association of american medical colleges

AGENDA

OSR ADMINISTRATIVE BOARD MEETING

June 19, 1985

8:30 am - 4:00 pm

Conference Room, AAMC Headquarters

I. Call to Order

II. ACTION ITEMS

A. Approval of April Meeting Minutes 1

B. Nomination of Student to Liaison Committee on Medical Education (applications to be distributed at meeting)

C. Health Planning ...Exec. C., p. 55

III. DISCUSSION ITEMS

A. OSR Plans for 1985 Annual Meeting 8

B. OSR "Future Challenges" Paper (to be mailed on 6/12)

C. Fall Issue of OSR Report 10

D. Issues of Transition between Medical School Residency (as raised in Memo from Dr. Brown to COD Board) 11

E. Review of AAMC MCAT Program ...Exec. C., p. 60

F. Investor Owned Teaching Hospital Participation in the Council of Teaching Hospitals ...Exec. C.,p. 67

IV. INFORMATION ITEMS

A. Reports from OSR Regional Chairpersons on Spring Meetings

B. Legislative Update from Mr. David Baime

C. Minutes from February and April LCME Meetings submitted by student participant Ms. Peggy Hasley 14

D. Memos from Ms. Hasley Re: Selection of Student Representative to the LCME 22

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

E. AAMC Clinical Evaluation Program Status Report 25

F. LCME Structure and Function of a Medical School (enclosure)

V. Old Business

VI. New Business

VII. Adjournment

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4:30 - 5:30 pm

Joint Meeting with COD Administrative Board (Item III.D)
Edison Room - Washington Hilton Hotel

6:00 - 7:00 pm

Joint Administrative Board Meeting
Military Room - Presentation by Representative Don Fuqua, Chair, Congressional Science Policy Task Force

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Noon - 1:00 pm on June 20

Joint Boards Luncheon
Hemisphere Room

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES
MINUTES

April 3, 1985
Washington, D.C.

Ricardo L. Sanchez, Chairperson
Rick Peters, Chairperson-Elect

Regional Chairpersons:
Vicki Darrow
Kim Dunn
John DeJong
Kirk Murphy

Representatives-at-Large:
Roger Hardy
Kent Wellish

AAMC Staff
David Baime*
James Bentley, Ph.D.*
Janet Bickel
John A. D. Cooper, M.D.*
Paul Elliott, Ph.D.*
Joseph Keyes*
James Schofield, M.D.*
August Swanson, M.D.*
Robert Van Dyke*

Guest
Sharon Scanlon, AMSA Legislative Coordinator*

*present for part of the meeting

I. Mr. Sanchez called the meeting to order at 9:00 a.m. The minutes of the January meeting were approved with the following addition: in the second sentence of item XII, "for the committees considered" after the word "applicants". Referring to Section 4 (A.4) of the Rules and Regulations of the OSR, members of the Board noted if the OSR membership has reached 120 participating schools, then at the 1985 Annual Meeting, the membership should elect five rather than four Representatives-at-Large. Board members commented that it would be advantageous to appoint this "fifth" person as the legislative coordinator for the year. Dr. Elliott said that there is still time to modify the OSR budget to accomodate an additional Board member. Ms. Bickel said she would look into the mechanisms of this change. Mr. Hardy announced that at its recent meeting the Central region elected Ms. Joann Fruth as its regional chair, so that the chair will have a full year to plan the spring meeting instead of undertaking the responsibility as late as November.

II. 1985 Annual Meeting

Mr. Sanchez summarized the guiding principles which members of the Board meeting informally the night before had agreed upon. The theme of OSR's meeting should speak to the hearts of all four years of medical students, should not be a series of scattered lectures, should increase their understanding of OSR and provide students with concrete and practical goals and ways of achieving them, and should carry forward the themes espoused in the GPEP (General Professional Education of the Physician) Report. There was also agreement that the OSR "Future Challenges" Paper should be widely distributed before the meeting, in time for

representatives to comment on and learn from it. Many Board members praised the draft of "Further Issues of Concern to OSR" prepared for the most part by Mr. Peters. Mr. Sanchez expressed the view that it could melded with the sections already approved by the Board and that a final section could be written on "Ideas for AAMC Future Directions" well before September. Mr. Peters requested that Board members give him any additional comments on the section as soon as possible. Ms. Darrow noted that the division of this section, i.e., 1) admission, 2) undergraduate medical education, 3) clinical education, and 4) teaching hospitals, could provide the basis for the breakdown for Annual Meeting small group discussions. The Board members also pointed out that, using the paper as a whole, such group process is important for OSR ownership of the document and that, to the extent that OSR has been pigeon-holed by other organizations, this paper should open some eyes.

The Board decided upon the following general theme for the main program on Saturday morning: "Beyond the GPEP Report: Practical Approaches to Change" and upon the schedule shown in an addendum to the minutes. It considered a number of possible speakers for the program. Mr. Sanchez promised to contact Julian Bond, Kenneth Ludmerer, Arnold Relman, and possibly Paul Starr. The speakers will be requested to provide realistic comments on medical education vis-a-vis their special perspective and to build bridges to the small group afternoon discussion sessions. AAMC President, Dr. John Cooper, will be asked to introduce the session and Dr. Kay Clawson, chair-elect of the Council of Deans will be asked to wrap it up, returning the focus to education and charging OSR members to pursue action routes. The seven topics chosen for the afternoon sessions, with the Board members responsible for the program's coordination are: 1) Evaluation Methods (Mr. Hardy); 2) Problems with Clinical Education (Mr. Peters and Mr. Murphy); 3) Curricular Integration of Health Care Cost Awareness and Ethics (Ms. Darrow); 4) Preventive Medicine (Ms. Dunn); 5) Legislative Affairs (Mr. DeJong); 6) Computer-Based Medical Education and Learning to Problem Solve (Mr. Sanchez); and 7) Financing Graduate Medical Education (Mr. Wellish).

III. Changes Approved by the National Board of Medical Examiners

Mr. Sanchez welcomed Dr. Swanson, Director, Department of Academic Affairs, and stated that it was not necessary to discuss the Executive Council agenda item on "Addition to the General Requirements for Graduate Medical Education."

Mr. Sanchez next gave an overview of the recent changes approved by the NBME at its annual meeting which he had obtained from the resident on the NBME's Study Committee to Review Parts I and II; it was the resident's view that the changes would decrease the stress students presently feel resulting from these examinations. Dr. Swanson, who appeared on a panel at the Board's meeting to discuss the changes, summarized why he believes that the changes will probably not reduce schools' use of National Board scores:

1) The NBME has changed the stated purpose of the examinations from the evaluation of students for licensure to the "comprehensive evaluation" of whether students understand the scientific principles and basic medical knowledge needed for subsequent educational experiences. In effect, therefore, Comprehensive Examination Committees of the NBME, composed of eight to ten members, will specify what should be taught in the nation's 127 medical schools. 2) In accord with the GPEP Panel recommendations, the Comprehensive Examinations will not report students' individual subscores in the various disciplines. However, aggregate disciplinary scores will be provided to each medical school so that the examination's influence on curriculum is likely to continue. Dr. Swanson referred the students to the actual GPEP recommendations which urge that standardized exams cannot replace reasoned, personal evaluations of the specific skills and overall abilities of students and that faculties' personal judgements of students' work are essential if future graduates are to be analytical, critical problem solvers. This move on the part of the NBME does not further this goal.

The Board discussed possible mechanisms of expressing students' opposition to the NBME, and it was suggested that they write as individuals to the NBME. Mr. Peters noted that at the recent Consortium of Medical Student Groups' meeting in Chicago, the other student organizations had voted to support OSR activities to decrease the NBME's influence on medical education. He also noted that, when he took Part I, he did not approve release of his scores to his school just to see what would happen; he subsequently released them in order not to compromise his effectiveness in other areas at his school, but wondered what could occur if many students protested in this manner. The idea was put forward that, since all states now accept FLEX for licensing purposes, students could adopt the position with their schools "if you want us to take the exams, you pay for them." Mr. Sanchez said that the Board should continue to investigate ways of ameliorating the NBME's influence on medical education.

IV. Comments from Dr. Cooper

Dr. Cooper gave the Board an overview of the dismal picture of federal funding for research, education and teaching hospitals. He described AAMC efforts to convince the House Ways and Means Committee that the proposed DRG adjustment for medical education did not reflect the intensity of care being rendered in teaching hospitals. He raised problems resulting from the recently released study by the Inspector General of the Department of Health and Human Services (DHHS), showing that some students had borrowed Health Education Assistance Loans (HEAL) for reasons not related to their education. This report also indicates that some financial aid officers are not meeting their responsibilities. He stressed the importance of students and their parents frequently writing their elected officials to reinforce their need for all federal loan programs and to work against the notion that most students abuse loans and will default on them. In response to

questions from the Board, he stated that medical care for the nation's poor was already in jeopardy and that non-profit organizations are also cutting back on their services to the poor. Health care providers are attempting to move rapidly to corner a share of the paying market. Finally, because of severe doubts about its methodology, the students asked his view of the on-going Study of the Financing of Graduate Medical Education being conducted by Arthur Young and Company. Dr. Cooper responded that its results will not be useful and that previous studies to determine the cost of educating residents have yielded quite various results.

V. Efforts to Support Financial Aid Programs

Mr. Sanchez welcomed Ms. Scanlon, AMSA Legislative Coordinator, and opened a discussion on creating as many lines of communication as possible among the various student organizations at the local level. He read the following consensus statement approved by the Consortium of the Medical Student Groups on March 31 in Chicago, regarding health professions training:

> "We believe that adequate Federal support for health education is essential if we are to ensure equal access to the health professions. The student assistance programs in Title VII of the Public Health Service Act and Title IV of the Higher Education Act provide aid to students who could not otherwise affort to finance a medical education.
>
> The 98th Congress reauthorized the Public Health Service Act's Title VII health professions training assistance programs. This included Health Professions Students Loans, Exceptional Financial Need Scholarships, Disadvantaged Assistance, and the Health Education Assistance Loan program. President Reagan vetoed this legislation and, in his FY86 budget, proposes to eliminate health education assistance.
>
> The Administration believes that because of an increasing supply of physicians, continued Federal support of health professions education is no longer necessary. This simply does not follow. Elimination of these scholarship and loan programs would not limit the number of students obtaining medical degrees. Instead, it would determine who enters the health professions. Already, high tuition costs and limited financial assistance have had an adverse effect on enrollment of low income and many minority students. If President Reagan's proposals were adopted, access to the health professions would be limited to only the wealthiest individuals in our society."

Dr. Elliott suggested that it may be appropriate to print this statement in the next issue of Student Affairs Reporter; Ms. Bickel agreed to see of the Weekly Activities Report would also be an appropriate place.

Mr. Baime, AAMC legislative analyst, gave the Board an overview of Capitol Hill activities related to aid programs. As was true in January, a health manpower bill is expected out of the Senate in a couple of weeks. He said that the Inspector General's report on HEAL abuses (see above) could cause problems during discussions of the Title VII programs; attacking this report without belaboring its recommendations is a public relations dilemma. He suggested that students should write to Department of Health and Human Services Secretary Heckler about the shoddiness of the report and stress why HEAL use is increasing and why cutting loans to medical schools will not cut the number of physicians but will affect who can afford to become a

physician. With regard to reauthorization of the higher education legislation, the first hearings will be held in Hartford in May; AAMC will be participating along with a number of other organizations. Of special concern are: GSL borrowing limits, definition of independent student, and the expired loan consolidation provisions.

VI. Liaison Committee on Medical Education's "Functions and Structure of a Medical School

Dr. Schofield, AAMC Director of the Division of Accreditation, explained to the Board that the document appearing in the Executive Council agenda, subtitled "Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree", represents the 13th draft and five years of work. He noted that once the document is approved by the AAMC Executive Council, the new standards become effective immediately, and work will begin to rewrite the medical education database which schools complete in preparation for an LCME site visit. The OSR Board commended the LCME for its work and expressed approval of the document.

Dr. Schofield also discussed with the Board his concerns about the invidious and ubiquitous trends to collect credentials pertaining to graduate education earlier and earlier from medical students. He requested the Board's cooperation in supplying him evidence of program directors' contacting junior students about applying for residencies and of directors' insisting that students complete clerkships at their institutions in order to be seriously considered; both of these trends take away medical students' academic freedom. He stated the intention of asking students during LCME site visits questions about program directors' demands for credentials prior to September of their senior year and of then going after the violators. The regional chairpersons agreed to raise this as a discussion topic at their spring meetings. Dr. Schofield said that the LCME team will also be asking about the system, as described in the new Standards, i.e., "The faculty and the chief academic officer must establish a system to assist students in selecting a future medical career and in developing a strategy for application to residency programs. This system should not permit disruption of a student's curriculum in general medical education by external pressures to make premature application to residency programs. Letters of reference or other credentials should not be provided until the fall of the student's senior year."

The students also asked Dr. Schofield about the LCME's use of NBME scores. He described the LCME's need for assurance that, when a new or different curriculum is created, its students meet national standards; something is needed on which to base a judgement. But from established schools, the LCME wants evidence of the individual faculty's estimate of their students; the LCME does not encourage a slavish use of the NBME. He expressed the view that professional associations should get more involved in seeing that local faculties develop their own examinations. Board members also discussed with Mr. Keyes, Director,

Department of Institutional Development, the staff background paper titled "The LCME's Use of NBME Examination Results". He noted that while many deans believe that NBME scores should only be reported on a pass/fail basis to students, other deans and faculty disagree with this idea. Because faculty and deans are accustomed to using NBME results for program evaluation, this issue is very complex and difficult.

VII. Nomination of NRMP Board of Directors

Board members agreed that they could do a better job of selecting the best candidate for various committees if the previous student to serve would write, as part of the expected annual report to the Administrative Board, a few comments about those qualities which would be most useful to a student serving on the committee.

ACTION: The OSR Administrative Board nominated as its strong first choice, David Resch (Southern Illinois) to serve on the NRMP Board of Directors and as its second choice, Jeffery Colyer (U. of Kansas).

VIII. Statement of Issues from the AAMC Committee on Financing Graduate Medical Education

Dr. Bentley, Associate Director, Department of Teaching Hospitals, explained that of the five issues set forth in this Committee's paper, AAMC constituents have reached agreement on only two: 1) the need for increasing use of non-hospital sites, especially ambulatory care settings, for residency training, and 2) if the medical center is pressed hard for money, then U.S. medical school graduates should be trained first, although this stance creates difficult political problems vis-a-vis U.S. citizens receiving degrees from non-LCME-accredited schools abroad. Dr. Bentley summarized the questions on which strong divisions exist: 1) If Medicare's support of graduate medical education ends, can teaching hospitals successfully compete for patient dollars with other providers such as HMOs or is a subsidy required in order to offer graduate education? 2) If a subsidy is required, should a societal funding mechanism be created or should each payer establish its own policies? 3) In order to minimize the fiscal risks to payers, program directors will have to give up some autonomy--regarding number of residents trained and the length of training period. Three options on the length of training which would be supported by separate funding are available: a) fund residents for a fixed number of years regardless of the specialty; b) fund residents only for the period of time necessary to obtain initial board eligibility; or c) fund residents in all accredited programs for initial and subspecialty training. Problems accrue with any of these options. Dr. Bentley noted that the purpose of the document is to stimulate people to think and talk about these issues. OSR members will be mailed a copy of it shortly.

Board members raised a number of questions regarding whether residents add costs to a health care site; Dr. Bentley responded that studies show that care always comes out cheaper without the residents but that

Board members raised a number of questions regarding whether residents add costs to a health care site; Dr. Bentley responded that studies show that care always comes out cheaper without the residents but that the products are all lumped together with overlapping effects and, therefore, the costs are very difficult to isolate. He predicted that in the future, hospitals will employ fewer residents and that these will do more than residents presently do. Also, hospitals will have incentives to keep the residents they train rather than to keep bringing in residents at the first-year level. Dr. Bentley described a scenario of health care providers competing on the basis of efficiency, access and comprehensiveness of services; of a large increase in the percentage of physicians who are salaried; and of distinct differences between the class of care provided for patients who can pay versus those who cannot. He said that some hospitals have already dropped residents out of a need to save money and that the difference between resident and staff salaries is decreasing. He stressed the importance of retaining the infrastructure of the present graduate medical education system but noted also the difficult questions that educators must face, e.g., does residency training need to be completed in three uninterrupted years?

IX. The formal portion of the meeting adjourned at 5:30 p.m.

1985 OSR Annual Meeting Schedule (as of 5/31)

Friday, October 25

3:30 - 4:30 p.m. Regional Meetings

4:30 - 5:30 p.m. Business Meeting

7:30 - 9:00 p.m. Student Leadership Workshop: More "Pearls of Change"

9:00 OSR Reception

Saturday, October 26

9:00 - 11:30 a.m. Plenary Session

From Apathy to Panic and Beyond: Actions to Shape a Better Education

Introductions: John A. D. Cooper, M.D.

Kenneth Ludmerer, M.D.

Assistant Professor of Medicine, Washington U. School of Medicine

Arnold Relman, M.D.

Editor, New England Journal of Medicine

Concluding Remarks:

1:30 - 3:00 p.m. Small Group Discussions

(1) Evaluation Methods (Mr. Hardy)

(2) Problems with Clinical Education (Mr. Peters and Mr. Murphy)

(3) Curricular Integration of Health Care Cost Awareness and Ethics (Ms. Darrow)

(4) Preventive Medicine (Ms. Dunn)

(5) Legislative Affairs (Mr. DeJong)

(6) Computer-Based Medical Education/Learning to Problem Solve (Mr. Sanchez)

(7) Financing Medical Education (Mr. Wellish)

3:30 - 5:00 p.m. Repeat of same 7 discussions

7:30 - 10:00 p.m. Regional Receptions

Sunday, October 27

8:30 - 9:30 a.m. Meet the Candidate Session

9:30 - 11:30 a.m. "OSR/AAMC Future Challenges" Discussion Sessions (4)

1:30 - 4:00 p.m. Business Meeting

4:00 - 5:30 p.m. Regional Meetings

Monday, October 28

1:30 - 3:00 p.m. Workshop

Aid for the Impaired Medical Student: A Program That's Working at U. of Tennessee

Hershel P. Wall, M.D., Associate Dean for Admissions and Students

U. of Tennessee College of Medicine

3:15 - 5:00 p.m. Workshop

Literature and Medicine: The Patient as Art

John H. Stone, M.D.

Poet and Director of Admissions, Emory U. School of Medicine

Fall Issue of OSR Report

At the April Board meeting it was decided that the next issue of OSR Report would be a composite of articles prepared by OSR Administrative Board members and staff. The number and topics of articles need to be decided and work begun by individual Board members; those with subjects in mind are asked to be prepared to outline them. The deadline for completion of articles is late August.

One topic agreed upon is "Nurses and Medical Students: Toward a Better Working Relationship". Staff has begun collecting resources to prepare this article. As envisioned, it would include a brief section on the different types of nurses and how they view their roles, a section on antecedents and examples of problems n physician/nurse relationships, and a final section on how medical students can build better team relationships and why they need to. Input from the Board on the article is welcomed. OSR member Ann Jobe, R.M., has agreed to help edit.

aamc association of american medical colleges

May 22, 1985

M E M O R A N D U M

TO: Members of the COD Administrative Board

FROM: Arnold L. Brown, M.D., Chairman

This is to solicit your thinking on matters which I suspect will be of continuing importance to the AAMC and to the Council of Deans. I hope that we can begin to consider them at our June meeting. They relate to the transition between medical school and residency education, the character, relationship and designation of those experiences, and the nature of our responsibility as medical school deans for the graduate medical education.

You are all familiar with the problems associated with the match both because you experience them at your own institution and because we have discussed them on a number of occasions: some specialties require an early match of students, not yet seniors, for programs they will be entering in their second postgraduate year. This requires decisions which are premature on the student's part, and evaluations from the school which it is not fully prepared to provide. This intrusion in the academic affairs of our own schools has been deplored on numerous occasions, yet, to date we appear powerless to intervene effectively. Perhaps all that need be done is to encourage the LCME to press its guidance on academic counseling and career guidance.

> The faculty and the chief academic officer must establish a system to assist students in selecting a future medical career and in developing a strategy for application to residency programs. This system should not permit disruption of a student's curriculum in general medical education by external proessures to make premature application to residency programs. Letters of reference or other credentials should not be provided until the fall of the student's senior year. (p. 14, Functions and Structure of a Medical School, "Academic Counseling and Career Guidance")

This is to the point, but it seems strange that we should, in effect, defer the matter to an accreditation forum.

Similarly, we seem powerless as a council to do more than deplore the situation that Bill Stoneman calls to our attention: the implicit (sometimes explicit) requirement of some program directors that a successful candidate for admission to a particular residency program will have already served an

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elective under his direction while still a medical student. Again the LCME speaks to this.

> ...the same rigorous standards for the content of each year of the program leading to the M.D. degree. The final year should complement and supplement the curriculum of the individual student so that each student will acquire appropriate competence in general medical care regardless of subsequent career specialty.
>
> The curriculum should include elective courses designed to supplement the required courses and to provide opportunities for students to pursue individual academic interests. Faculty advisors must guide students in the choice of elective courses. If students are permitted to take electives at other institutions, there should be a system centralized in the dean's office to screen the student's proposed extramural program prior to approval and to ensure the return of a performance appraisal by the host program. (pp. 13-14, Functions and Structure of a Medical School, "Content")

At the COD Spring Meeting in Scottsdale a notion developed at the new deans' open forum that generated a fair amount of enthusiasm and interest. It was that we ought to abandon the practice of referring to medical students as undergraduates and revise our nomenclature to refer to them as graduate students, and to residents as postgraduate students. David Brown has written to seriously urge that we adopt this set of designations. He argues that the majority of students entering medical school have fulfilled the requirements for the baccalaureate degree; their studies are equivalent to the breath and depth of most graduate programs; that most curriculum expectations are based on the students' development of conceptual thinking and analytic thought processes such as occur in traditional graduate programs; and that residency programs, in their expectation of the mastering of a focused discipline, are analagous to traditional postgraduate experiences. He argues that the change will help students recognize that they are expected to: 1) develop broad conceptual thinking abilities, 2) learn to use scientific data and methods to integrate complex information for hypothesis formation and testing using primary literature sources, and 3) become independent thinkers using scholarly approaches to problem solving. Similarly, he argues that the designation will encourage faculty to set and achieve objectives as described in the GPEP report.

In the context of our discussion of financing graduate medical education, Dan Tosteson suggested that some of these issues, together with matters related to the transition between medical school and residency programs, including the nature of the fourth year medical school experience, could not be suitably resolved in the absence of a better conceptualization of the proper role of the medical school during this crucial period in physician training. The question arises as to how much progress we have made in assuming "corporate responsibility for graduate medical education," or indeed, transforming graduate medical education into a truly academic enterprise. The splintered responsibility for graduate education, which is illustrated by the autonomy of the specialty boards in determining the length of training required, suggest a need for a somewhat greater institutional presence in the process. This is perhaps a long winded lead-in to the question that I would

like to have you reflect on; namely, what role should medical schools and particularly their deans play in graduate medical education?

Finally, while we have each forwarded our own notions to Don Fredrickson of the Howard Hughes Medical Institute on objects of its generousity most efficacious to the achievement of societal good, it occurs to me that it might be useful for the Association to reflect on this matter as a collective. Such deliberation might result in a somewhat less parochial image of the objectives to be served by the use of these funds.

As you recall, we had the idea that the discussion groups established for the COD Spring Meeting, each of which appears to be a microcosm of the Council, might prove to be an interesting channel for the exchange of views. Consequently, I am enclosing a copy of the original list (Tom Meikle's absence and the shifting attendance required adjustment for the meeting itself) for your use in this fashion should you desire to do so. You may also wish to forward this letter or one of your own design to provide the initial contact.

I know you are all either exhausted from, or eagerly anticipating, the '85 commencement exercises. I trust these will go well for you and free your mind to cogitate on what I think are some fascinating questions.

Liaison Committee for Medical Education

Minutes February 19 - 20 Meeting

I. Fully Accredited Programs

Two schools were conferred full accreditation for an intermediate period of time. One school was conferred accreditation for a short period.

II. Action Deferred

Action was deferred on one school (due to the arrival of new data, subsequent to the site visit) until an interim site visit can be arranged.

III. Probationary Extension

One school was placed on extended probation until completion of a full survey team report.

IV. Interim Reports

Twelve interim progress reports were accepted.

V. Standards for Accreditation

Draft 12 of the Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree was approved unanimously. This document will be transmitted to the C.M.E. of the AMA and to the Executive Council of the AAMC for approval.

Once approved, the Survey Data Base and Self-Study Instructions will need to be modified to reflect the new standards. Catherine Willner (AMA student representative) and I will work on the set of questions that are sent to medical students.

VI. Other Agencies Setting Standards

The Arkansas State Government perceives a doctor defecit for their state and thus is legislating an increase in the size of the entering medical school class. The school budget has been increased by ten percent to carry out this expansion. The LCME views this precedent with concern. Class size is determined by the LCME according to the school's faculty, budget, plant and other specifications outlined in the Standards. Quality of education is felt to precede health manpower as a priority. The LCME will make a limited site visit to the Arkansas medical school prior to the next meeting to look into this matter.

The California Board of Medical Quality Assurance (BMQA) has ruled against an applicant for state licensure until he completes two additional weeks of training in general surgery. The physician in question is a graduate of an LCME approved medical school in Colorado. This again raises the question: Who sets standards for medical education? The debate continues with BMQA. The importance of establishing Draft 12 as the new standard is clear.

VII. Observers

Ms. Barbara Binker from the Department of Education attended the meeting as part of a review of the LCME by the DOE this spring. Mr. Donald Sallee, a medical student from the University of Missouri, attended the meeting as part of a senior year elective.

VIII. Enclosures

The enclosed was included in our agenda for the February meeting and may be of interest to you.

Respectfully Submitted,

Peggy B. Hasley

TABLE 1

U.S. Medical Schools

Tuition, Student Fees, and All Other Expenses, First Year Class

1983-84 and 1984-85

	1983-84			1984-85		
	RANGE	MEDIAN	AVERAGE	RANGE	MEDIAN	AVERAGE
Public Medical Schools*						
Tuition						
Residents	$ 0-7,296	$3,174	$3,127	$ 0-8,084	$3,550	$3,516
Nonresidents	900-26,337	7,000	6,903	900-26,337	7,980	7,863
Student Fees	0-3,652	198	446	0-1,775	223	361
All Other Expenses[1]	3,000-10,783	6,890	6,750	3,000-11,807	7,000	6,989
Private Medical Schools						
Tuition**	3,700-18,750	11,683	11,711	4,500-19,600	12,700	12,596
Student Fees	0-1,780	300	344	0-1,800	371	377
All Other Expenses[1]	2,400-13,200	7,067	7,446	2,500-13,000	7,992	8,051

*Excludes Uniformed Services University of the Health Sciences which does not charge tuition or student fees.

**The following private medical schools report a lower tuition for residents of the state: Baylor, Ponce, Loyola Stritch, Mayo, Pittsburgh, Temple, Tulane, Eastern Virginia, the Medical College of Wisconsin, and Caribe-Cayey.

[1] Includes room and board, books and supplies, transportation, etc.

TABLE 2A

PUBLIC MEDICAL SCHOOLS - TUITION, FEES, AND ALL OTHER EXPENSES,
FIRST-YEAR MEDICAL STUDENTS, 1984-85, RANKED BY RESIDENT TUITION

SCHOOL	TUITION		FEES	TUITION & FEES		OTHER EXPENSES
	RESIDENT	NON-RESIDENT		RESIDENT	NON-RESIDENT	
U OF CAL. - DAVIS	0	4870	1305	1305	6175	6802
U OF CAL. - IRVINE	0	4948	1384	1384	6332	7402
U OF CAL. - LOS ANGELES	0	4908	1344	1344	6252	7500
U OF CAL. - SAN DIEGO	0	4930	1366	1366	6296	5660
U OF CAL. - SAN FRANCISCO	0	5002	1438	1438	6440	8070
TEXAS A & M	300	900	650	950	1550	6850
U OF TEXAS - DALLAS	300	900	237	537	1137	7135
U OF TEXAS - HOUSTON	300	900	255	555	1155	7950
U OF TEXAS - SAN ANTONIO	300	900	204	504	1104	11807
TEXAS TECH	300	900	424	724	1324	8879
U OF TEXAS - GALVESTON	400	1200	629	1029	1829	9960
EAST CAROLINA	1070	3826	336	1406	4162	5996
NORTH CAROLINA	1070	3826	307	1377	4133	4917
NEW MEXICO	1320	3586	30	1350	3616	7800
MARSHALL	1690	4300	262	1952	4562	7500
MASSACHUSETTS	1844	NA	135	1979	NA	8366
WEST VIRGINIA	2090	4790	0	2090	4790	6935
LOUISIANA, SHREVEPORT	2200	NA	NI	2200	NA	6600
PUERTO RICO	2250	*	200	2450	*	5500
OKLAHOMA	2296	5751	122	2418	5873	5000
LOUISIANA, NEW ORLEANS	2400	NA	120	2520	NA	8500
FLORIDA, SOUTH	2591	5999	93	2684	6092	6500
NORTH DAKOTA	2600	5200	174	2774	5374	7326
FLORIDA	2674	6082	NI	2674	6082	6209
GEORGIA	2715	8142	171	2886	8313	6374
NEBRASKA	2822	5020	300	3122	5320	6500
ALABAMA	2904	11616	1094	3998	12710	7000
SOUTH CAROLINA, UNIV. OF	3000	6000	NI	3000	6000	8400
HAWAII	3020	11570	56	3076	11626	7065
WASHINGTON, UNIVERSITY OF	3054	7734	0	3054	7734	5200
LOUISVILLE	3096	7085	95	3191	7180	7718
UTAH	3111	6741	189	3300	6930	5565
KENTUCKY	3180	7169	358	3538	7527	7275
MED UNIVERSITY OF SO. CAR.	3300	6600	NI	3300	6600	7660
CONNECTICUT	3425	7980	1775	5200	9755	7000
ARIZONA	3470	NA	NI	3470	NA	7930
ARKANSAS	3500	7000	350	3850	7350	5400
ALABAMA, SOUTH	3600	7200	708	4308	7908	6000
INDIANA	3600	8500	0	3600	8500	7000
OHIO, NORTHEASTERN	3750	7500	638	4388	8138	5375
IOWA	3920	8520	0	3920	8520	5588
ILLINOIS, SOUTHERN	3963	11889	617	4580	12506	7500
OREGON	4029	8718	469	4498	9187	5975
OHIO STATE	4161	11685	171	4332	11856	5067
NEVADA	4180	9900	NI	4180	9900	8000
TENNESSEE, EAST	4266	6820	312	4578	7132	7257
TENNESSEE, UNIVERSITY OF	4350	6903	0	4350	6903	6000
MISSOURI, COLUMBIA	4573	7393	67	4640	7460	5980
MARYLAND	4816	9630	600	5416	10230	6500
KANSAS	4830	9630	125	4955	9755	7000
VIRGINIA, UNIVERSITY OF	4870	9690	48	4918	9738	5955
VIRGINIA, MEDICAL COLLEGE	4900	9100	282	5182	9382	5360
MISSISSIPPI	5000	9000	61	5061	9061	7528
ILLINOIS	5032	14976	992	6024	15968	7938
MICHIGAN STATE	5139	10278	0	5139	10278	7500
SOUTH DAKOTA	5200	10800	325	5525	11125	10000
WAYNE STATE	5330	10660	250	5580	10910	8100
MISSOURI, KANSAS CITY	5362	9840	0	5362	9840	3000
WRIGHT STATE	5400	7980	260	5660	8240	7716
SUNY - BUFFALO	5500	8300	324	5824	8624	8500
SUNY - STONY BROOK	5500	8300	70	5570	8370	8000
CINCINNATI	5529	8646	369	5898	9015	7500
SUNY - DOWNSTATE	5550	9850	105	5655	9955	5850
SUNY - UPSTATE	5550	8850	80	5630	8930	6175
OHIO, MEDICAL COLLEGE OF	5550	7350	200	5750	7550	9700
MICHIGAN, UNIVERSITY OF	5928	11312	50	5978	11362	5020
WISCONSIN, UNIVERSITY OF	6014	8732	0	6014	8732	4180
MINNESOTA, DULUTH	6065	12130	275	6340	12405	6200
COLORADO	6348	26337	475	6823	26812	6840
VERMONT	6540	16350	275	6815	16625	6960
MINNESOTA, MINNEAPOLIS	6936	13873	336	7272	14209	8500
UMDNJ - NEW JERSEY MEDICAL	7175	8965	209	7384	9174	7500
UMDNJ - RUTGERS	7175	8965	153	7328	9118	7137
PENNSYLVANIA STATE	6084	12628	293	8377	12921	8497

TABLE 3A

PRIVATE MEDICAL SCHOOLS - TUITION, FEES, AND ALL OTHER EXPENSES,
FIRST YEAR MEDICAL STUDENTS, 1984-85 ,RANKED BY TUITION

SCHOOL	TUITION	FEES	TUITION & FEES	OTHER EXPENSES (Minimum)
HOWARD	4500	403	4903	8850
BAYLOR	8400	461	8861	10211
BOWMAN GRAY	8400	0	8400	7000
ORAL ROBERTS	8500	350	8850	7150
MOREHOUSE	9000	845	9845	7984
DUKE	9180	565	9745	6876
MEHARRY	9500	825	10325	13000
VANDERBILT	9500	300	9800	6000
CHICAGO PRITZKER	9975	402	10377	7800
CREIGHTON	9990	35	10025	6610
JOHNS HOPKINS	10300	1800	12100	8220
EMORY	10450	223	10673	7150
MIAMI	10491	50	10541	10500
MERCER	10500	197	10697	7800
YALE	10500	0	10500	7620
CASE WESTERN RESERVE	11350	754	12104	10430
STANFORD	11424	0	11424	6555
PENNSYLVANIA, UNIVERSITY OF	12070	465	12535	8315
HARVARD	12100	645	12745	7755
NEW YORK UNIVERSITY	12100	900	13000	5200
COLUMBIA	12250	530	12780	8215
ROCHESTER	12300	588	12888	6430
PENNSYLVANIA, MEDICAL COL. OF	12425	860	13285	8135
LOMA LINDA	12500	0	12500	8700
RUSH	12540	NI	12540	7315
MOUNT SINAI	12600	400	13000	8800
WASHINGTON UNIV (ST. LOUIS)	12800	NI	12800	7265
PONCE	13000	441	13441	9395
WISCONSIN, MEDICAL COLLEGE OF	13000	30	13030	12619
ALBERT EINSTEIN	13100	350	13450	6800
JEFFERSON	13175	8	13183	8290
CALIFORNIA, SOUTHERN	13320	175	13495	8820
BROWN	13330	359	13689	6145
TEMPLE	13426	511	13937	7600
SAINT LOUIS	13550	0	13550	8048
LOYOLA STRITCH	13600	371	13971	7341
CORNELL	13660	NI	13660	6740
DARTMOUTH	13780	290	14070	6330
NORTHWESTERN	13815	150	13965	7000
VIRGINIA, EASTERN	14000	420	14420	10300
ALBANY	14200	0	14200	6375
TULANE	14520	NI	14520	8520
HAHNEMANN	14630	520	15150	8485
MAYO	14900	NI	14900	6835
CARIBE, CAYEY	15000	21	15021	2500
TUFTS	15425	575	16000	9000
~~BOSTON UNIVERSITY~~	15800	500	16300	8000
PITTSBURGH	16900	70	16970	11300
NEW YORK MEDICAL	17200	175	17375	9392
CHICAGO MEDICAL	17910	410	18320	8735
GEORGE WASHINGTON	18500	150	18650	9250
GEORGETOWN	19600	572	20172	8950

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DIVISION OF STUDENT SERVICES

Total Applications = 35,944

U.S. MEDICAL SCHOOL ENROLLMENTS FOR 1984-1985

Racial/Ethnic Category	New Entrants				First-Year Enrollments+				Total Enrollments			
U.S. Citizens (and Permanent Residents):	Men	Women	Total	Percent of Total	Men	Women	Total	Percent of Total	Men	Women	Total	Percent of Total
White	9,029	4,265	13,294	81.1	9,219	4,387	13,606	80.0	38,297	16,935	55,232	82.4
Underrepresented Minorities												
Black	494	477	971	5.9	585	563	1,148	6.8	2,142	1,802	3,944	5.9
American Indian or Alaskan Native	44	23	67	.4	50	27	77	.5	165	92	257	.4
Mexican American/Chicano	211	79	290	1.8	236	93	329	1.9	767	359	1,126	1.7
Puerto Rican (Mainland)	67	45	112	.7	70	48	118	.7	226	154	380	.6
(Subtotal)	(816)	(624)	(1,440)	(8.8)	(941)	(731)	(1,672)	(9.8)	(3,300)	(2,407)	(5,707)	(8.5)
Other U.S. Students:												
Asian or Pacific Islander	705	386	1,091	6.7	727	397	1,124	6.6	2,481	1,282	3,763	5.6
Puerto Rican (Commonwealth)	150	79	229	1.4	155	81	236	1.4	625	292	917	1.4
Other Hispanic	147	82	229	1.4	158	85	243	1.4	696	291	987	1.5
(Subtotal)	(1,002)	(547)	(1,549)	(9.4)	(1,040)	(563)	(1,603)	(9.4)	(3,802)	(1,865)	(5,667)	(8.5)
Foreign Students:												
Black	20	11	31	.2	23	13	36	.2	63	35	98	.1
Other	55	21	76	.5	55	20	75	.4	218	84	282	.4
(Subtotal)	(75)	(32)	(107)	(.7)	(78)	(33)	(111)	(.7)	(281)	(99)	(380)	(.6)
All Students:	10,926	5,469	16,395*	100.0	11,282	5,715	16,997*	100.0	45,700	21,316	67,016~	100.0
Column % by gender:	66.6	33.4	100.0		66.4	33.6	100.0		68.2	31.8	100.0	

+ First-year enrollment includes new entrants and those repeating the initial year.
* New Entrants and First-Year Totals includes 5 students from whom racial/ethnic information was not available.
~ Total Enrollment includes 30 students from whom racial/ethnic information was not available.
Source: 1984-1985 Fall Enrollment Survey. Reflects enrollment at 127 schools.

NATIONAL APPLICANT POOL
ENTERING CLASS STATISTICS 1980-1984

OFFICIAL

	1980 Entering Class	1981 Entering Class	1982 Entering Class	1983 Entering Class	1984 Entering Class
Total Applicants	36,100	36,727	35,730	35,200	35,944
Female	10,664	11,673	11,685	11,961	12,476
Male	25,436	25,054	24,045	23,239	23,468
Racial/Ethnic					
Black	2,594	2,644	2,600	2,558	2,620
American Indian/Alaskan Native	147	160	137	161	150
White	28,645	28,998	27,816	27,474	27,826
Mexican-American/Chicano	449	515	504	507	555
Asian/Pacific Islander	1,774	1,976	2,222	2,325	2,775
Puerto Rican (Mainland)	191	222	212	214	253
Puerto Rican (Commonwealth)	465	476	501	503	526
Other Hispanic	646	675	611	623	732
Unidentified	1,189	1,061	1,127	835	507
Accepted Applicants	17,146	17,286	17,294	17,209	17,194
Female	4,950	5,333	5,451	5,632	5,731
Male	12,196	11,953	11,843	11,577	11,463
(Withdrew After Acceptance)	(556)	(626)	(727)	(729)	(799)
Racial/Ethnic					
Black	1,057	1,037	1,001	1,019	1,049
American Indian/Alaskan Native	62	68	56	70	72
White	14,025	14,030	13,941	13,828	13,723
Mexican-American/Chicano	240	281	284	263	286
Asian/Pacific Islander	720	824	973	1,020	1,203
Puerto Rican (Mainland)	102	113	110	117	126
Puerto Rican (Commonwealth)	221	246	211	225	236
Other Hispanic	256	266	278	273	271
Unidentified	463	421	440	394	228

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Division of Student Services
1776 Massachusetts Avenue N.W. Suite 301
Washington, D.C. 20036-1989

PREPARED BY:
Richard R. Randlett
10/22/84

MINUTES

LIAISON COMMITTEE ON MEDICAL EDUCATION

April 15 - 17, 1985

I. Full Accreditation Decisions

No. years full accreditation	No. of schools
10	1
8	1
5	2
4	1
1	2
decision deferred	1

One school was given continued provisional accreditation on probation. The LCME is close to removing accreditation from this school.

II. Progress Reports for Continued Accreditation

Progress Reports were accepted for seven schools. Decision for acceptance was deferred for one school pending a full report. One school was requested to send an additional Progress Report in 1987.

III. Standards for Accreditation

The LCME's new Standards for Accreditation have been unanimously approved by the AMA-CME and the AAMC Executive Council. The Survey Data Base, Self Study Instructions, Team Secretary's Guide, and Annual LCME Questionnaire will be modified to reflect the new Standards. Of note in these Standards is the separation of criteria to which medical schools must comply, from those which schools should comply. This separation will assist Survey Teams and the LCME to objectify the evaluation process.

IV. Federal Department of Education Evaluation of the LCME

The LCME is coming under review by the DOE Division of Eligibility and Agency Evaluation this spring for continued recognition. Criteria and Procedures for Recognition of Nationally Recognized Accrediting Agencies and Associations is enclosed for your information. (Ms. Bickel will make available at the meeting).

MEMO:
Date 5-4-85
TO: OSR
FROM: Peggy Hasley
REGARDING: Junior VS. Senior Student Representative to the LCME

I understand that the OSR is considering the pros and cons of nominating a third year versus a fourth year student representative to the LCME. I have some views on that which you may wish to consider.

Advantages of electing a junior student:

1. Learning the ropes significantly assists students' understanding of the process and hence the relevancy of their commentary.
2. A known quantitiy is far more acceptable to other LCME members. I think the other members view my comments more favorably now that I am known to them.
3. Students who enter in the third year are invited to attend Site Visits during their senior year thus maximizing their potential impact.

Disadvantages of electing a junior student:

1. Medical school demands significantly more of us in the third than in the fourth year. My third year student associate on the LCME felt she had very little time to read the reports, while I was able to devote a good deal of time to prepare for the meetings.

2. Electing senior students for a one year term increases the number of students who benefit from membership on the LCME.

3. A mature articulate senior student will be able to compensate for the disadvantages associated with a short term of office.

Ultimately the decision depends upon your priorities. If you prefer to maximize student impact on the LCME, then I recommend chosing a student based upon qualifications rather than placement in medical school training. If maximizing opportunities for students is your aim, then I suggest you choose the most qualified senior student. I defer to your judgement.

MEMO:
TO: Students elected to the LCME by the OSR
FROM: Peggy Hasley, student representative to the LCME during the 1984-1985 academic year
DATE: May 5, 1985
REGARDING: This memo is intended to serve as an informal adjunct to: "The Role of Students in the Accreditation of U.S. Medical Education Programs." I hope that the following information and advise will assist your preparation for the LCME meetings.

The LCME meets four times each year in either Washington D.C. or Chicago, alternating the location of the meetings annually. If you are appointed as a senior student you will attend all LCME functions at one or the other city. If appointed during your junior year, you will have the opportunity to join a survey team and will visit medical schools under evaluation anywhere in the country. Participation on site visits only occurres during your second year as an LCME member. Thus students appointed in their senior year do not go on site visits.

LCME meetings are conducted as follows: Generally they run for one and a half days except during the summer meeting which may extend up to four days. The first day of most meetings begins at noon and finishes at 5PM. Decisions are made regarding the conferral of full term accreditation to approximately six to eight schools utilizing the full survey reports. The second day begins at 8:30AM and usually ends around noon. This day discussion centers on the more concise progress reports for approximately ten to twelve schools. The meeting concludes with a discussion of ongoing issues of concern to the LCME such as the LCME standards, ACGME activities, and the DOE evaluation of the LCME. Students are free to make comments at any time during the meetings. You do not vote, but may make motions. Moreover after the first meeting you will be asked to present one progress report each meeting.

To prepare for the meetings you are expected to read the full survey report for each school on the agenda (about 150 - 200 pages per report) and to submit written comments to be included in the agenda. Shortly before the meeting you will receive a 500 page agenda containing LCME member comments to the survey reports,progress reports, and sundry information. It is helpful to read all but the progress reports in the agenda.

You would do well to know the full scale survey reports. These reports focus on the following subjects: finances, faculty, administration, student data and opinions, curriculum, physical plant, library, residences, graduate education, continuing medical education, and a review of the basic science and clinical departments individually. I found it a better use of my time to confine my attention to those aspects of medical education with a direct impact on the student experience. I payed attention primarily to the curriculum, student views, faculty, residencies, library, and student access to the administration.

Clearly, membership on the LCME involves a significant sacrifice of time if attended to conscientiously. In the balance, in my opinion, it is well worth it. My advise to a student starting out on the LCME would be as follows:

1. Know the standards for accreditation well. This would be an invaluable asset. Constant referral to the "must" and "should" specifications in the standards will objectify the evaluation process.

2. Prioritize the most important issues concerning each school clearly in your mind, then confine your comments to these issues. To say nothing at these

meetings is a misuse of your opportunity. To attempt to dominate the discussion will undermine the value of your comments.

3. Of course: Know of what you speak. Off the cuff remarks are a waste of time. Research the issue well utizing the survey reports, agenda, and outside resources if possible.

4. Keep contact with your sponsoring organization. Minutes after each meeting should not include the names of schools under discussion. Try to attend an OSR meeting to report on your experiences.

5. Any questions? Call me at home (412) 363 8554, or at work: The University Health Center of Pittsburgh (412) 647 2323 (paging operator).

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The AAMC Clinical Evaluation Program

Status Report, May, 1985

Xenia Tonesk, Ph.D. Director

The AAMC Clinical Evaluation Program is designed to assist clinical faculties in evaluating students during their undergraduate and graduate clinical education. Phase I of the Program, from 1978 through 1982, focused on identifying problems with current evaluation systems. This phase consisted of 1) site visits to approximately thirty medical schools; 2) a survey of clerkship coordinators in the six major specialties (medicine, surgery, obstetrics-gynecology, pediatrics, psychiatry, family medicine); and 3) interviews with several hundred clinical faculty, department chairs, residents, and medical students regarding evaluation policies, practices, and problems. The results of Phase I appear in the booklet, The Evaluation of Clerks: Perceptions of Clinical Faculty(1) and the accompanying editorial, "Clinical Judgment of Faculties in the Evaluation of Clerks".(2)

In 1983, Phase II was introduced by an information packet, "Clinical Faculty Invited to Join Expanded Program."(3) A Program Advisory Group was appointed, chaired by Daniel Federman, M.D. from Harvard Medical School. Persons responding to the tear sheet included in the packet were placed on the Program Mailing List(4) and receive the latest information about program activities.

In Phase II the Program consists of four components: 1) The Project on the Self-Assessment of Clinical Evaluation Systems, 2) An Annotated Review of Evaluation and Education Along the Clinical Continuum, 3) Workshops for Diagnosing and Managing Problem Residents and Medical Students, and 4) a Study

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of the Changing Clinical Environment and Its Impact on the Evaluation of Medical Students and Residents. A detailed description of the Project on the Self-Assessment of Clinical Evaluation Systems and discussion of some preliminary results follow.

The purpose of the Project on the Self-Assessment of Clinical Evaluation Systems is to develop self-assessment materials for use by medical schools and/or clinical departments. With these materials, interested persons will be able to: 1) describe the formal and informal structure of their current evaluation systems; 2) assess the strengths and weaknesses of those systems; 3) determine the level of satisfaction of those involved with the systems; 4) decide on needed changes; 5) implement the changes; and 6) monitor the impact of the changes.

Currently nine medical schools are piloting the materials designed to accomplish the six steps. They include the University of California, Los Angeles; University of California, San Francisco; Jefferson Medical College; Louisiana State University, New Orleans; McMaster, University of Oklahoma; University of Pennsylvania; University of Washington; and Uniformed Services University of Health Sciences.

The philosophy underlying the project is that clerkship coordinators, clinical faculty, and appropriate Dean's office personnel should expand their definitions of "evaluator" to include functioning as managers of evaluation systems. An evaluation system can apply to a service, a clinical department, or a medical school. Each individual evaluator should view himself as a manager of the component of the evaluation system for which he is responsible within his unit. The management perspective introduces concepts such as the effective use of human resources, management of information flow, and the assessment of quality of information transmitted.

The self-assessment materials consist of five instruments designed to provide information about four areas identified in Phase I as needing attention. The areas include: 1) obstacles to student evaluation, 2) problem students, 3) content of evaluation, and 4) evaluation policies and practices. The five instruments and the four areas addressed appear in Figure 1.

Preliminary results have been obtained from seven of the nine pilot schools regarding serious system problems identified through the use of the System Problem Checklist. Clerkship coordinators have identified 1) the breakdown in the transmission of information across rotations and clerkships, 2) the lack of an early-warning system regarding problem clerks, and 3) faculty unwillingness to record negative evaluations, as serious problems which they must address. Clinical faculty and residents have cited as serious problems the following: 1) the lack of information available about problems which clerks bring with them into their rotation; 2) the lack of training of faculty and housestaff as evaluators; 3) failure by clerkship coordinators and/or Dean's office personnel to act on negative information they receive about a problem student; 4) inadequate guidelines for handling problem students; and 5) faculty unwillingness to record negative assessments.

Other preliminary data have been obtained from seven pilot schools using the Problem Student Checklist. Types of problem students frequently encountered by faculty include the disorganized student and the student who cannot focus on what is important. Students whom clinical faculty find difficult to evaluate and/or manage include the excessively shy, non-assertive student, the student with a psychiatric or substance abuse problem, the bright student with poor interpersonal skills, the student who challenges everything, and the "con artist".

Final results from the pilot study will be available by the Fall of 1985.

References

1. Tonesk, X. The Evaluation of Clerks: Perceptions of Clinical Faculty. Association of American Medical Colleges, 1983.

2. Tonesk, X. Clinical Judgement of Faculties in the Evaluation of Clerks. *Journal of Medical Education*, *58*:213-214, 1983.

3. Tonesk, X. Clinical Faculty Invited to Join Expanded Program. Association of American Medical Colleges, 1983.

4. AAMC Clinical Evaluation Program List of Persons Expressing Interest in Self-Assessment of Clinical Evaluation Systems. Association of American Medical Colleges, August, 1984.

AAMC Clinical Evaluation Program

Project on the Self-Assessment of Clinical Evaluation Systems

Figure 1

Self-Assessment Materials for Diagnosing

Clinical Evaluation System Problems