is appropriate, but that its introduction might be most productive in interdisciplinary courses since it would increase the amount of faculty interaction across traditional departmental lines and a sense of faculty ownership of the curriculum activity outside of their own disciplines.
3. There was a call to rotate the primary responsibility for teaching from year to year so that in any one year fewer faculty are involved with the students and will know them better and be more sensitive to their learning needs. A major national student complaint is the "parade of stars."
4. Acknowledging the truth that the examination drives the system, there was a call for more "faculty examinations" as opposed to discipline examination. These would be examinations which would evaluate developing physician characteristics beyond the cognitive, which also would cross departmental lines and involve such things as problem-solving skills, technical skills, relating to patients, and other professionals and the ability to handle stress. If successfully done, this could unify the faculty in institutional concern about the total maturation of the student, rather than simply the cognitive conquest of the faculty's own discipline.

### III. INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

There is a developing consensus among medical school deans that a combination of forces will establish the need for medical schools to assume a larger role in the administration, coordination, and quality control of graduate medical education programs. A number of schools have already assumed this responsibility either by virtue of having direct fiscal control over the funding and distribution of residency positions or indirectly through the establishment of consortia or other forms of governance in which the dean's office has a major role. There is a strong sense that the assumption of more direct institutional responsibility for the conduct of GME programs could and should lead to the development of enhanced and improved coordination between the undergraduate and GME programs of a given institution.

It is also generally recognized and accepted that the ever increasing need to develop new modes of ambulatory care experiences and other forms of outreach educational endeavors will increase the dependency on the dean's office to play an increasingly influential role in graduate medical education. This situation will become more the rule as individual schools are placed in the position of assuring a greater share of the resource burden for the conduct of graduate medical education programs.

Three specific recommendations enjoy wide support and acceptance among members of the Council of Deans. They are:

1. Medical schools which have not already done so should begin developing mechanisms for assuming a larger share of the responsibility for the governance of graduate medical education programs. As a corollary to this recommendation, the AAMC role in graduate medical education should be expanded.
2. Medical schools together with their teaching hospitals should align themselves in a cooperative relationship to form a common organization which governs each school's graduate medical education programs.
3. The dean and hospital directors should be directly involved in every residency program review at their institutions.

It was apparent from the workshops and the business meeting of the Council of Deans that there are major concerns regarding two aspects of the institutional responsibility for graduate medical education about which a firm consensus does not exist. These are:

1. A Need for Improved Communication to the ACGME and Residency Review Committees

It is apparent that many deans are frustrated by policy decisions which are seemingly made in isolate by these important national bodies. Such decisions often impact on the integrity of a medical school's educational program or on the utilization of scarce resources available to support graduate medical education programs. Although it seemed neither reasonable nor feasible to increase COD representation to these bodies, a consensus developed which emphasized a need to better instruct the AAMC's representatives to the ACGME of its positions on those policy matters important to the organization and to develop a strategy designed to ensure continued representation from the AAMC to the ACGME by its appointees. This matter should probably be reviewed at regular periodic intervals by the Executive Council of the AAMC and the results of those deliberations should be reported back to the COD.

2. Some dean's recommended that a National Task Force composed of medical educators, teaching hospital directors, and representatives of industry and government should be appointed to evaluate the state of graduate

medical education in the United States and to recommend strategies for the future. Some thought that such a Task Force might parallel the composition of the GME Commission that was empaneled by Governor Cuomo in New York State. While support was expressed for this concept, an equal amount of concern was expressed about the consequences of such a Task Force. It appeared that this is a concept that requires further study and elaboration before it is ready for acceptance by the Council of Deans.



#### IV. TRANSITION TO RESIDENCY EDUCATION

The "Transition to Residency Education" topic was excellently introduced by Dr. Rosenberg, who summarized the problems and the issues and offered some possibilities for solutions. These remarks should be used as an introduction to the topic. The deans' discussions express deep concerns about the impingement of graduate medical education selection processes on the fourth year of medical education, and, on occasion, the third year as well.

The following recommendations were presented in the form of a resolution for adoption by the Council of Deans.

Be it resolved that,

- "1) All medical colleges through their deans, department chairpersons and faculty ensure the continuity and quality of medical education in the third and fourth year. This effort will include:
  - a) Dean's letters and transcripts will not be sent before October 1.
  - b) Core clerkships will occur only in their own institutions and electives will not be permitted to intrude on these clerkships.
  - c) Fourth year experiences will be carefully evaluated as to quality and balance of education.
  - d) Every effort will be made within each College for department chairpersons and residency program directors to give up independent match systems and informal actions about residency selections.
  
- 2) The AAMC will advocate to the LCME that the evaluation of these policies and practices in each College be included as an important

part of the accreditation processes (a must, not a should) for all medical colleges. Support from the AMA will be sought in establishing these criteria.

- 3) The AAMC will take the initiative in establishing an AMCAS-like system for residency application and selection.
- 4) The NRMP can and should manage the match for all applicants."

Additional suggestions from other groups include:

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

Most of the groups conceptualized the issues as educational ones related to the quality of education in the fourth year. As one group said, "the faculty must recapture the fourth year as a sound educational experience."

The following timetable was suggested. In their April and June meetings the Administrative Boards and the Executive Council of the AAMC should discuss and hopefully approve the resolution. The matter should be considered at the Fall meeting of the Association in its Assembly. Implementation should begin as soon as possible, but would occur with residents entering the first year of training July 1, 1988. The Council expressed the hope that the Committee on Graduate Medical Education recently appointed will include these sentiments of the COD in its deliberations and conduct its work expeditiously so that the above timetable can be accommodated.