association of american medical colleges

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

January 22, 1987
8:30 a.m.
Washington Hilton Hotel
MAP ROOM

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

COTH ADMINISTRATIVE BOARD

Chairman: Spencer Foreman, MD
Montefiore Medical Center

Chairman-Elect: J. Robert Buchanan, MD
Massachusetts General Hospital

Immediate Past Chairman: C. Thomas Smith
Yale-New Haven Hospital

Secretary: John E. Ives
Shands Hospital

Gordon M. Derzon
University of Wisconsin Hospital and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Jerome H. Grossman, MD
New England Medical Center

William H. Johnson,Jr.
University of New Mexico Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

Charles M. O'Brien, Jr.
Georgetown University Hospital

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

C. Edward Schwartz
University of Minnesota Hospitals and Clinics

Barbara A. Small
Veterans Administration Medical Center

AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

January 21-22, 1987	The Washington Hilton Hotel Washington, DC
April 15-16, 1987	Same
June 17-18, 1987	Same
September 9-10, 1987	Same

COTH SPRING MEETINGS

May 13-15, 1987	The Fairmont Hotel Dallas, TX
May 11-13, 1988	The New York Hilton Hotel New York, NY
May 10-12, 1989	The Hotel del Coronado San Diego, CA

AAMC ANNUAL MEETINGS

November 7-12, 1987	The Washington Hilton Hotel Washington, DC
November 12-17, 1988	The Marriott Hotel Chicago, IL
October 28-November 2, 1989	The Washington Hilton Hotel Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 21-22, 1987
Washington Hilton Hotel
Washington, DC

WEDNESDAY, January 21, 1987

6:00p	JOINT ADMINISTRATIVE BOARDS MEETING WITH CONGRESSMAN WAXMAN (D-CA) Jefferson East Room
7:00p	JOINT BOARDS RECEPTION AND DINNER Monroe West Room

THURSDAY, January 22, 1987

8:00am	JOINT BOARDS MEETING WITH MANPOWER PRESENTATION BY DR. THOMAS KENNEDY Jefferson West Room
8:30am	COTH ADMINISTRATIVE BOARD MEETING Map Room
12:00noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Georgetown West Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Georgetown East Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 22, 1987
WASHINGTON HILTON HOTEL
Map Room
8:30a-12:00noon

I.	CALL TO ORDER	
II.	CONSIDERATION OF THE MINUTES	Page 1
III.	REPORT FROM AAMC PRESIDENT, DR. PETERSDORF	
IV.	ESTABLISHMENT OF A JOINT AAHC/AAMC FORUM	Executive Council Agenda-Page23
V.	AAMC POSITION ON NBME SCORE REPORTING	Executive Council Agenda-Page 30
VI.	IMPENDING NEW YORK LEGISLATION AND THE NBME	Executive Council Agenda-Page 33
VII.	FINAL REPORT FROM THE TRANSITION COMMITTEE	Executive Council Agenda-Page35
VIII.	TREATMENT OF RESIDENTS AND FELLOWS FOR GSL DEFERMENTS	Executive Council Agenda-Page 53
IX.	HEALTH MANPOWER INITIATIVES	Executive Council Agenda-Page-57
X.	TAXATION OF UNRELATED BUSINESS INCOME	Executive Council Agenda-Page 58
XI.	NEW BUSINESS	
XII.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 11, 1986

PRESENT

C. Thomas Smith, Chairman
Sheldon S. King, Immediate Past Chairman
Spencer Foreman, MD, Chairman-Elect
Robert J. Baker
J. Robert Buchanan, MD
Gordon M. Derzon
Gary Gambuti
John E. Ives
Larry L. Mathis
Eric B. Munson
Charles M. O'Brien, Jr.
Raymond G. Schultze, MD

ABSENT

James J. Mongan, MD
Barbara A. Small
AHA Representative

GUESTS

Richard Janeway, MD
Edward J. Stemmler, MD
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD
James B. Erdmann, PhD
Robert Jones
Richard M. Knapp, PhD
Sonia M. Kohan
Robert G. Petersdorf, MD
Nancy E. Seline
John F. Sherman, PhD
August G. Swanson, MD
Judith L. Teich
James Terwilliger
Kathleen Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING MINUTES

September 11, 1986

I. CALL TO ORDER

Mr. Smith called the meeting to order at 8:00a in the Map Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the June 18-19, 1986 COTH Administrative Board meeting.

Before moving directly to the agenda, Mr. Smith reminded Board members that this would be the last meeting of the Board as it was presently constituted. He indicated that the Board would not have a breakfast meeting in New Orleans as has been the custom in the past as it is not believed to be necessary.

As indicated, Jim Mongan, MD has agreed to chair the COTH Spring Meeting Planning Committee for the 1987 COTH Spring Meeting which will be held in Dallas, May 13-15. Serving on that committee with Dr. Mongan will be Paul Griner, MD, Strong Memorial Hospital, Rochester, NY; David Hitt, Methodist Hospital, Dallas; Delanson Hopkins, Rhode Island Hospital, Providence; Barabara Small, Veterans Administration Medical Center, San Diego; and Michael Stringer, University of California Medical Center, San Diego. The committee will be meeting on November 10. If Board members have any recommendations, it was suggested they contact Dr. Mongan as soon as possible.

In the August 15 Board memorandum announcing the September meeting, Board members were reminded that John Reinertsen serves as a member of the Professional and Technical Advisory Panel of the Hospital Accreditation Program of the JCAH. Before adjournment, the Chairman indicated that he hoped the Board would briefly discuss problems that institutions may be having with any aspect of the hospital accreditation program.

Mr. Smith introduced Jim Terwilliger, a staff associate in the Department of Program Planning and Policy Development; and Sonia Kohan, a new member of the staff of the Department of Teaching Hospitals. Sonia is a native of Johnstown, PA, who earned a BS from Penn State and recently was awarded a Master's Degree from the Health Systems Management Program at Rush University in Chicago. She joined the department as an Administrative Fellow on July 15, 1986, and Mr. Smith asked that each Board member welcome her to the group.

III. DISCUSSION WITH THE AAMC PRESIDENT

Mr. Smith welcomed Dr. Petersdorf to the COTH Administrative Board meeting, and indicated the group's pleasure at having the opportunity of an introductory discussion with him. Dr. Petersdorf expressed his pleasure at being selected to serve as the AAMC President and indicated he had some general observations that he would like to share with the group, and then answer questions or listen to observations that members of the Board might have. The following points summarize his presentation:

- The Council of Teaching Hospitals presently has four of 21 members of the AAMC Executive Council. He indicated that the matter of equity and governance of the AAMC for all constituent bodies was an item to which he was giving attention. The matter needs to be approached sensibly and with sensitivity.

- There is a need to find a way to involve house officers in the AAMC organization. This is probably an activity which would best be served by an organizational relationship to the Council of Teaching Hospitals.

- The relationships of the various groups (e.g., Group on Public Relations, Group on Business Affairs, Group on Medical Education, etc.) to AAMC councils and their staffing within various departments of the AAMC does need to be re-examined.

- Jim Bentley has been made a member of the AAMC Executive Staff.

- Graduate medical education funding issues are responsibilities that rest firmly with the constituents and Board of the Council of Teaching Hospitals. Different ways need to be found to meet the service responsibilities currently met by the housestaff, and resistance needs to be forthcoming in the constant requests of chiefs of service for more house officers.

- In an effort to ascertain the views of the constituents with regard to the current and future mission of the AAMC, a survey questionnaire will be sent to all constituents. They will be asked what they do and do not consider worthwhile, what might be done in addition to current services, and what services might not be needed.

- There appears to be no medium range plan of what the Association hopes to accomplish on a three to five year basis. There is some question as to whether or not one can have such a plan if the major focus of the organization is on affairs in Washington, DC. An effort will be made to formalize a visitation program to member institutions to be sure the "Washington mentality" does not dominate the thinking of the staff. An effort will be made to determine whether or not a medium to long range planning document would be a useful project to undertake.

The following questions were raised:

- What is the current and future thinking with regard to the relationship with the Association of Academic Health Centers? This is a "tricky" issue on which the staff and the leadership are working. It is very important, and every effort will be made to bring the two organizations closer together.

- Is any consideration being given to changing the name of the organization? Probably the name that would best suit this organization is the Association of Academic Health Centers; however, that name is already in use. The Association of Academic Medical Centers gives a decisively medical orientation to the organization, and might not be much of an improvement over the current Association of American Medical Colleges.

- The role of the housestaff in the organization was identified. Is any similar role being considered for purposes of doctoral candidates in the basic sciences disciplines? This is a good suggestion which should be given some consideration.

- The wide variety of organizations, particularly in the Council of Teaching Hospitals, and the fact that many of them do not feel a strong allegiance to the organization, suggests the possibility that a subset of councils or a regional council or organization might be a useful exercise to get closer to the membership. Is any consideration being given to such structural change? There is a tradeoff here between an organizational approach and fragmentation of the organization and its decision making process. Perhaps a better way to approach this issue might be to identify particular staff members who exhibit expertise with respect to the particular kind of subsets of the organization to which the question refers.

- How would you characterize current reltationships with the American Hospital Association and the American Medical Associaton? Relationships with both these organizations appear to be very good. Settings have arisen where Carol McCarthy from the AHA has been present at meetings where AAMC staff has also been present; the staff has excellent relationships with the staff of the American Hospital Association. Meetings have been arrnaged with Jim Sammons, MD, and Roy Schwartz, MD and relationships with these two individual are being developed carefully and hopefully improving. There will be those occasions when disagreements arise, but efforts will be made to work them out quietly with as little public display as possible.

- Has any thought been given to the organizational location or representation of faculty practice plan issues and those individuals who are responsible for faculty practice plans? That is an excellent question and an important issue. It will be addressed, but how this group will be represented or where best to place this responsibility is not yet clear.

- Is there a role for the AAMC in international medical education? There was at one time a Division of International Medical Education within the AAMC. That division no longer exists. The organization has been pursued many times for staff time and financial contributions to various international medical education efforts. Kat Turner has been responsible for some recent efforts in that regard, and while efforts will be stepped up a bit, it is not an item which will be on the front burner of the AAMC agenda in the immediate future.

Mr. Smith thanked Dr. Petersdorf for his thoughts and his candor.

IV. AMBULATORY CARE TRAINING ACT

The Board was asked to consider what position the AAMC should take regarding a bill introduced by Senator Kennedy entitled the Ambulatory Care Training Act of 1986. A lengthy description of the bill, the AAMC's previous positions on similar proposals, and the questions to be considered by the Board were provided in the Executive Council agenda. Dr. Knapp began the discussion by noting the item in the Executive Council agenda and asking if the Board members had any questions regarding its content. There being none, the Board proceeded to discuss the five questions and the overall strategy problem summarized at the end of the agenda item. These questions were:

- Whether funding for residents in the ambulatory care setting should come through the teaching hospital?

- Whether the AAMC should support a weighting system which differentially supports residents entering various specialty programs?

- What the AAMC's reaction should be to the publication of data on the amount of Medicare funds paid to each institution for graduate medical education?

- What the AAMC's position should be regarding the elimination of Medicare payment for foreign medical graduates who had not passed the FMGEMs exams, but who had been previously certified by the ECFMG?

- What the AAMC's position should be regarding the proposed linkage between the reduction in the payments for the Medicare direct medical education passthrough and the reduction in the count of residents used in the calculation of the indirect medical education adjustment?

The overall strategic question that the Board was asked to address was whether or not the AAMC should support any change in graduate medical education payments at this point, given the advice from many key congressional staff members that the very healthy financial positions of teaching hospitals might lead to cutbacks in their payments if new proposals were introduced.

The Board took up each question in order. On the first question, it was agreed the teaching hospital had long served as the source of funding for residency training. By retaining this single primary source of funding, the hospital retained central control over the quality of the education provided in the nonhospital-based training settings. There was a consensus that residents in ambulatory care settings, regardless of whether those settings were otherwise affiliated with a hospital, could be paid for and should be paid for, from teaching hospital revenues.

With respect to the weighting system contained in the proposed bill, it was noted that there were no disincentives proposed but that the introduction of a weighting system could lead to inclusion of disincentives (or negative weights) in the future. In addition, there was opposition to federal government intervention into the types of training programs conducted by each hospital, believing that each hospital should determine what types of residency training programs were best suited for the patient population for which it was providing care. Finally, there would need to be a clear consensus on the objectives the incentives were to serve if those incentives were to be supported. Therefore, the Board opposed the weighting system proposed in the bill.

The proposed publication of hospital-specific information regarding Medicare payments for graduate medical education was discussed briefly by the Board in light of remarks made the previous evening by Dr. William Roper, administrator of the Health Care Financing Administration. Dr. Roper had indicated that he believed the public deserved more information, including mortality/morbidity rates of various institutions, and price and payment information available from the Health Care Financing Administration. It was agreed that publication of most types of information and data, including education cost payments, is not something the AAMC can responsibly oppose. However, it was recommended that it would be appropriate for the members of the Council of Teaching Hospitals to be made aware that such publication was likely, regardless of whether the Kennedy bill was passed or not. The Board also believed that the AAMC should not take a new position with regard to funding for foreign medical graduates.

The AAMC's traditional position has been to oppose Medicare funding for all foreign medical graduates. No change in this position was thought to be appropriate for the foreign medical graduates who had been certified by the ECFMG but had not passed the FMGEMs exam. The Board understood that some might raise the argument that the proposal was unfair since the FMG's in question had met all of the criteria for certification when they had taken the exam, and that this would represent an ex-post-facto change of rules.

There was a lengthy discussion regarding the proposed linkage between the counts for the direct and indirect medical education payments. There was some confusion as to why there should be a difference in the two counts and why such a difference should be supported. Dr. Foreman clarified that the intent of the direct medical education payment was simply to pay for the allowable stipends and benefits received by the housestaff as well as the allowable faculty salaries and the other administrative costs of the residency training programs, but that the indirect medical education adjustment was a proxy factor for severity of illness of the patients in a teaching hospital and a whole host of other factors which were somewhat related to the fact that the hospital conducted residency training programs. Ms. Seline and Dr. Bentley provided further clarification regarding the separable purposes of the direct and indirect medical education adjustments and went on to explain that the purpose served by the direct medical education adjustment required that residents be counted as prescribed by the rules set forth under the Consolidated Omnibus Budget Reconciliation Act, which allowed full payment for residents up to their initial residency training period plus one year (with a maximum of five years) and after a transition year, half payment for residents in their advanced training years. However, the indirect medical education adjustment was intended to measure characteristics of the institution, not to influence the types of residency training programs established by the hospital. In measuring those characteristics, HCFA counted all of the residents and fellows present in the institution in 1982, and incorporated all of those residents into the determination of the regression analysis which produced the formula used to pay the adjustment. Since all residents were incorporated into the determination of this formula, which is merely a proxy variable, the Board believed it was appropriate to continue to count all of those residents in the "pay out" of the indirect medical education adjustment. The Board had taken a similar position in 1985 when the proposed reductions in payments for direct medical education would have curtailed payments for residents in the sixth and seventh year of training or their second year or beyond for fellowship training. Thus, this position was merely an extension of the Board's previous position.

In considering the overall strategy question, Dr. Knapp made the Board aware of advice that the AAMC had been given in the spring of 1986 from key staff members of the House and Senate committees. Those key staff members had indicated that the AAMC's members were particularly vulnerable to cuts in payments as a result of the Inspector General's report indicating large profits in teaching hospitals. The staffers believed there would be little sympathy for teaching hospitals during the policy debates. Their advice was to keep teaching hospital issues from being raised. If an issue was brought to the table, even an issue such as the Ambulatory Care Training Act in which there was both a positive and negative side, it was probable the negative provision would be enacted but the increases proposed would be rejected. In following that advice, the AAMC staff has acted to keep the AAMC out of the limelight in pertinent discussions,

believing that if the Congressmen and Senators are not forced to think in particular about teaching hospitals for one proposal or another, they will not be inclined to make specific cuts that will harm teaching hospitals. The AAMC has thus resisted attempts to move the bill forward. Notwithstanding the AAMC's resistance, the bill was drafted by Dr. Reiselbach (an IOM fellow working in Senator Kennedy's office) and introduced by Senator Kennedy, and it received immediate support of Senators Heinz and Hatch. The Association of Academic Health Centers upon seeing the bill sent out a fairly positive statement describing the bill. For this reason, the bill has received some attention, and is likely to receive more attention within the academic medical community as Dr. Reiselbach contacts various groups of individuals and others involved in the academic medical community and asks for support of this proposal.

V. THE MEDICARE DIRECT MEDICAL EDUCATION PASSTHROUGH AND THE INDIRECT EDUCATION ADJUSTMENT: FUTURE ISSUES

Dr. Bentley opened the discussion about possible proposals to change Medicare funding of direct medical education payments and the indirect medical education adjustment. For the direct payment, responses to an AAMC survey by 110 COTH members were used to demonstrate the large variation present in hospital costs per resident. The staff is concerned that this variation will be used by the Administration and perhaps Congress to set limits on GME payments. For the indirect adjustment, continuing increases in the case mix indices for teaching hospitals are expected to result in proposals to recalculate downward the percentage used for the indirect adjustment. With no Administrative Board meeting scheduled until January and with HCFA and congressional staff developing proposals, AAMC staff sought guidance from the Board on appropriate AAMC positions.

The Board first directed its attention to the direct medical education payments and the variation in allowable costs per resident. Messrs. Gambuti and Baker stated their view that much of the variation represented efforts to maximize reimbursement. Dr. Foreman expressed two concerns: first, that the available AAMC data was confounded with errors and; second, that an effort should be made to understand the reasons for the variations before taking any policy position on them. Without disagreeing with Dr. Foreman, Dr. Buchanan noted that if CBO finds similar variation in costs per resident, the AAMC should not jeopardize its reputation by defending absolutely the variation in costs per resident. Mr. Munson supported the need for credibility and noted the discussion of the variation had not been shared yet with the membership. Mr. Baker suggested it might be possible to go on the offensive by defining a standard for the cost of graduate medical education. This suggestion stimulated a discussion of the variation in faculty salaries paid to support GME. Mr. Smith noted this variation might be locally necessary, and was technically allowable; however, the payer was beginning to view the variation as unacceptable. Dr. Buchanan observed that the responses from COTH members were clustered with a number of "outliers." Dr. Foreman agreed this was true for the presented data but opposed accepting the mean or median as an appropriate cost just because it was a statistical average. The Board consensus was that the AAMC should alert its COTH members to the variation in costs per resident and suggest "bench marks" that hospital CEO's could use to assess their hospital's vulnerability to payment limitations. The Board encouraged staff to work with HCFA and CBO staff in order to explore the factors contributing to the variation in costs per resident.

The discussion of the indirect adjustment was quite brief with Board members taking the position that the AAMC should hold to its present policy that the adjustment is an empirically determined value which will change as other factors in the system change. To ensure that COTH members understand the causes of further decreases in the indirect adjustment, the Board urged staff once again to alert COTH members and explain what lies ahead.

VI. THE COMMONWEALTH FUND GRANT TO ANALYZE TEACHING HOSPITAL DATA

During the summer, The Commonwealth Fund approved a three-year grant to the AAMC to assemble, analyze, and publicly report data on teaching hospitals and the impacts of alternative public policies on them. Jim Bentley briefly summarized how the grant grew out of the efforts of the Commonwealth Fund Task Force on Academic Medical Centers and outlined the approach anticipated for the project.

VII. REPORT ON ISSUES BEFORE THE ACCREDITATION COUNCIL ON GRADUATE MEDICAL EDUCATION

Dr. Foreman and Mr. Munson delivered a report on the five issues currently before the Accreditation Council on Graduate Medical Education (ACGME). These issues are:

1. Resident Stipends and General Essentials: Page 2 of the General Requirements section of the Essentials of Accredited Residencies was modified by the addition of a sentence under "Facilities and Resources" which reads, "Further, financial support of residents is necessary to assure that residents are able to fulfill the responsibilities of their educational programs." This change was ratified by the Committee on Structure and Functions; it was accepted instead of suggested language which would have made the issue of financial support an essential for accreditation.

2. Fees/Reserves: The issue concerns the size of the reserves the ACGME should have. Currently, there is a reserve of approximately three months of the annual operating budget. The American Board of Medical Specialties (ABMS) feels that this reserve should be closer to 8-12 months. Dr. Foreman and Mr. Munson expressed their feeling that a three month reserve is sufficient for the ACGME's purposes. Dr. Foreman stated that the ACGME has unlimited "tax" authority in that institutions must pay for surveys, so that it does not need huge reserves.

3. Performance of AMA as ACGME contractor: Dr. Foreman and Mr. Munson stated that there is dissatisfaction with the AMA's performance, and that the means of evaluating this performance are insufficient. There is "mounting dissatisfaction" with the quality of staff support; the American Hospital Association appears to be the most dissatisfied. The quality of staffing provided by the AMA apparently does not compare favorably to that provided by the AAMC; the capabilities and quality of the AAMC staff are more highly regarded.

4. Malpractice Insurance and General Essentials: The Committee on Structure and Functions considered a request submitted by the Council on Medical

Education of the American Medical Association to revise the General Requirements with regard to professional liablity coverage for residents. The Committee decided to reconsider the matter at its next meeting after staff has had an opportunity to conduct additional research into the legal ramifications of the concerns raised during the Committee's discussion.

5. Anesthesiology 4th Year: Mr. Munson reported that this proposal passed eight to seven.

VIII. NIH CENTENNIAL CELEBRATION

Dr. John Sherman reported that the National Institutes of Health will be observing the 100th anniversary of the establishment of the Hygienic Laboratory of the Marine Hospital, Staten Island, its predecessor agency in the federal government for medical research. The centennial celebration events will occur over a year-long period beginning October 1, 1986, and the Centennial Committee is seeking contributions to defray the costs of the centennial observances.

The AAMC Executive Council approved a donation of $5,000. to the NIH Centennial Committee, and adopted a resolution honoring the NIH Centennial. Dr. Sherman also reported that there will be special recognition of NIH at the AAMC Annual Meeting in New Orleans in October.

IX. CALIFORNIA BALLOT PROPOSAL

Dr. John Sherman reported on an amendment to the November 1986 California ballot which proposes a ceiling of $64,000 for salary and fringe benefits on employees of the State of California. The amendment offers a provision to establish the governor's salary at $80,000./year; all other state salaries would be tied to this and would be limited to 80% of that figure ($64,000.). The amendment would also not permit sick leave or annual leave to be carried forward to the next year.

Discussion centered on the potentially devastating effects which this amendment would have on medical education, biological research, and patient care throughout the state of California. If the amendment is enacted, it is estimated that 90% of the faculty of the state medical schools would suffer significant reductions in income. Although the amendment contains a provision that could be used to exempt select classes of employees, the exemption would require a two-thirds roll call vote of the legislature.

Dr. Schultze and Mr. King pointed out that although many organizations are opposed to the amendment, the electorate may not be sufficiently aware of its implications and may not be taking it seriously enough. A coalition of concerned individuals and organizations has been established to fight proposition 61, and seems to be gaining momentum in gathering support to oppose the amendment. Dr. Schultze also reported that a group at the University of California at Los Angeles is participating in a "doomsday" exercise to study the possible effects of the amendment and potential responses to it, such as "privatizing" the University of California.

AAMC staff recommendations concerning this issue were: 1) a letter from the AAMC to the coalition deploring the potential consequences of the amendment, and 2) the coalition request for a financial contribution to the campaign be declined.

ACTION: It was moved, seconded, and carried that the above staff recommendations be adopted.

X. AAMC POSITION ON NBME SCORE REPORTING

At its June meeting, the Executive Council voted that the AAMC should use its influence to encourage NBME to report scores on a pass/fail bais only to both students and medical schools. This action was taken after the issues was brought to the Council's agenda under new business. Several individuals expressed concern that there had not been adequate debate or discussion of the subject and that proper procedure had not been followed. As a result, Dr. Virginia Weldon requested action on whether the Executive Council should reopen this issue for further discussion and another vote.

ACTION: It was moved, seconded, and carried to recommend the Executive Council reopen this issue.

XI. ADJOURNMENT

Prior to adjournment, the Chairman reminded the Board that the COTH staff suite at the Annual Meeting in New Orleans will be open late afternoon and early evening on Sunday, October 26. Individuals should feel free to stop by and bring a friend. The suite number has not been assigned as yet but will be under Dick Knapp's name. Also, there will be a reception at 5:00p, Monday, following the COTH General Session. The Chairman urged that those Board members who had not yet registered for the Annual Meeting do so.

The Chairman indicated that it had been a pleasure to serve as Chairman of the AAMC Council of Teaching Hospitals Administrative Board for the past year. Dr. Buchanan, on behalf of the Administrative Board, expressed thanks to Mr. Smith for his excellent leadership throughout the year. There being no further business, the meeting was adjourned at 11:45a.