AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW
WASHINGTON, DC 20037-1126
TELEPHONE: (202) 828-0400



# ORGANIZATION OF RESIDENT REPRESENTATIVES

# ADMINISTRATIVE BOARD AGENDA

## FEBRUARY 26-27, 1992

## WASHINGTON, D.C.

Directions and notes:

Hotel accommodations will be provided at the Washington Hilton and Towers, 1919 Connecticut Avenue, NW, Washington, D.C. The hotel is located a short taxi ride from the Washington National Airport. For those members arriving at Dulles airport, there is a shuttle service (Washington Flyer) that will take you to downtown Washington. The hotel is a short cab ride away from the shuttle station.

The joint OSR/ORR reception and dinner will be held at the AAMC headquarters building, 2450 N Street, NW, Washington, D.C. in conference room 130. The conference room is located on the first floor.

The ORR administrative board will meet at the AAMC headquarters building in conference room 128. Please stop at the concierge desk when you arrive at AAMC and she will direct you to the conference room.

The AAMC offices are located a short cab ride from the Hotel. Taxis should be readily available from the Washington Hilton. Please try to share a taxi ride with other ORR board members in order to save energy and our budget! For those of you who prefer to walk, the AAMC office is a twenty-minute walk from the hotel. Please call me for directions. I would not recommend anyone walking alone at night.

The joint boards reception and dinner will be held at the Washington Hilton. The joint boards session and lunch on Thursday will also be held at the hotel.

Please call me if you have any questions or need additional information.

Look forward to seeing you next week!

**Association of American Medical Colleges**
**Organization of Resident Representatives**
**Administrative Board Meeting**

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| Tuesday | | |
| Joint OSR/ORR reception | AAMC headquarters,<br>2450 N Street NW<br>conference room 130 | 5:00-5:45 p.m. |
| Joint OSR/ORR dinner | AAMC headquarters,<br>2450 N Street NW<br>conference room 130 | 5:45-7:00 p.m. |
| Wednesday | | |
| Call to order | AAMC headquarters,<br>2450 N Street NW<br>conference room 128 | 8:00-8:45 a.m. |
| Approval of November, 1991 minutes | | |
| Report of Officer's Retreat | Bernarda and Joseph | |
| Report on the Generalist and Health Care Reform Task Forces | Michelle Keyes-Welch | |
| Summary of AAMC reorganization | Michelle Keyes-Welch | |
| Discussion of proposed bylaws | | 8:45-10:15 a.m. |
| Break | | 10:15-10:30 a.m. |
| Orientation to AAMC | | |
| Group on Public Affairs and Saving Lives | Joan Hartman Moore<br>Director<br>Section for Public Relations | 10:30-11:00 a.m. |
| Division of Biomedical Research | Thomas Malone, Ph.D.<br>Vice President<br>Division of Biomedical Research | 11:00-11:30 a.m. |
| Liaison Committee on Medical Education and accreditation | Donald Kassebaum, M.D.<br>Vice President<br>Division of Educational Research and Assessment | 11:30-12:00 p.m. |
| Lunch | | 12:00-1:00 p.m. |

(Kenneth Shine, M.D., Chair of the Council of Deans and Dean of UCLA School of Medicine will join the ORR for lunch. Dr. Shine will brief the administrative board on the activities of the COD.)

| | | |
|---|---|---|
| Council of Academic Societies | S. Craighead Alexander, M.D.<br>Associate Dean for Affiliated Institutions<br>Hahnemann University<br>Chair-elect, CAS | 1:00-1:30 p.m. |
| Section for Resident Education | Joyce Kelly, Ph.D.<br>Associate Vice President<br>Alison Evans, Research Assistant<br>Division of Clinical Services | 1:30-2:00 p.m. |
| Council of Teaching Hospitals | | 2:00-2:30 p.m. |
| Academic publishing and Academic Medicine | Addeane Caelleigh<br>Editor<br>Academic Medicine | 2:30-3:00 p.m. |
| Division of Minority Health, Education and Prevention | Herbert Nickens, M.D.<br>Vice President<br>Division of Minority Health, Education and Prevention | 3:00-3:30 p.m. |
| Legislative Update | Mary Beth Bresch White<br>Legislative Analyst<br>Office of Governmental Relations | 3:30-4:00 p.m. |
| Women in Medicine | Janet Bickel<br>Assistant Vice President for Women's Programs | 4:00-4:30 p.m. |
| Continued discussion of bylaws | | 4:30-5:30 p.m. |
| Adjourn | | 5:30 p.m. |
| Return to hotel, leisure time | | 5:30-6:30 p.m. |
| Joint boards speaker | Burton Lee III, M.D.<br>Physician to the President<br>Washington Hilton, Hemisphere room | 6:30-7:30 p.m. |
| Joint boards reception/dinner | Washington Hilton<br>Monroe room | 7:30-9:30 p.m. |

Thursday

| | | |
|---|---|---|
| Joint boards breakfast and speakers | Washington Hilton<br>Lincoln East room | 7:00-9:00 a.m. |
| | Robert G. Petersdorf, M.D.<br>President<br>Association of American Medical Colleges | |
| | Senator Dale Bumpers (D-AR) | |
| Return to AAMC headquarters for ORR administrative board meeting | | 9:00-9:30 a.m. |
| Identify topics for discission at 1992 meetings | | 9:30-11:30 a.m. |
| Interest in ORR newsletter | | |
| Correspondence from Neil Parker, M.D., Barbara Tardiff, M.D., Laurel Leslie, M.D. | | |
| Questions and answer session | | |
| Concurrent meetings: | | |
| Bernarda Zenker, M.D. report to the Council on Academic Societies | | 10:00-10:15 a.m. |
| Bernarda Zenker, M.D. report to the Council of Teaching Hospitals | | 10:15-10:30 a.m. |
| Bernarda Zenker, M.D. report to the Council of Deans | | 10:30-10:45 a.m. |
| Adjourn ORR administrative board meeting | | 11:30 a.m. |
| Return to hotel for joint boards luncheon | | 11:30-12:00 p.m. |
| Joint Boards luncheon | Washington Hilton<br>Hemisphere room | 12:00-1:00 p.m. |
| Return to AAMC headquarters for Executive Council meeting (shuttle bus provided) | | 1:00-1:30 p.m. |
| Executive Council Meeting | AAMC Headquarters<br>conference room 130 | 1:30-3:30 p.m. |

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

# PROCEEDINGS
# OF THE
# ORGANIZATION OF RESIDENT REPRESENTATIVES

**NOVEMBER 9-10, 1991**
**WASHINGTON, D.C.**

**Organization of Resident Representatives**
**November 9-10, 1991**

## Participants

Reid Adams, M.D.
General Surgery
University of Virginia Health Sciences

Peter Anderson, M.D.
Otolaryngology
Oregon Health Sciences University

Joseph Auteri, M.D.
Thoracic Surgery
Columbia-Presbyterian Medical Center

Natalie Ayars, M.D.
Psychiatry
UCLA Neuropsychiatric Institute

Dai Chung, M.D.
General Surgery
University of Texas/Galveston

John Comerci, M.D.
Obstetrics and Gynecology
St. Barnabas Medical Center (NJ)

Denise Dupras, M.D., Ph.D.
Internal Medicine
Mayo Graduate School of Medicine

John Fattore, M.D.
Plastic Surgery
Massachusetts General Hospital

Carl Gold, M.D.
Anesthesiology
Boston University Medical Center

Cathy Halperin, M.D.
Obstetrics and Gynecology
Rush-Presbyterian-St. Luke's Medical Center

Donald Hangen, M.D.
Orthopedic Surgery
Harvard Combined Residency Program

Mark Hashim, M.D.
Anesthesiology
Virginia Commonwealth University

Thomas Head, M.D.
Neurology
University of Alabama Medical Center

J. Rene' Herlong, M.D.
Pediatrics
Baylor College of Medicine

Richard Hogan, M.D.
Internal Medicine
University Health Center of Pittsburgh

James Hopfenbeck, M.D.
Pathology
University of Utah

Joseph Houston, M.D.
Psychiatry
George Washington Medical Center

Carol Karp, M.D.
Ophthalmology
University of Michigan

Laurel Leslie, M.D.
Pediatrics
University of California, San Francisco

Stephen Lewis, M.D.
Psychiatry
University of Texas Southwestern

Karen Lin, M.D.
Neurology
Mayo Graduate School of Medicine

Cheryl McDonald, M.D.
Internal Medicine
University of Alabama Medical Center

Richard Obregon, M.D.
Radiology
University of Colorado

Joshua Port, M.D.
Orthopedic Surgery
University Health Center of Pittsburgh

Kevin Robertson, M.D.
Otolaryngology
University of Illinois

Kelly Roveda, M.D.
Pathology
University of South Alabama

Michael Sanchez, M.D.
Emergency Medicine
Joint Military Medical Command-San Antonio

J. Kevin Smith, M.D., Ph.D.
Radiology
University of Alabama

Susan Vaughan, M.D.
Psychiatry
Columbia-Presbyterian

Julie Weaver, M.D.
Pediatrics
Medical College of Virginia

Bernarda Zenker, M.D.
Family Practice
University of Oklahoma Health Sciences Center

John T. Lindsey, M.D.
Plastic Surgery
University of Texas Southwestern

Mary Elise Moeller, M.D.
Pediatrics
Methodist Hospital of Indiana

Michele Parker, M.D.
Family Practice
UCLA Family Practice Center

Louis Profeta, M.D.
Emergency Medicine
University Health Center of Pittsburgh

William Rosen, M.D.
Ophthalmology
University of California, Davis

Geronimo Sahagun, M.D.
Internal Medicine
Oregon Health Sciences University

Michael Sherman, M.D.
Anesthesiology
SUNY Health Science Center at Brooklyn

Barbara Tardiff, M.D.
Anesthesiology
Oregon Health Sciences University

Thomas Waddell, M.D.
Thoracic Surgery
Toronto General Hospital

Benjamin Yokel, M.D.
Dermatology
Johns Hopkins Hospital

AAMC staff

Robert G. Petersdorf, M.D.
President

William Butler, M.D.
Chair, AAMC Assembly

Robert H. Waldman, M.D.
Vice-President, Designate
Division of Graduate Medical Education

August G. Swanson, M.D.
Vice-President
Division of Graduate Medical Education

Robert Beran, Ph.D.
Associate Vice-President
Division of Academic Affairs

Michelle Keyes-Welch
Staff Associate
Division of Graduate Medical Education

Lynn Milas
Administrative Assistant
Division of Graduate Medical Education

unable to attend:

Elaine Kaye, M.D.
Dermatology
Harvard Dermatology Training Program

# Proceedings

Saturday

Dr. Petersdorf, President, welcomed the members of the Organization of Resident Representatives to the AAMC and the annual meeting and offered his support for the newly formed organization. Dr. Petersdorf commented that residents are an important and integral component of the medical education system and their voice in the AAMC is important. The Association represents all of academic medicine: faculty, deans, students, academic medical centers, and now, residents. There are also special interest groups within the Association including the Group on Public Affairs, Group on Faculty Practice, Group on Student Affairs, Group on Business Affairs and the Group on Educational Affairs.

Dr. Petersdorf also commented on the five barriers to implementing the Organization of Resident Representatives. Firstly, Dr. Petersdorf's predecessor did not advocate for a resident group because of concerns that the organization would become a housestaff union. Secondly, residents are transient members of medical education. However, the Organization of Student Representatives was organized in the early 1970's and provides important input for the AAMC. Thirdly, it was easy to organize the student representatives; each medical school was asked to designate one student. Organizing a housestaff group was more difficult because of the diversity and number of training programs. After considerable discussion about the appropriate method to designate residents, the AAMC decided to ask a selected list of Council of Academic Societies (CAS) members to designate two residents each to the ORR. Twenty-one CAS members representing program directors or chairs of clinical departments were asked to designate residents. Fourth, financing travel and programmatic expenses for the ORR will be costly, but the AAMC has decided to provide funds for the travel and meeting expenses of the ORR. Lastly, initially, there was no clear purpose for the organization or set of objectives.

Despite initial barriers to implementing an Organization of Resident Representatives, the Association proceeded with plans to develop it. Dr. Petersdorf offered his continued support of the ORR and encouraged all members to participate in the group and other AAMC activities.

Dr. William Butler, chairman of the AAMC Assembly, spoke on the need for an Organization of Resident Representatives within the AAMC. Dr. Butler pointed out that the emphasis and importance of graduate medical education have increased dramatically in the last fifty years. In 1940, only five thousand graduate training positions were available. In 1960, the number of graduate training positions had increased to over thirty thousand, and by 1990 there were over eighty thousand training positions. Four hundred of the academic medical centers and major teaching hospitals provide 78%

of the training positions in graduate medical education.

Dr. Butler also reiterated that the AAMC represents the continuum of medical education through its interests in undergraduate curriculum, accreditation of graduate training programs, federal financing of medical education and other topics that relate to medical education. Though other groups in the AAMC representing Deans, faculty and academic medical centers can provide input into the Association on graduate medical education issues, the ORR will play a vital role in assisting the AAMC in policy development, providing additional input into the Association and improving graduate medical education. Dr. Butler also offered his support for the ORR and encouraged representatives to participate fully in the group and the AAMC.

Dr. Waldman, Vice-President, designate, of the Division of Graduate Medical Education, facilitated a discussion between representatives about the four biggest problems in graduate medical education: access to care, cost of health care, control of graduate medical education and decreasing emphasis on education in the academic medical centers.

Dr. Waldman pointed out that there are large underserved populations in the country, particularly in rural and inner-city settings. Affluent areas may also have a shortage of primary care physicians. Graduate medical education may be able to provide a partial solution to the problems of access to care by decreasing the number of graduate medical education training programs in specialties with an adequate supply of physicians. Increasing the number of training positions in primary care programs will not solve the problem since many of the programs are unable to fill the number of existing positions. Related topics include the role of foreign medical graduates in providing care to the underserved and the closure of weak training programs that provide care to the underserved. Dr. Waldman indicated that the increasing costs of medical care are sometimes attributed to residents who order too many tests and the higher costs of treatment provided by specialists as compared to the care provided by generalists.

Dr. Waldman also pointed out the difficulty in identifying the group(s) responsible for the graduate medical education curriculum and the distribution of training programs. Medical schools feel that the hospital maintains much of the control and emphasizes service needs rather than education. Residency Review Committees are often unable to close weak programs; the ACGME and professional boards have been unable to suppress the proliferation of subspecialties and subspecialty training programs.

Dr. Waldman expressed his concern that too many academic medical centers place more emphasis on research and patient care service and less emphasis on the education and training of students and residents. The educational programs of an academic medical center

are the least productive, generate the least money and are often seen as less important than service and research.

ORR members responded to Dr. Waldman's comments by focusing on the importance of generalism and primary care physicians. All members agreed that more generalists are needed; representatives offered insight and many suggestions for improving the supply and distribution of generalist physicians. ORR members cited a lack of respect for generalists as one reason for students not pursuing a career in the primary care specialties. A tenure track for teachers and clinicians would combat some of the obstacles faced by primary care educators in academic medicine and might also provide additional "respect".

Participants also cited the need for more primary care role models and mentors in medical school, residency and in practice. Many members cited nurturing role models in other specialties that influenced their specialty choice decision. Despondent residents seen during the medicine rotation will not motivate students to choose internal medicine.

Participants also cited a need for primary care role models in medical school that expose students to the generalist physician's practice, including rotations in private physicians' offices and community or rural hospitals. Some members commented that their medical school did not provide this experience; other members commented that their medical school did provide this experience and it was very beneficial. Many participants cited the need to emphasize the importance of community training programs and community rotations.

ORR members also focused on the lack of primary care experiences in the medical school curriculum and recommended primary care rotations in the first two years of medical school instead of waiting until the clerkship years. ORR members who graduated from medical schools with an emphasis on primary care supported these recommendations and felt that early and frequent exposure to primary care and nurturing role models in primary care do have an impact on the specialty choices of medical students.

ORR members also expressed concern over the costs of medical education and indebtedness; some representatives felt that these factors did influence specialty choice while other members believed that their specialty choices were not influenced by debt or the costs of medical school.

Representatives cited the need for educating society of the important role that generalist physicians play in providing health care because some patients prefer to be treated only by specialists regardless of the ailment. Other representatives described primary care experiences and felt that society does appreciate the generalist physician and wants to be treated by the primary care

physician, not a group of specialists.

Some members commented that access to primary care may improve if pre-medical students interested in providing this care are counseled and encouraged to attend medical school. Preferential admissions treatment to qualified students interested in practicing in rural and/or underserved areas is a way to provide additional primary care physicians.

Participants also pointed out that their training institutions, for the most part, provide tertiary care with less emphasis placed on primary care. Residents in these training programs do not have the opportunity to rotate in primary care settings. Institutions can provide both tertiary care and primary care education experiences for students and residents by providing additional rotations to clinics, community hospitals and physicians' offices.

Representatives also commented on the need to educate federal and state legislatures of the importance of primary care and its influence on access to health care.

Participants generally concluded that focusing on developing role models, providing primary care exposure early in medical school and residency will provide more incentives to choosing primary care rather than limiting the number of specialist training positions which will only increase the competitiveness of these specialties.

Dr. Swanson provided a summary of the AAMC's interest in graduate medical education which began in 1876 with the first efforts to organize the Association. At that time most schools were proprietary operations run by practicing doctors for profit. One requirement for membership in the AAMC was that the name of the graduate should be on the school's diploma. Many of the schools found this requirement unacceptable, and there was no further discussion until 1890.

In 1890, the AAMC required that all member medical schools have a graded curriculum. The quality of the curriculum was evaluated by Dr. Fred Zappfe, Secretary of the AAMC from 1898 to 1948.

Stimulated by Flexner's condemnation of most schools and his admiration and endorsement of medical education that had been established at Harvard, Johns Hopkins and the University of Michigan, proprietary schools rapidly disappeared and most schools became university based.

Hospital-based graduate medical education began principally as a year of internship. Dr. Arthur Bevan, chair of the AMA Council on Medical Education and Hospitals from 1904 to 1928, set out to stimulate the medical schools and their parent universities to develop graduate medical education programs. Also during this time, specialty boards began to organize, thus establishing a

pattern of independent, autonomous bodies of specialists in medical education. By 1933, five certifying boards had been established. Also in 1933,the Advisory Board for Medical Specialties (later known as the American Board of Medical Specialties) was established. The purpose of this board was to improve certification methods and procedures. Seven additional boards were founded during this decade.

In 1939, an ABMS Commission on Graduate Medical Education published its report. The focus of the commission was to make graduate medical education a true graduate discipline, clearly different from a transient period of hospital work.

After World War II, there was rapid growth in the number of residency positions. In 1940, there were 5,118 positions. By 1950, there were 19,364 positions. Some mechanism to determine whether residency programs sponsored by hospitals were of sufficient quality was needed. A model was first developed by internal medicine through a tripartite effort of the American College of physicians, the American Board of Internal Medicine and the AMA Council on Medical Education and Hospitals. Subsequently in 1950, the American College of Surgeons, the American Board of Surgery and the AMA Council founded a similar joint conference committee for surgery. These became the models for a graduate medical education accreditation system and were renamed residency review committees (RRCs) in 1953.

The RRC accreditation system had a characteristic which caused concern among some medical educators. Each RRC operated independently and focused solely on programs in its specialty with little consideration of the sponsoring organization and its other training programs. This created a fragmented system of graduate medical education with highly variable program quality.

In 1965, an AAMC committee released a report entitled Planning for Medical Progress Through Education. The report focused on the need for the university to assume responsibility for medical education. The following year the AMA's Citizens Commission on Graduate Medical Education issued its report. The Commission recommended that teaching hospitals should accept the responsibilities and obligations of providing graduate medical education and should make its programs a corporate responsibility rather than the individual responsibility of particular medical or surgical services.

As a result of the reports, AAMC was reorganized and the Council of Teaching Hospitals (COTH) and the Council of Academic Societies (CAS) were established. Both the AMA's Commission and a subsequent CAS report recommended the formation of a single organization to unite the fragmented graduate medical education structure with the authority to conduct the accreditation of residency programs. These recommendations ultimately resulted in the formation of the Liaison Committee on Graduate Medical Education (LCGME) in 1972.

The LCGME was not viewed with pleasure by the RRCs or the AMA's Council on Medical Education. Efforts to require evidence of institutional responsibility for graduate medical education were resented and blocked.

Finally, in 1980 the LCGME was reorganized into the Accreditation Council for Graduate Medical Education (ACGME). Also during this decade, COTH worked with HCFA and Congress to develop what eventually was called the "indirect medical education payment" to provide funds for the more costly care required by patients admitted to teaching hospitals. An AAMC report on financing graduate medical education also influenced Medicare to revise the resident stipend and payment policies.

The Association also developed a policy recommending limiting duty hours to 80 hours per week and providing one 24 hour day out of seven free of program responsibilities. The Association has approved the revisions in the General Requirements of the Essentials of Accredited Residencies that recommended a schedule of one night in three on duty and one day a week free of program responsibilities. The AAMC also approved a second revision that requires each RRC to have a policy that ensures that residents are not unduly stressed and fatigued.

Since the AAMC was reorganized in 1965, it has played an ever increasing role in the development of graduate medical education. ORR member contributions will provide added insight into AAMC's continuing efforts to improve the education and training of physicians in the United States.

Michelle Keyes-Welch provided a summary of the structure and organization of AAMC's constituency, governance and staff. A summary of the presentation is provided in the agenda book in addition to a organizational chart of the governance structure and AAMC staff.

Dr. Robert Beran, Associate Vice President of the Division of Academic Affairs, provided representatives with a summary of AAMC initiatives relating to debt management and answered specific questions relating to loan repayment and debt management. Dr. Beran commented that there had been increased emphasis on debt management because of the increasing costs of medical education and the rising amounts of funds that students borrow. Dr. Beran pointed out that the AAMC has faced barriers to assisting students and residents because legislatures see the need to concentrate on other areas, particularly in undergraduate education. Residents and students are seen as future high income earners and there is less sympathy for the high debt of medical students and residents, however, medicine has the longest training period of any other profession and the ability to repay loans during this period is often difficult.

AAMC, in cooperation with the new Section for Resident Education, will provide loan repayment, deferment and other debt management information to one contact person in each teaching hospital. This contact person will not be an expert but will serve as a resource person for residents and can assist them with debt management and loan deferment problems.

Dr. Beran commented on the current status of two bills on loans for medical education, HR 3508 and S 1933. The proposed language requires institutions to maintain specified default rates. If institutional borrowers exceed the default rate, higher insurance premiums may be charged to later borrowers attending the institution. The institution with a high default rate also may be asked to set aside reserve accounts to cover the loans of default borrowers.

The proposed legislation also addresses three deferment classes: hardship, disability and full time enrollment. Residents would not conform to any of the three classes as the language is presently written, so the AAMC is working hard to tie the economic hardship criteria with an income to debt ratio, repayment that is income sensitive to the financial position of its borrowers.

Dr. Beran also expressed concern over the consumer debt of residents in addition to the student loan debt. Residents with a limited income may pay credit card and consumer debt first and neglect payments on their educational loans. Dr. Beran cautioned that student loans are a part of the credit report, and lenders and banks are reporting late or delinquent accounts. Dr. Beran also encouraged residents to submit their deferment forms in a timely manner to avoid technical default.

Sunday

Representatives and AAMC staff began the second day with a brief question and answer session. Dr. Waldman pointed out in the question and answer session that the ORR will need to develop rules and regulations and to begin thinking about its involvement with other groups and sections within the AAMC.

Members running for the administrative board were asked to provide a brief summary of their qualifications and interest in the ORR. Members also identified topics of future interest including: medical informatics, debt management, residents as teachers, transition from medical school to residency, undergraduate education curriculum, generalism and primary care physicians, financing graduate medical education, disability insurance, service vs. education, resident supervision, ambulatory education and ambulatory care, and chemical dependency.

Bernarda Zenker was elected as chair; Joseph Auteri was elected chair-elect. The following members will serve a two year term on

the administrative board: Mary Elise Moeller, Joshua Port and Louis Profeta. Rene' Herlong, Michele Parker, Carl Gold and Barbara Tardiff will service on the administrative board for a one year term.

Chair, Bernarda Zenker, commented that the ORR administrative board was very diverse with representation from both sexes and a mix of both primary care and non primary care specialties. Members did express concern that no underrepresented minorities were members of the ORR, and Dr. Waldman offered to communicate this concern to the CAS during the annual meeting.

Bernarda closed the meeting by encouraging participation from all representatives and asked members to keep in contact with her, the administrative board and AAMC staff.

Invited Participants
Generalist Physician Task Force
Association of American Medical Colleges

Jordan J. Cohen, M.D.
Dean
State University of New York
Stony Brook, New York

Robert Massad, M.D.
Chair
Department of Family Medicine
Montefiore Medical Center
Bronx, New York

John Stoeckle, M.D.
Chief, Medical Clinics
Massachusetts General Hospital
Boston, Massachusetts

Bernarda Zenker, M.D.
Family Practice Resident
University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Emery A. Wilson, M.D.
Dean
University of Kentucky College of Medicine
Lexington, Kentucky

Paul Freedman, M.D.
Department of Surgery
Baystate Medical Center
Springfield, Massachusetts

Harold J. Fallon, M.D.
Chair
Department of Medicine
Medical College of Virginia
Richmond, Virginia

Catherine DeAngelis, M.D.
Associate Dean for Academic Affairs
John Hopkins University School of Medicine
Baltimore, Maryland

W. Douglas Skelton, M.D.
Dean
Mercer School of Medicine
Macon, Georgia

Robert B. Johnson
Executive Director
Grady Memorial Hospital
Atlanta, Georgia

Samuel Hellman, M.D.
Dean
University of Chicago Pritzker School of Medicine
Chicago, Illinois

Sheldon King
President
Cedars-Sinai Medical Center
Los Angeles, California

David Graham
Medical Student
East Carolina University School of Medicine

John Farrar, M.D.
Department Chief
Medical Director's Office
Veterans Administration
Washington, D.C.

Robert Dickler
General Director
The University of Minnesota Hospital and Clinics
Minneapolis, Minnesota

Marjorie A. Bowman, M.D.
Chair
Department of Family and Community Medicine
Bowman Gray School of Medicine
Winston-Salem, North Carolina

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January 31, 1992

Memorandum to AAMC Staff

From: Robert G. Petersdorf

Subject: Reorganization at AAMC

As you know, almost immediately after the death of Dr. Louis Kettel the Association began recruitment efforts for a new Vice President for Academic Affairs. However, after giving the matter considerable thought and reviewing the qualifications and abilities of staff already on board at the Association, I have decided to suspend recruiting for that position and to implement a reorganization of the several divisions and sections units of the AAMC.

This plan (as laid out on the attached organization chart) will allow us to utilize the talents of our current staff in new and more effective ways and will accommodate some restructuring to accomplish new programmatic goals. This plan has the additional advantage of enabling us to fill some key vacancies immediately and to concentrate our recruitment efforts on the Vice President for Clinical Services position.

The major elements of the reorganization plan are:

**Creation of a Division of Medical Education and Graduate Medical Education with Dr. Robert Waldman as Vice President:** The new Division will encompass most of the programs and staff previously located within the Division of Academic Affairs (DAA) and the Division of Graduate Medical Education (DGME). Dr. Waldman, who joined the AAMC in November to head the new Division of GME, will become Vice President of this newly created division; Dr. Robert Beran will continue as Associate Vice President. Within the new division will be the Section for Student Services, the Section for Student Programs, the Section for Educational Programs, and a Section for Graduate Medical Education. The constituent groups that will be staffed from this division are Council of Deans, Organization of Student Representatives, Organization of Resident Representatives, Group on Student Affairs, and Group on Educational Affairs.

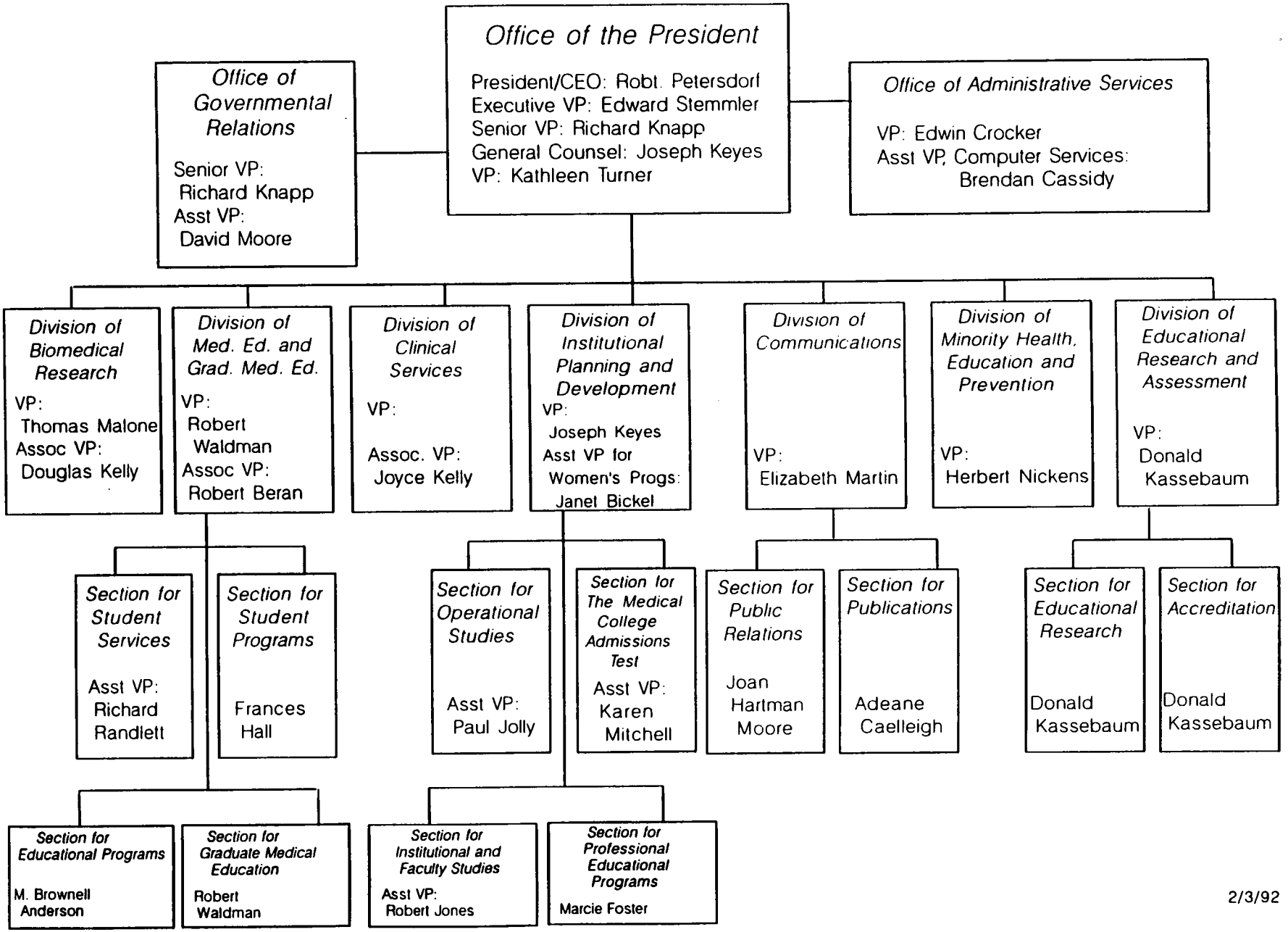
**Creation of a Division of Educational Research and Assessment with Dr. Donald Kassebaum as Vice President:** This is a new programmatic division and a new position on the executive staff. Dr. Kassebaum will carry the Section for Accreditation (LCME) responsibilities with him to this new Division and will add to his portfolio supervision of the research activities related to three AAMC questionnaires (pre-medical, matriculating students, and graduation) previously located in the Division of Academic Affairs. Staff who work on those questionnaires will be transferred to the Section for Educational Research in this Division. Dr. Kassebaum will also assume responsibility for activities in continuing medical education and international medical education which had been, respectively, in DAA and DGME. Don will continue as an associate editor of Academic Medicine. The creation of this new division recognizes Don's contributions to the Association and provides a focal point for educational research studies using the AAMC data resources.

**Changes in the Division of Institutional Planning and Development:** This Division will continue to be headed by Joseph Keyes, who also serves as the Association's General Counsel. The Section for Accreditation, as mentioned above, is moved from this division. A Section for the Medical College Admission Test is moved to this Division from the former Division of Academic Affairs; all staff currently associated with the MCAT move with this section. A Section for Professional Educational Programs is formed with existing staff under the direction of Marcie Foster. The Section for Institutional Studies is renamed the Section for Institutional and Faculty Studies to acknowledge Dr. Robert Jones' work with faculty affairs deans. Additionally, Janet Bickel's work with the Association's Women in Medicine program is recognized by her promotion to Assistant Vice President for Women's Programs.

**Changes in the Office of the President:** David Moore is promoted to Assistant Vice President for Governmental Relations. Kat Turner's title is changed from Vice President for Special Projects to Vice President.

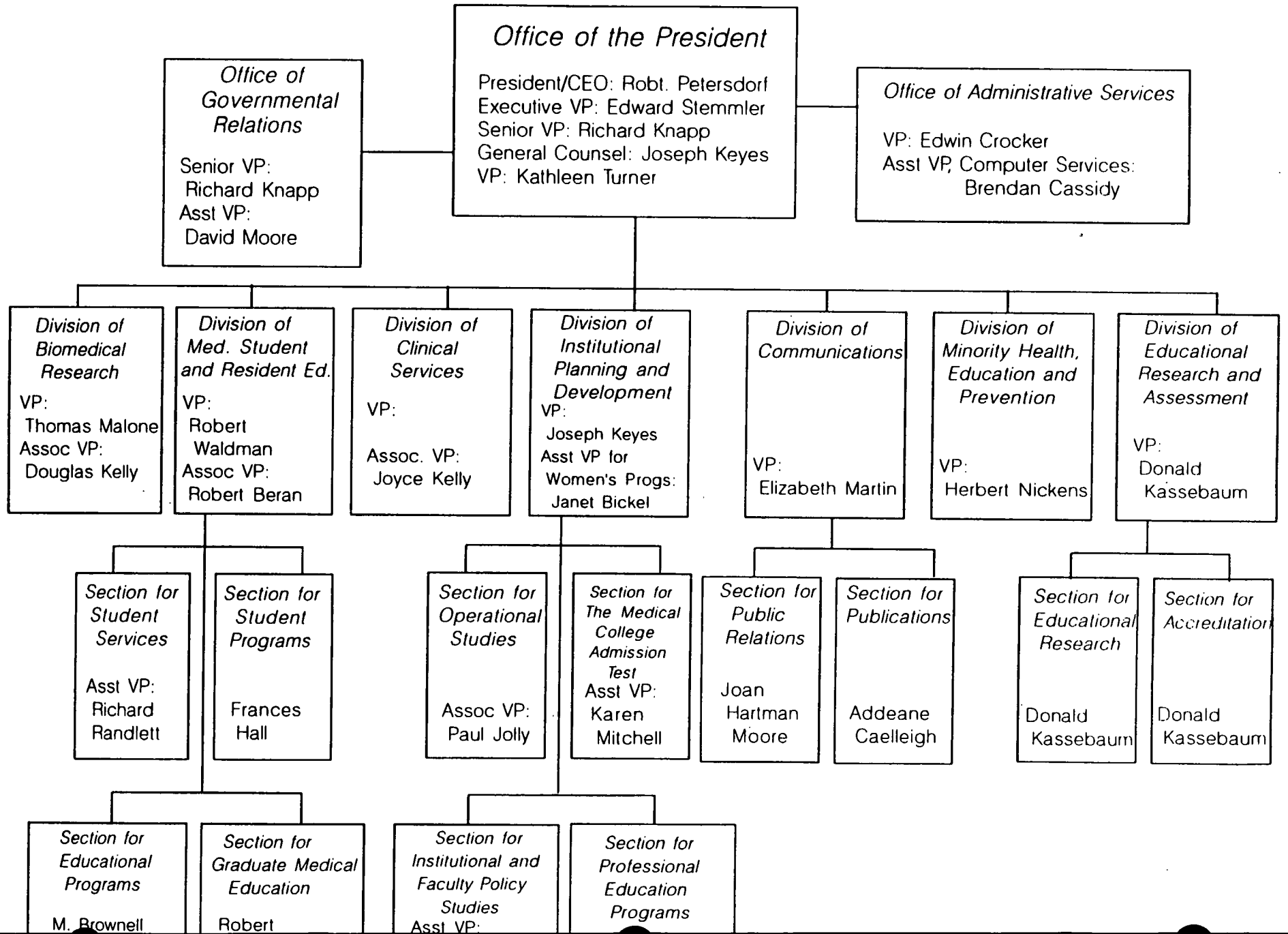
This reorganization is effective on February 3. Transition to the new structure, including moving a few offices, should be accomplished by March 3.

# AAMC Organization Chart




2/3/92

# AAMC Organization Chart



# RULES AND REGULATIONS
# OF THE
# ORGANIZATION OF RESIDENT REPRESENTATIVES
# THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ADOPTED BY THE ORGANIZATION OF RESIDENT REPRESENTATIVES

—

APPROVED BY THE EXECUTIVE COUNCIL

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The Organization of Resident Representatives was established with the adoption of the Association of American Medical Colleges bylaw revisions of November, 1991.

Section One-Name

The name of the organization shall be the Organization of Resident Representatives (ORR) of the Association of American Medical Colleges.

Section Two-Purpose

The purpose of this organization shall be 1) to provide a mechanism for the interchange of ideas and perceptions among resident physicians and others concerned with medical education, 2) to provide a means by which resident physician views on matters of concerns to the Association may find expression, 3) to provide a mechanism for resident physician participation in the governance of the affairs of the Association, 4) to provide a forum for resident physician action on issues that affect the delivery of health care, 5) to provide professional and academic development opportunities.

Section Three-Membership

A member of the Organization of Resident Representatives shall be resident physicians or fellows designated by the member organizations of the Council of Academic Societies of the Association of American Medical Colleges that represent chairs of medical school clinical departments or directors of residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Two resident representatives shall be designated by each of these member organizations by a process appropriate to the governance of the designating organization. The selection process should involve resident input to the extent possible by the organization's administrative structure and governance. The president or chair of the organization will respond to the Association with the names of the two resident physicians the organization wishes to designate.

Each member of the Organization of Resident Representatives shall be entitled to one vote at meetings of the ORR.

Section Four-Officers and Administrative Board

The officers of the Organization of Resident Representatives shall be as follows:

1) The chairman whose duties shall be to:

   a) preside at all meetings of the ORR
   b) serve as ex officio member of all committees of the ORR
   c) communicate all recommendations and actions adopted by the ORR to the Executive Council
   d) represent the ORR on the Executive Council

2) The chairman-elect whose duties are to preside or otherwise serve in the absence of the chair and to succeed the chair in that office at the completion of his/her term of office. If the chair-elect succeeds the chair before the expiration of their term of office, such service shall not disqualify the chair-elect from serving a full term as chair.

The term of office of the chair and chair-elect shall be one year.

The chair-elect will be elected annually at the time of the annual meeting of the Association of American Medical Colleges.

There shall be an administrative board composed of the chair, chair-elect, immediate past chair and six members-at-large. The term of office of the members-at-large shall be for one year, and this service shall not disqualify them from serving a full term as chair-elect, chair and immediate past-chair if so elected[1]. Each member-at-large of the administrative board will be elected annually at the time of the annual meeting of the Association of American Medical Colleges.

Nominations for chair-elect and the administrative board will be accepted with appropriate supporting materials (curriculum vitae and a statement of intent) prior to the annual meeting. Additional nominations may be made by the membership at the Organization of Resident Representatives at the time of the election.

Candidates for each respective office will be allowed three minutes to provide a brief summary of their qualifications and interest in the Organization of Resident Representatives. Election will be by closed ballot. The first to be called will be for chair-elect. The nominee receiving the most votes shall be elected.

The next ballot will be for members of the administrative board. All organization members will have six votes for the six members-at-large of the administrative board. Each ballot must have six separate names or the ballot will be disqualified. The six individuals receiving the highest number of votes shall be elected.

The administrative board shall be the Organization of Resident Representative's executive committee to manage the affairs of the Organization of Resident Representatives and to take any necessary interim action that is required on behalf of the Organization.

Section Five-Representation on the AAMC Assembly

The Organization of Resident Representatives is authorized twelve seats on the AAMC Assembly. Representatives of the Organization to the Assembly shall be determined according to the following priority:

1) the chair of the Organization of Resident Representatives

2) the chair-elect of the Organization of Resident Representatives

3) the immediate past-chair of the Organization of Resident Representatives

4) members-at-large of the administrative board of the Organization of Resident Representatives

5) additional members as designated by the chair of the Organization of Resident Representatives

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[1] At the first meeting of the Organization of Resident Representatives, four members-at-large of the administrative board were elected to a two year term to facilitate an orderly transition and to allow administrative board members additional time to create an appropriate organizational and structural foundation. Following the conclusion of the four members' term of service, all at-large administrative board positions shall be for one year as stated above.

Section Six-Meetings, Quorums and Parliamentary Procedure

Regular meetings of the Organization of Resident Representatives shall be held in conjunction with the Association annual meeting.

Special meetings may be called by the chairman upon majority vote of the administrative board provided that there is at least thirty days notice given to each member or the Organization of Resident Representatives and appropriate funding for a special meeting is available.

A simple majority of the voting members shall constitute a quorum.

Formal actions may be taken only at meetings at which a quorum is present. At such meetings decisions will be made by a majority of those present and voting.

Where parliamentary procedure is at issue, Roberts Rules of Order shall prevail, except where in conflict with Association bylaws.

All Organization of Resident Representatives meetings shall be open unless an executive session is announced by the Chairman.

Section Seven-Operation and Relationships

The Organization of Resident Representatives shall relate to all three Councils of the Association of American Medical Colleges and shall be represented on the Executive Council by the chairman of the Organization of Resident Representatives.

Section Eight-Adoption and Amendments

These Rules and Regulations shall be adopted and may be altered, repealed, or amended by a two-thirds vote of the voting members present and voting at any annual meeting of the membership for which thirty days prior written notice of the Rules and Regulations change has been given, provided that the total number of votes cast for the changes constitute a majority of the Organization's membership.

Discussion topics for 1992 ORR meeting

I. Primary Care

A. medical student exposure
B. recruiting premedical and medical students into primary care

II. Graduate Medical Education Curriculum

A. outpatient education
B. curricular innovations
C. mentoring
D. residents as teachers and learners
E. VA's role in graduate medical education

III. Residency Environment

A. work hours and supervision
B. protected time for research and reading
C. maternity and paternity leave
D. debt management

IV. Evaluation

A. clinical skills assessment

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO SANTA BARBARA · SANTA CRUZ

OFFICE OF THE DEAN
UCLA SCHOOL OF MEDICINE
CENTER FOR THE HEALTH SCIENCES
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1722

November 16, 1991

Michelle M. Keyes-Welch
Staff Associate
Office of Graduate Medical Education and International Programs
Association of American Medical Colleges

Dear Ms. Keyes-Welch:

Thank you for your letter of 10 October 1991 and copies of materials from the CoGME meeting. I found much of this very interesting and useful. As you suggested, I will call the CoGME office and ask to be placed on their mailing list.

I applaud the new Organization of Resident Representatives and believe they will serve a very useful function as the AAMC increasingly proactive in Graduate Medical Education and the continuum of undergraduate to postgraduate and even continuing medical education. My only concern, in looking over the CAS groups, is perhaps an under representation by Internal Medicine. I note at least six surgical associations. With over ten medical specialty programs (fellowships), perhaps there needs to be associations similar to plastic surgery, otolaryngology and ophthalmology or at least one association for the medical specialties. I will ask APDIM to address this.

I spoke with Dr. Kirson about the new Section on Resident Education. I will discuss with our Dean who should represent UCLA Medical School. However, in the interim, I would appreciate any information, mailings, and notification of future meetings (Spring ?). If I am correct, Ms Joyce Kelly will be responsible for this section.

Again, thank you for the information. I would appreciate if you could pass a copy of this letter along to Ms. Kelly or appropriate staff who will be involved with the SRE.

Sincerely,

Neil H. Parker, M.D.
Associate Dean, Housestaff Training Program

NHP:tkr

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW
WASHINGTON, DC 20037-112
TELEPHONE (202) 828-0400

December 3, 1991

Neil H. Parker, M.D.
Associate Dean, Housestaff Training Program
UCLA School of Medicine
Center for the Health Sciences
10833 Le Conte Avenue
Los Angeles, California 90024-1722

Dear Dr. Parker:

Thank you for your letter of November 16th and for your support of the new Organization of Resident Representatives (ORR).

The ORR held its first meeting November 9-10,1991 in Washington during the AAMC's annual meeting. Our goals for the first meeting included providing a brief introduction to the Association's history, structure and function and electing an administrative board. ORR members also developed a preliminary list of issues of interest for future meetings. We were very pleased with the outcome of the first meeting; the residents were very enthusiastic and eager to begin developing an organizational framework. As you may know, Michele Parker, a resident in family practice at UCLA, was elected to the administrative board.

The ORR is not a representative body like the AMA's Resident Physician Section. The ORR was primarily organized to provide professional growth and development programs for resident physicians and to provide the AAMC with resident input on medical education issues.
However, we do recognize your concerns about the composition of the ORR and we are currently evaluating our list of CAS members and may expand our criteria to include more societies eligible to designate residents. The final decision, however, rests with the executive council of the AAMC. I will certainly communicate your concerns to members of the ORR for discussion at the February administrative board meeting.

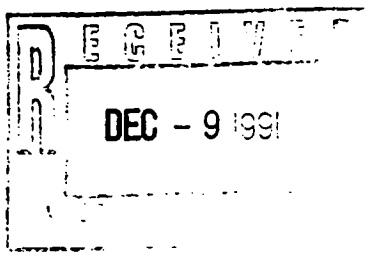
Again, thank you for your support of the Organization of Resident Representatives.

Sincerely,

Michelle Keyes-Welch

Michelle Keyes-Welch
Staff Associate
Division of Graduate Medical Education

Barbara E. Tardiff, M.D.
Department of Anesthesiology
Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, Or 97201




15 November 1991

Ronald F. Albrecht, M.D.
President, Association of Anesthesia Program Directors
Department of Anesthesiology
University of Illinois
1740 W. Taylor St., Suite 3200
Chicago, IL 60612

Dear Dr. Albrecht:

Thank you for offering me the privilege of serving as a representative to the AAMC's newly established Organization of Resident Representatives (ORR).

The ORR had its first meeting in conjunction with the AAMC in Washington D. C., November 8-10. Of necessity, organizational issues occupied much of our time. We did begin to identify and explore some global issues of special concern to residents—namely, access to care, the cost of medical care, control of the graduate medical education curriculum and balancing educational needs against clinical and research needs within institutions. We elected a nine person administrative board including a chair and chair-elect. I was honored to be elected to serve on this administrative board. The administrative board will be meeting in conjunction with the Executive Committee of the AAMC in February, June and September.

The level of involvement and enthusiasm of all of the participants and the plethora of ideas which surfaced was impressive. I am confident that the ORR will contribute to and complement the AAMC component societies. Indeed, it might be appropriate and valuable for representatives to the ORR to participate in the meetings of their respective academic speciality societies as well as AAMC interdisciplinary committees and forums. In the future, you may want to consider specifically inviting the ORR representatives selected by the AAPD to participate in some of your activities at the AAMC Annual Meeting. This participation might serve to attune resident representatives to the concerns of anesthesia program directors as well as provide you with resident input on specific issues.

Again, I want to express my appreciation to you and the AAPD for the opportunity to serve as an ORR representative. I will keep you informed as this fledging group develops. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Barbara E. Tardiff M.D.

Barbara E. Tardiff, M.D.

cc: Dr. Wendell Stevens, Chairman, Department of Anesthesiology, Oregon Health Sciences University

Dr. Robert H. Waldman, Vice-President for Graduate Medical Education, Association of American Medical Colleges

1/15/92

Dear Michelle -

Just wanted to mention a few things before the executive group melts

1- One thing we've had difficulty with this year in the American Academy of Pediatrics Resident Section is that only 5/21 people from the prior years returned to the Executive Committee. While this brings new energy + ideas, we spent most of our first meeting reeducating people about the AAP etc. I wondered if we might to look at changing the regular members of the ORR on a staggered basis as we are doing with the 9 core members to try to keep some consistency and momentum. Unfortunately at our meeting, it was hard to get to any concrete actions + we're going to have to rely on our spring meeting. I thought if 1/2 of the delegates for each specialty changed annually, there'd be more continuity.

2- I really appreciate all the info from the Washington office. Here's some of the recent stuff we sent out from the AAP office; we're also including a story in our newsletter to all residents this February

Thanks again for your help getting everything out to all of us.

Laurel Leslie

(on my professional stationery!)

merican
cademy of
ediatrics

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one (708) 228-5005





TO: Program delegates to the AAP Resident Section
FROM: Resident Section Executive Committee
RE: Mailing #1 on Student Loan Deferment and Delegate Job Description
DATE: January 1992

Greetings! Hope you have all recovered from the holidays and are still surviving residency. Thanks for agreeing to be your program's delegate to the AAP Resident Section

In this mailing, we have included two items. First, WE NEED YOUR HELP URGENTLY! This February, the House and Senate vote to reauthorize the Higher Education Act of 1965 which deals with LOAN DEFERMENT, a topic near and dear to all of us. The bottom line is that current proposals, Senate bill 1150 and H.R. bill 3553, would eliminate student loan deferment for interns and residents and limit forbearance. Please let residents in your program know and contact your senators and representatives. Enclosed is a flyer to xerox and distribute at your programs as well as a comparison of the two bills. There will also be more details in the AAP Newsletter that all resident members of the AAP will get in February. Thanks in advance for your help.

We have also enclosed the official job description of a program delegate to the AAP Resident Section in this mailing: a copy has also been set to your program director. This is to give you a guideline as to what being a program delegate is all about. Please call your district coordinator or alternate district coordinator if you have any questions (phone numbers on back of job description). They are available to help you figure out what the AAP Resident Section does and to provide resources for you. If you are not sure you have the time for or interest in the position, please let your program director know and contact Linda Lipinsky, our section coordinator, at 1-800-433-9016.

We're glad to have you all as an active part of our Resident Section. We've been busy working on board fees, disability insurance, and medical student recruitment into pediatrics. If you or any one you know are interested, call Linda; we'd love your help!

Thanks again for your help to the Resident Section and hope to see you next fall at the AAP National Meeting in San Francisco!

Laurel

Laurel Leslie
Secretary/Treasurer

# ATTENTION ALL RESIDENTS!!!

## LOAN DEFERMENT MAY BE CANCELLED!

*Current proposals on Capital Hill, Senate bill 1150 and H.R. bill 3553, would eliminate student loan deferment for interns and residents and limit forbearance.*

NOW IS THE TIME TO
CONTACT YOUR SENATORS AND HOUSE
REPRESENTATIVES BEFORE IT'S TOO LATE. . .

For more information, call the American Academy of Pediatrics Resident Section at 1-800-433-9016 or speak with your AAP Program Delegate.

## GET THE WORD OUT.

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**
**Future Meeting Dates**

**1992**

| | |
|---|---|
| February 26-27 | **ORR Administrative Board**/AAMC Executive Council<br>Washington Hilton & Towers, Washington, D.C. |
| June 24-25 | **ORR Administrative Board**/AAMC Executive Council<br>Washington Hilton & Towers, Washington, D.C. |
| September 16-17 | **ORR Administrative Board**/AAMC Executive Council<br>Park Hyatt Hotel, Washington, D.C. |
| November 6-12 | AAMC Annual Meeting<br>New Orleans Hilton, New Orleans, Louisiana |

**1993**

| | |
|---|---|
| February 24-25 | **ORR Administrative Board**/AAMC Executive Council<br>Park Hyatt Hotel, Washington, D.C. |
| June 16-17 | **ORR Administrative Board**/AAMC Executive Council<br>Park Hyatt Hotel, Washington, D.C. |
| September 22-23 | **ORR Administrative Board**/AAMC Executive Council<br>Park Hyatt Hotel, Washington, D.C. |
| November 5-11 | AAMC Annual Meeting<br>Washington Hilton Hotel, Washington, D.C. |