Jordan J. Cohen, MD
President
Association of American Medical Colleges
Washington, D.C.
1994 – 2006

Scholar, leader, educator, communicator, mentor, healer, innovator

Malcolm C. Cox, MD
July 1994 – June 1995

David Korn, MD
July 1995 – August 1997

Gene A. Kallenberg, MD
March 1996 – February 1997

Carl E. Hunt, MD, PhD
September 1996 – July 1997

Herbert M. Swick, MD
July 1998 – December 1999

Daniel S. Blumenthal, MD, MPH
July 2000 – December 2000

Donald O. Nutter, MD
August 2000 – September 2001

Julien F. Biebuyck, MB, DPhil
January 2001 – April 2002

Thomas S. Inui, MD, MSc

Eugene C. Corbett, MD, MS
July 2002 – June 2003

Daniel H. Winship, MD
August 2003 – July 2004

Joel Kupersmith, MD
October 2003 – July 2005

Charles L. Rice, MD
July 2004 – July 2005

David E. Longnecker, MD
July 2004 – August 2005

Deborah C. German, MD
August 2005 – July 2006

Dave A. Davis, MD
October 2005 – August 2006

Linda L. Blank
October 2005 – December 2006
The AAMC scholar-in-residence program was named for Robert G. Petersdorf, MD, who served as President of the Association from 1986 to 1994 and was a beacon for the profession’s evolution to the 21st century. Upon his retirement, the AAMC honored Dr. Petersdorf for his leadership, values and scholarship by establishing this endowed program, which has brought 17 visiting scholars to Washington in the 12 years since its inception.

During that time, visiting scholars have incorporated their broad expertise with research pursuits in such critical areas as medical education, organizational leadership, accountability in academic medical centers, and educating for professionalism. With their vast knowledge of the immediate issues and concerns facing academic medical centers today and in the future, the Petersdorf Scholars are able to integrate invaluable insight with contemporary level experience for their projects and the Association.

At the same time, the scholars have the advantage of working one-on-one with AAMC staff. Each scholar is sponsored by a senior member of the Association’s staff and works closely with that individual and other staff colleagues from the beginning of the designated research initiative to its completion.

Applicants to the program need a minimum of seven years of professional experience directly related to their proposed area of study. The Petersdorf Scholars do not receive a stipend for their work, but the Association does cover all project costs and can help with living arrangements during the in-residence tenure at the AAMC.

The following pages summarize – in the words of the past and present Petersdorf Scholars – the compilation of their work and related reflections. Collectively they have published 40 peer reviewed journal articles, chapters, books and monographs, and another dozen are definitive works-in-progress to be completed before 2007. In addition, by the end of 2006, the 17 scholars will have completed a total of 150 presentations of their AAMC-related work within diverse venues including AAMC national meetings as well as other national and international professional meetings, invitational conferences, grand rounds, visiting professorships, faculty development workshops, and leadership roundtables.

The Petersdorf Scholars celebrate the gift of time from their busy often chaotic professional careers to conduct research, advance the profession and experience reflection. Therefore, it is with sincere appreciation to Jordan J. Cohen, MD, President of the Association of American Medical Colleges (1994-2006) that this publication is dedicated for his direct involvement as a role model for the Petersdorf Scholars, and his distinct vision and unwavering commitment as a conscience for the profession.

Kathleen S. Turner
Vice President for Membership and Constituent Services

Linda L. Blank
Robert G. Petersdorf Scholar-in-Residence
DESCRIPTION OF PROJECT

During the early 1990s, in a rather rare spirit of agreement, policy makers and leaders of academic medicine and the then emerging managed care industry reached an alarming conclusion: traditionally-educated physicians were ill-equipped for the practice of high quality, cost-effective medicine. Today this statement still rings true and bears testament to the glacial rate of change that characterizes so many reform efforts. In the previous decade, one of the many factors hampering reform was the absence of an integrated system of governance for graduate medical education. Hospital executives, clinical service chiefs, department chairs and medical school deans were (and oftentimes remain) more competitive than collaborative. And residency program directors were unwilling or unable to bring historically separate programs – even those in the same city affiliated with a single medical school or health system – together for the common good.

Policy makers reasoned that the day when medical education could be confined to a single entity – the university hospital or its surrogate – had passed. Once said, then new systems for addressing physician workforce issues seemed reasonable and necessary for the measurement, maintenance and enhancement of educational quality, for the administration of educational programs, for allowing input from various stakeholders, and providing for an equitable distribution of resources. Then there were “too many” physicians; now there are “too few”. No wonder the confidence intervals around our forecasting methods are questioned.

Bringing individual GME programs together in cooperative “consortia” – organizations stronger than traditional affiliations but short of outright mergers – seemed like a reasonable idea. A few consortia already existed but no one knew what was really out there, so when I posed the question to the new President of the AAMC, with characteristic humility Jordan replied, “Let’s find out”. Which is how I became the first Petersdorf Scholar-in-Residence and how a laboratory-based chief of medicine decided to spend the rest of his career asking questions about medical education rather than epithelial electrolyte transport.

Working with the AAMC Advisory Panel on Strategic Positioning for Health Care Reform, and building on previous work by the Association and the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), Catherine Dower at the Center for the Health Professions at the University of California, San Francisco and I designed, administered and analyzed a national survey on graduate medical education consortia. For the purposes of the survey, we defined GME consortia as formal partnerships, involving two or more separate institutions and including a minimum of two separate disciplines formed to reorganize or strengthen graduate medical education and characterized by shared and joint decision making. Some thirty such consortia were identified nationwide.
Consortia proved to have a number of features in common. They almost always included a medical school but very few included other health professional schools (so they provided little or no opportunity for inter-professional education or team-based care delivery, something still sorely lacking in medical education today). Interestingly, consortium members felt able to cooperate on education while still competing in the health care market place (a lesson the broader medical education community has yet to learn). Most were organized democratically, with a governance structure that allowed for equal representation and input from all members.

Almost all consortia voiced the dual mission of simplifying the administration and enhancing the quality of graduate medical education, but consortia had limited enthusiasm for reshaping the physician workforce. Two-thirds reported reductions in administrative costs and a majority reported gains in training program accreditation. However, for the most part, consortia had only nominal authority to set educational standards and monitor residency program quality, and relatively few were able to restructure existing training programs. Although nearly two-thirds of consortia considered the important goal of increasing the output of generalist physicians, few supported limiting the overall numbers of physicians trained or reducing the output of subspecialists (almost prescient, given present day physician workforce needs).

We concluded that consortia provide a viable mechanism for reforming the administration and management of graduate medical education programs, and that their more widespread adoption would help to rationalize the fragmented graduate medical education system. It was equally clear, however, that by themselves they would be unlikely to effect fundamental changes in medical education. And in the absence of appropriate incentives, they would fail to impact physician workforce reform.

In its Ninth Report to the Secretary of the U.S. Department of Health and Human Services, the Council on Graduate Medical Education crafted many of its recommendations on this work. In attempting to define the organizational structure that would best serve both educational quality and physician workforce goals, the Council called for competitive funding of a series of consortium demonstration projects and federal, state and private sector reimbursement incentives for the organization of consortia. But ideas in Washington usually have at best an evanescent lifetime, interest in consortia waned, and neither of these recommendations was adopted. Today, the governance of graduate medical education remains as fragmented as it was at the time.

**MOTIVATION**
The impetus for me was straightforward – to learn more about the organization and governance of medical education.

**PUBLICATIONS**


Cox M. Educational Consortia: A New Model for Medical Education? In *Proceedings from: Do Departments of Internal Medicine Fit In Integrated Delivery Systems?* Association of Professors of Medicine, Washington, DC; 1998. pp.73-80.

**PRESENTATIONS**
Project findings were presented from 1995-1998 at 25 invitational national and regional meetings including the Association of American Medical Colleges and Council on Graduate Medical Education.

**BIOSKETCH**
In February 2006, Dr. Cox was appointed Chief Academic Affiliation Officer of the Department of Veterans Affairs in Washington, DC. From 2003-2006, he was the Carl W. Walter Distinguished Professor of Medicine and Dean for Medical Education at Harvard Medical School where he was instrumental in launching an extensive review of medical education and initiating joint degree programs with the Harvard Business School (MD/MBA) and Harvard College (MD/PhD social science program). He received his medical degree from Harvard Medical School, completed postgraduate training in internal medicine and nephrology at the Hospital of the University of Pennsylvania and later served as Associate Chief of Staff for Research and Chief of the Medical Service at the Philadelphia VA Medical Center and Vice Chair of the Department of Medicine, Associate Dean for Network & Primary Care Education and Associate Dean for Clinical Education at the University of Pennsylvania School of Medicine.
I arrived at the AAMC in July 1995 to begin a sabbatical stay of uncertain duration and initially without a defined project. On April 1, I had stepped down from nearly 11 years as Stanford University Vice President and Dean of the School of Medicine. In August 1967, I joined Stanford's Department of Pathology as Professor and Chair and left my research career at NIH. My task was to rebuild a department that had pretty much disintegrated during the 1959-60 relocation of Stanford's medical school from San Francisco to the university campus. During 17 years as Chair and 11 years as Dean, I had never taken a sabbatical because of the pressure of university responsibilities, but I had scrupulously “banked” my earned time, and in 1995 it totaled 21 months.

During nearly three decades, Stanford University had become my passion and, increasingly, my life, so much so that I had done no planning, indeed, given scant consideration to my “life after the deanship.” I recognized that my scientific career was long ended (although the laboratory I founded continues to flourish to this day), and I really hadn’t a clue about what I might do next. But one thing did become increasingly clear to me as my final months in office flew by, namely, for my sake and that of the medical school, I had to get off the campus. So in early 1995, I spontaneously called Jordan Cohen, whom I did not really know or had ever had a conversation with, and asked whether I might “perch” for a while at the AAMC and at no cost to it.

My prior AAMC interactions had been modest: I had attended many Annual Meetings but very few Spring Meetings of the Council of Deans, had served on the AAMC Task Force on Physician Supply, had been appointed to the Advisory Panel on Research, and was serving as Chair of the AAMC Task Force on Medical School Financing. I certainly was not a member of AAMC’s political inner circle. Notwithstanding, Jordan was exceedingly kind and gracious, and, as I recall from our very brief conversation, he responded by saying something like, “Sure, come on over; we’d love to have you.”

I arrived at the AAMC, assigned to the former Division of Biomedical Research (DBR), in one of the hottest, most wretchedly humid summers in years, utterly at sea as to what I would do with myself next. As Dean, I had abundant staff who managed my affairs completely, 24/7/52; at the AAMC, I poached timidly on a slim DBR staff, tried not to get in anyone’s way and to be helpful; I did not know how to start a
computer, let alone use one. But the Task Force on Medical School Financing became my first anchor, and its staff director, Robert Jones, my intellectual colleague and friend. Over the next two years, Robert and I wrote the Task Force report, which still stands as the authoritative document on the topic, and we completed and published a project on the cost of educating a medical student, which also stands as the definitive study to date. I also published several major papers on academic medicine and contributed ideas to national science policies.

REFLECTIONS

My sabbatical period restored my intellectual vitality, as well as my sanity. While I was learning all over again to be a lecturer and scholar, achieving enough mastery of simple computing to feel wonderfully self-sufficient, and in a very real sense “rejoining the world of the living,” I was also becoming ever more impressed with and comfortable in the AAMC environment. Jordan and the staff were extraordinarily gracious and hospitable; I felt welcomed, even embraced, from the moment I arrived, a wounded bird desperately in need of R&R.

The months flew by and I still wasn’t certain of my professional future, which created a persistent sense of uneasiness and many restless nights. I had been asked to look at several open deanships, but really did not wish to do that job again in an alien locale. For nearly a year I was negotiating a professorship at the University of Maryland’s Baltimore (UMB) campus where I would create a new Center and Program in Science Policy. And then, as had happened so many times in my career, fate intervened and out of the blue I was offered the position I now hold. On the day Jordan talked with me, I was about to sign a contract with UMB, so resigned was I to becoming a daily commuter to Baltimore.

It took me about five minutes to accept Jordan’s offer, and as I have often stated, this position, my fourth career, has been wonderfully fulfilling in all respects. Indeed, in satisfaction and pure joy, it ranks with my earliest years at Stanford, when I was constantly being challenged by the building of a new department and a new research program during what was probably the most turbulent period in 20th century academe. For my new opportunity, I am eternally grateful to Jordan and the unparalleled leadership he has given the AAMC.

PUBLICATIONS


BIOSKETCH

Since September 1997, Dr. Korn has served as Senior Vice President for Biomedical and Health Sciences Research at the Association of American Medical Colleges. From 1984-1995, he was the Carl and Elizabeth Naumann Professor and Dean of the Stanford University School of Medicine, Vice President of Stanford University from 1986-1995, Professor and Chair, Department of Pathology at Stanford, and Chief, Pathology Service, Stanford University Hospital, 1967-1984. A member of the Institute of Medicine, Dr. Korn has been President, American Association of Pathologists (now American Society for Investigative Pathology); President, Association of Pathology Chairmen; member, Board of Directors and Executive Committee, Federation of American Societies for Experimental Biology; and member, Board of Directors, Association of Academic Health Centers.
DESCRIPTION OF PROJECT

My interest in working at the AAMC was centered on the then current national movement to reform the curricula of US medical schools. We at George Washington University, like many of our peers across the country, were engaged in an introspective study of our curriculum. This was in response to a national expression on many levels of dissatisfaction with US physicians by patients, payers and society as a whole. There was dissatisfaction with doctors’ ability to listen to patients, treat them cost-effectively and to contribute to the care of the increasing ranks of the underserved. While not the sole source of these problems to be sure, society seemed to be placing some of the blame for the system’s problems squarely on the shoulders of its physicians. Several national demonstration projects funded by both government and private foundations were underway to recast the goals and to reshape the structure of the undergraduate curriculum in order to meet society’s criticisms. One of the key components of these efforts revolved around clinical experience for medical students starting early in their education. Associated with this were increased instructional time in communications, professionalism and the doctor-patient relationship.

At GW I had the fortune of being part of our school’s efforts to undertake curriculum reform. It was a heady time full of innovation and new program development. We were a part of a national movement and I developed the desire to study some of these changes and to find out what others were experiencing as they went through this involved process. Initially, I approached the AAMC Office of Primary Care which was transitioning its activity and profile, and then met Dr. Whitcomb who was also interested in studying some of the changes going on in medical education. We designed a study to survey and visit a representative sample of medical schools that were actively redesigning their clinical education with an emphasis on increasing exposure to patient care, communication skills, the doctor-patient relationship, and community medicine activities during the pre-clinical years. At about the same time Dr. Carl Hunt had written to Mike with a similar interest in pediatric clinical education and when he arrived at the AAMC we coalesced as a team for this project for the better part of a year.

Our dynamic duo (Carl and I) visited 26 medical schools over the next six months and honed our approach into a modern day Flexnerian visit of 1 – 1.5 days that often humorously began with the paraphrased statement: “We’re from the AAMC and we’re here to help!” During these visits we met with the Dean, most of the faculty leading and
participating in curricular change and usually a group of medical students who were experiencing the new program and the new curriculum. All whom we met treated us with wonderful hospitality, openness and a real interest in the anecdotal wisdom we were accumulating along the way. I will always fondly recall the dinners and car rides with key leaders from these various schools, during which we often gained our best insights into what makes change happen and how people react to it. And through this process I became good friends with Carl Hunt as well. We finally concluded our visits and then spent some long weeks writing up our insights and published our findings in Academic Medicine and Archives of Pediatrics & Adolescent Medicine.

Along the way we participated in many ongoing conferences and activities at the AAMC. These included most memorably the Medical School Objectives Project (MSOP), which became the fore-runner (in my opinion) of the current ACGME General Competencies, which, in turn, have become the benchmark for all professional competency assessment in medicine, from undergraduate to proposed post-licensure periodic evaluation. There were always interesting, innovative presentations happening weekly at the AAMC, a number of which included presentations to the staff by Jordan Cohen himself, and as scholars-in-residence we were there to participate and enjoy the intellectual stimulation and collegiality.

As a result of this exposure and the work I was able to participate in at the AAMC, I was invited to make a number of presentations in various educational venues over the next several years. In addition to this, upon my “return” to GW full-time I was named Assistant Dean for Curricular Projects as I continued to play a leadership role in the medical school’s newly developing curriculum. These educational innovation efforts provided some of the greatest personal and professional fulfillment that I have experienced in my faculty career.

**MOTIVATION AND REFLECTIONS**

I had the great fortune to serve as a Petersdorf Scholar at the AAMC while retaining my position as Chief of the Division of Family Medicine in the Department of Health Care Sciences at the George Washington University School of Medicine and Health Sciences. For the majority of my time I worked with Carl Hunt, MD, PhD – a “primary care neonatologist” – as he used to humorously call himself.

I will always remember the excellent working relationships I experienced at the AAMC with Mike Whitcomb, Brownie Anderson, and all the support staff in the Division of Medical Education. It was clear that Jordan Cohen’s work ethic and principles were palpable on a day-to-day basis throughout the organization and contributed to the positive and creative atmosphere we experienced. I am also happy to have learned that our early experiences contributed to the continued success of the Petersdorf Scholar-in-Residence Program at the AAMC. I would strongly commend this opportunity to other faculty educators at any stage in their careers. It cannot but add to one’s perspective and life experience and result in one being a better educator and a better faculty role model after its conclusion.

**PUBLICATIONS**


**PRESENTATIONS**

At least 15 national, regional and grand rounds presentations resulted from this work, including at the 1997 and 1998 AAMC Annual Meetings, Group on Educational Affairs, Association of Academic Health Centers, Society of Teachers of Family Medicine, and Society of Directors of Research in Medical Education.

**BIOSKETCH**

Dr. Kallenberg is Professor of Clinical Medicine, Vice Chair, Department of Family and Preventive Medicine, and Division Chief of Family Medicine at the University of California, San Diego. He received his medical degree from the University of Cincinnati College of Medicine and completed his internship and residency in family medicine at Los Angeles County Harbor-UCLA Medical Center in Torrance. He was appointed Assistant Professor of Health Care Sciences and Medicine in 1982 at George Washington University in Washington, DC. After becoming Associate Professor, he was named Chief of the Division of Family Practice in 1990 and Assistant Dean for Curricular Projects at George Washington University School of Medicine and Health Sciences in 1998.
DESCRIPTION OF PROJECT

Dr. Gene Kallenberg and I conducted site visits to 26 U.S. medical schools in 1997 to obtain an overview of the strategies being developed to carry out education in the ambulatory care setting. We also used information from 12 additional schools that were not visited, and consulted individuals responsible for the evaluation of five grant programs dedicated to national curriculum reform. We identified three main strategies that were used to provide medical students the kinds of educational experiences they need to understand and practice in the ambulatory care setting. These were: (1) longitudinal preceptorships, (2) multi-specialty clerkships, and (3) activities that are community oriented and population-based. We also identified several issues and challenges related to the implementation of these curricular changes which included: curricular management issues; developing and maintaining a network of practicing physicians willing to serve as preceptors; evaluating curricular innovations; and assessing student performance. We concluded our project with general observations about the need for ambulatory care education, the difficulties that continue to be encountered that have to be overcome for successful implementation, and a final recommendation that relevant learning experiences should be incorporated into existing course work or clinical experiences.

MOTIVATION AND REFLECTIONS

My motivation to become a Petersdorf Scholar-in-Residence was prompted by the opportunities to:

1. Change my academic career focus
2. Conduct an in-depth analysis of state-of-the-art curriculum innovations in ambulatory undergraduate medical education in a spectrum of representative American medical schools, and
3. Describe national trends and innovative strategies

My experiences as a Scholar-in-Residence had a major impact on my subsequent academic health center-based career. Upon my return to the Medical University of Ohio, I co-chaired the committee responsible for developing and implementing a new First and Second Year medical
school curriculum, and I subsequently chaired the Year 1-2 curriculum subcommittee. In addition, I actively participated in the ongoing evaluation and fine tuning of the curriculum and served as course director for the new Year 2 Problem-Based Learning Course. These experiences were also invaluable at the National Institutes of Health in regard to program development and evaluation related to training and to professional and public education and awareness initiatives.

PUBLICATIONS


PRESENTATIONS

Findings from our project were presented in two separate sessions at the 1997 Annual AAMC Meeting. Selected aspects of our findings were also presented at Pediatric Grand Rounds and in other conference formats at the Medical University of Ohio.

BIOSKETCH

Dr. Hunt is a graduate of the University of Rochester and Yale University School of Medicine. Residency training in pediatrics and fellowship training in neonatal-perinatal medicine were obtained at the University of Minnesota, Minneapolis. He has served on the medical school faculties of the University of Minnesota, Northwestern University, and the Medical University of Ohio. He was Head, Division of Neonatology at Children’s Memorial Hospital and was Professor and Vice Chair, Department of Pediatrics at Northwestern University Medical School. From 1988-97, he was Chair of the Department of Pediatrics at the Medical University of Ohio. His primary research focus has been on the control of breathing and sleep disorders in children, with a particular emphasis on Sudden Infant Death Syndrome. In 2001, Dr. Hunt was appointed Director of the National Center on Sleep Disorders Research of the National Heart, Lung, and Blood Institute of the National Institutes of Health. Earlier this year, he was appointed Special Assistant to the Director of the National Heart, Lung, and Blood Institute.
DESCRIPTION OF PROJECT

Over the past 11 years, medical professionalism has garnered a great deal of attention from medical schools, accreditation and professional organizations, certifying boards and practicing physicians. Despite the intense focus on professionalism, there was in the late 1990s no common understanding about what comprised professionalism, and no common framework that could be used to develop curricula or assessment tools. My project focused on the nature and pedagogy of medical professionalism, in an effort to advance the dialogue about this important issue and to determine how medical schools were addressing the development of professional values in their students.

The first stage of the project was an extensive literature review, not only of medical literature but also that of other disciplines, such as sociology. Questions included: What comprises professionalism, not only in medicine but in other professions? What is it about the nature of professional work that distinguishes it from other fields of endeavor? What professional values are integral to medicine? Seminal work by Louis Brandeis, Eliot Freidson, William Sullivan, and Richard and Sylvia Cruess, among others, helped shape and confirm my own thoughts that medical professionalism must be grounded both in the nature of a profession and in the nature of physicians’ work, and that a profession becomes a way of life with a moral value. Informal but structured interviews with key leaders from medical schools and professional organizations provided further insight into the scope of (and disagreements regarding) medical professionalism. Presentations at the 1999 meetings of the AAMC, the Council of Academic Societies, and selected regional meetings of the Group on Student Affairs and Organization of Student Representatives solicited additional useful information. It became apparent that, despite a great deal of productive attention, there was little common understanding of what, exactly, medical professionalism entailed. One major goal of my project, therefore, became an attempt to derive a normative definition of professionalism, designed to promote continuing discussion and dialogue.

In 1998, both the AAMC and the AMA Section on Medical Schools sponsored meetings that focused on professionalism. From these meetings there emerged a consensus among senior medical educators that medical schools should offer both didactic and experiential learning experiences designed to promote the development of professionalism in medical students and residents. Thus, a second major project goal was to determine how medical schools were addressing professionalism in undergraduate medical education. With colleagues in the Division of Medical Education (DME), I designed and conducted a two part survey of US medical schools. The first stage sought general information about how schools addressed
professionalism, while the second stage was a detailed curricular review of 41 schools. The survey focused on four key attributes of professionalism (subordinating self-interest, demonstrating high ethical and moral standards, responding to societal needs, and evincing core humanistic values).

We found that while most schools were addressing professionalism in some manner, learning activities varied from brief comments during orientation to vertically integrated programs that extended over two or more years. While many schools acknowledged its importance, fewer were attempting to evaluate or monitor the professional development of medical students. In 1999, the survey results were published in the annual education issue of the Journal of the American Medical Association.

My project has enabled me to continue to address issues of professionalism in settings as diverse as premedical student groups, workshops for medical school faculty, and meetings of national professional organizations. The project has resulted indirectly in six publications that, I trust, have helped draw attention to the importance of professionalism in contemporary medical education and practice.

MOTIVATION AND REFLECTIONS
For a number of years, I had been interested in professionalism and the development of professional values during undergraduate medical education. During the 1990s, medical professionalism became a major focus of interest in academic medicine and professional societies. I was interested in making a contribution to the understanding and teaching of professionalism as an integral element in the practice of medicine.

Key to the success of my project was support from DME colleagues, particularly Deborah Danoff, MD, Michael Whitcomb, MD, Cynthia Woodward and Brownie Anderson. I remain most grateful for their interest and encouragement.

AAMC President, Dr. Jordan Cohen, has long nurtured one other activity in which I have been pleased to play a role that was independent from but a corollary to being a Petersdorf Scholar – the Music in Medicine presentations at the annual AAMC Meetings. Since 1994, these have provided the welcome respite of live musical performances, ranging from jazz to classical chamber music, and from medieval songs to German lieder. They have explored the medical conditions of composers, the physics and physiology of playing wind instruments, musical descriptions of illness, and illness as a creative spark among other topics.

PUBLICATIONS

PRESENTATIONS
Meetings of Southern Regional Group on Student Affairs/Organization of Student Representatives and Southern Group on Educational Affairs, 1999; Council of Academic Societies Spring Meeting, 1999; AAMC Annual Meeting, 1999; American College of Obstetricians and Gynecologists Annual Meeting, 2000; American Osler Society Annual Meetings, 1999 and 2003

Visiting Professorships: University of Kentucky, 1999; University of South Carolina School of Medicine, 2001; Mayo Medical School, 2002; University of Nevada School of Medicine, 2005

BIOSKETCH
Since 2000, Dr. Swick has been Executive Director of the Institute of Medicine and Humanities, a joint program of Saint Patrick Hospital and Health Sciences Center and the University of Montana in Missoula. He is a University of Montana Professor, and Clinical Associate Professor of Medicine, University of Washington School of Medicine, and hosts Collegium Medicum, a weekly Montana Public Radio program that explores medicine through the lens of the humanities. A graduate of the Johns Hopkins University School of Medicine, he also completed training there in pediatrics and child neurology. He spent 30 years in academic medicine, holding faculty and administrative appointments at the Medical College of Wisconsin as Associate Dean for Medical Education and Senior Associate Dean for Academic Affairs and the University of Kansas School of Medicine as Senior Associate Dean for Academic Affairs and Interim Executive Dean, School of Medicine.
DESCRIPTION OF PROJECT

My project centered on learning about how medical students are taught the content areas of public health and population health. It provided me with a unique opportunity to conduct telephone interviews with associate deans, course directors, and students at 23 U.S. medical schools selected to represent a diversity of types of institutions: public, private, community-based, research intensive, and those with relatively traditional as well as those with more innovative curricula. I found that most population and public health teaching programs represent one or more of five organizational arrangements: a preclinical course; a longitudinal integrated course; a clinical clerkship; a carved-out portion of a course or clerkship; or instruction integrated into a clinical clerkship. Major issues at many schools were faculty preparedness; responsibility for the teaching program (Dean’s office/departmental); evaluation of teaching; evaluation of student performance; “drift” away from integrated models; and the role of public health schools and programs. I concluded that, at many schools, the traditional approach to teaching population health through a short preclinical epidemiology or public health course was being replaced by attempts to integrate the population health perspective throughout the curriculum. The rate-limiting factor for this movement was often the number and the deployment of faculty with the requisite skills to teach population health. Although the report on the project was never published, I presented it at a retreat of the chairs of departments of preventive medicine at the 2001 Association of Teachers of Preventive Medicine Annual Meeting, and many remarked to me that they found the information useful. The information was certainly helpful to me and my faculty as we developed our educational program at Morehouse School of Medicine.

As a Petersdorf Scholar, I also spent part of my time learning about AAMC efforts to improve the “pipeline” of minority students leading to medical school or graduate school in public health, and visited an AAMC grantee at the University of Illinois at Chicago. This led to a presentation at the 2001 Annual Meeting of the American Public Health Association.
In addition, I used the time away from my usual routine to focus on a number of other writing projects, and began or completed several manuscripts that eventually did find their way into print. These included several journal articles, an edited report for the World Health Organization, and a book on community-based research. Finally, I also was able to prepare several grant proposals that subsequently were successfully funded.

**MOTIVATION AND REFLECTIONS**

My project was a study of how public health and population health are taught to medical students in the United States. It was motivated in part as a follow-up to the AAMC 1998 Medical School Objectives Project Report of the Population Health Perspective Panel. This project related closely to my work in medical education at Morehouse School of Medicine. I enjoyed my experience with the AAMC very much and the time it afforded to focus and be productive.

**PUBLICATIONS**


**BIOSKETCH**

Dr. Blumenthal is a graduate of Oberlin College and the University of Chicago School of Medicine. He completed his residency in pediatrics at Charity Hospital of New Orleans (Tulane Division), received a master of public health degree from Emory University, and is board-certified in pediatrics and in preventive medicine. Dr. Blumenthal served as a VISTA Volunteer physician in Lee County, Arkansas; as an Epidemic Intelligence Service Officer with the Centers for Disease Control and Prevention in Atlanta; and as a medical epidemiologist with the World Health Organization Smallpox Eradication Program in India and Somalia. From 1975-80, he was Assistant Professor in the Department of Community Health at the Emory University School of Medicine and the medical director of a neighborhood health center. In 1980, he joined the faculty of the Morehouse School of Medicine, and in 1985 was appointed to his current position as Professor and Chair of the Department of Community Health and Preventive Medicine. Eight years later he became Associate Dean for Community Programs. He also has served as President of the Association of Teachers of Preventive Medicine, Chairman of the Medical Care Section, and a member of the Governing Council of the American Public Health Association. Currently he is a member of the Board of Regents of the American College of Preventive Medicine.
DESCRIPTION OF PROJECT

The project goals included the following:

- to define the organization, structure, content, and conduct of the clinical curriculum in US and Canadian medical schools;
- to identify examples of innovations being implemented in the design and conduct of the clinical curriculum; and
- to identify issues of concern related to the clinical education of medical students.

The major project methods included a comprehensive literature review, analysis of many AAMC databases and reports, a web-based survey of all US medical education deans, and site visits to 22 US and Canadian medical schools that featured interviews with educational administrators, student clerkship directors, and senior medical students.

The project goals were achieved and this permitted a comprehensive assessment of the clinical education of medical students. Analysis revealed a number of major issues of concern regarding the quality of students’ clinical educational experiences, and led to the recommendation of five major actions that schools should consider taking to correct deficiencies and improve the educational experience. With the focus on aligning the design and conduct of the clerkship experiences with the assessment of students’ performance in meeting well-articulated learning objectives, the key recommendations promote:

1. acquisition of fundamental clinical skills that are needed throughout professional careers,
2. providing adequate exposure to enough patients during clerkship experiences,
3. reaffirmation and integration of contemporary issues in medicine that were introduced during the first two years,
4. developing a system that fosters appropriate recognition and rewards to faculty for their contributions to the education of medical students, and
5. recognition and accountability by institutional leadership that medical student education is the primary and unique mission of medical schools.
In Fall 2001, the AAMC published our work as a 15-page monograph entitled, *The AAMC Project on the Clinical Education of Medical Students*. The project and its results were presented at a focus session during the 2001 AAMC Annual Meeting, and the project report was subsequently distributed to the deans of all US and Canadian schools. In July 2001, I retired from the Feinberg School of Medicine at Northwestern University as Professor of Medicine Emeritus. I have been delighted to continue to work with the AAMC DME staff on medical education issues, including consultation for the “Preparation for the Professions Project” at the Carnegie Foundation for the Advancement of Teaching.

**MOTIVATION AND REFLECTIONS**

Motivated by my experience during a 35-year career in medical education and academic leadership, and by service on the Liaison Committee on Medical Education, I developed this project, under Dr. Whitcomb’s guidance, to study the changing environment for medical student education in academic medical centers as well as to identify problems and needs in the clinical curriculum. Follow up work, primarily intended to disseminate project results and stimulate curricular revision and quality improvement in medical student clinical education then occurred over the following two years.

**PUBLICATIONS**

Nutter DO and Whitcomb ME. *The AAMC Project on the Clinical Education of Medical Students* (Monograph), Association of American Medical Colleges, Washington, DC; Fall 2001.

**PRESENTATIONS**

As an outgrowth of the project, over the past four years, Dr. Whitcomb and I have presented and discussed material from the project with medical educators and academic leaders in many venues around North America. These include the AAMC Council of Deans Spring Meeting, meetings of various specialty society leadership groups, medical school grand rounds and conference plenary sessions, and the Millennium Conferences of the Carl J. Shapiro Institute for Education and Research at Harvard Medical School and Beth Israel Deaconess Medical Center in Boston.

**BIOSKETCH**

A graduate of the Johns Hopkins University and George Washington University School of Medicine, Dr Nutter trained in internal medicine and cardiology at George Washington University and Emory University. In 1968, after service as a research cardiologist in the US Air Force aerospace laboratories he joined the faculty at the Emory University Medical School, rising to the ranks of Professor of Medicine (Cardiology), and Associate Professor of Physiology, and to positions as Director of the Medical Scientist Training Program, and Executive Associate Dean. He was a Robert Wood Johnson Health Policy Fellow (RWJHPF) at the Institute of Medicine of the National Academy of Sciences in Washington, DC (1978-79), served on the RWJHPF Board of Directors (1982-88), and directed the Health Policy Task Force for the Carter Center in Atlanta (1982-84). In 1985, Dr. Nutter moved to Northwestern University where he was appointed as Professor of Medicine and became Vice Dean with responsibility for the medical school’s students, faculty, and academic programs. He was a member of the Advisory Board for the Fogarty International Center at the National Institutes of Health (1997-2000). Recent service for the Association of American Medical Colleges has included membership on the Liaison Committee on Medical Education (1996-2002), chair of the Expert Panel on Medical Education (1999-2000), and as Robert G. Petersdorf Scholar-in-Residence (2000-01). At present, Dr. Nutter serves as Vice Chair, Board of Directors of the Foundation for Advancement of International Medical Education and Research.
DESCRIPTION OF PROJECT

Initially, we set out to define the best practices, amongst all medical schools, in the selection, recruitment, appointment and development of department chairs in academic medicine. We had noted that, despite department chairs’ key leadership position in the medical school their performance expectations were invariably unclear. As a result, it became apparent that the dean, the department chair, and the faculty, might each have divergent ideas concerning the responsibilities and expectations of the chair.

Our approach widened to include a study of relevant aspects of higher education, specifically the selection and recruitment of university presidents. We also included a study of major business practices related to identifying future corporate leaders and the “succession planning” culture prevalent in most large business organizations. Two collaborators then joined the project, Joseph Keyes, JD, Senior Vice President, Division of Medical School Affairs who had a passionate interest in academic medical leadership training, from his thirty-year experience with running the popular biannual seminars for Chairs and Deans, and William Mallon, EdD, Assistant Vice President, Division of Medical School Services and Studies who had just joined the Division. We also began discussions with the Wharton School and leadership consultants, particularly with Thomas Gilmore who later became a member of the advisory board of our “Successful Chair” publications.

A decision was made to combine our studies and subsequent recommendations into a major AAMC publication. As the intended audience was rather diverse and could be divided into distinct groups (Deans, Hospital CEOs, Chairs, and Faculty), we elected to use a three “module” format for our publication so that each of these groups could focus on their own areas of interest. The first module was Search, Selection, Appointment and Transition of the Medical School Department Chair. The second module defined the Characteristics, Responsibilities, Expectations and Skill Sets of Chairs. And the third module described Chair Performance, Evaluation, Rewards and Renewal.

Our project was true to the basic tenets of the AAMC philosophy, as we extended the work of previous national AAMC conferences, incorporated the Council of Academic Societies Chairs’ Objectives Project, and then canvassed the opinions of all deans, chair organizations, and AAMC faculty groups, as well as other education associations based in Washington, DC.

Julien F. Biebuyck, MB, DPhil
Petersdorf Scholar-in-Residence

January 2001 – April 2002

PROJECT: The Role of Department Chairs: Responsibilities and Accountability for Balance of Missions

SPONSOR: Robert F. Jones, PhD
Senior Vice President
Division of Medical School Services and Studies

“Julien Biebuyck’s time as scholar-in-residence was rich in contributions to our culture in addition to the publications that emerged from it. He brought a genuine interest in medical school organizational issues, a scholarly orientation, and real-world experience. I still remember fondly the lively and engaging discussions. Ours was a team that genuinely enjoyed working with each other.” – Robert Jones
Our project goals included:

- Documenting the characteristics in the selection and development of successful department chairs by identifying good practices in chair accountability and performance-related rewards and highlighting chairs’ key role in advancing medical schools’ missions.

- Characterizing the role of the department chair in fulfilling the differing expectations of the dean and hospital CEO, in ensuring a balance of all missions, and in developing the talents of each faculty member.

- Analyzing the causes of chair failures, and exploring the possible avoidance of failure by selection practices, early career development of skill sets, mid-career mentoring, and continuing long-term career development.

Following the Petersdorf Scholar position, I became Senior Consultant for Academic Management Programs in the Division of Medical School Affairs.

**MOTIVATION AND REFLECTIONS**

Beginning in 1996, I was involved in three major AAMC national conferences devoted to department chair issues and came to know Robert Jones. In addition, I had led several department chair search committees and a dean’s search committee at The Pennsylvania State University, and had become acutely aware of the lack of definition of chair responsibilities and expectations in medical schools. Finally, prior to my AAMC study I had researched the background issues which led to department chairs being fired. A sabbatical from my university enabled me to initiate the planning of the AAMC study which resulted in my appointment as a Petersdorf Scholar by Jordan Cohen. He was extremely supportive and a valued, wise resource and advisor throughout my tenure at the Association.

Building on this experience, I was able to initiate and launch the Council of Deans Fellowship Program during 2002-2004. The main goal of this program was the development of future leaders in academic medicine. The fellowship was designed for candidates interested in being considered for deanships in the near future. The fellows spent time at a designated dean-mentor’s home base, at the AAMC Office and attending Council of Deans and other AAMC meetings.

Being a Peterdorf Scholar was particularly gratifying to me as I had long admired Robert Petersdorf. While I was a Nuffield Research Fellow in the laboratory of Hans Krebs at Oxford University in 1971, Dr Petersdorf (then Chair, Department of Medicine, University of Washington) spent his sabbatical year in the same lab. During that year I learned much about American academic medicine, and I have followed his career and his writings closely ever since.

**PUBLICATIONS**


AAMC Library Collection: Dr. Biebuyck established *The Robert G. Petersdorf Scholar-in-Residence Leadership Collection* by donating 125 books on leadership from his personal library to the AAMC library.

**PRESENTATIONS**

Findings from our project were presented at the Council of Deans 2001 Spring Meeting, Council of Teaching Hospitals and Health Systems 2002 Spring Meeting and AAMC 2002 Annual Meeting.

**BIOSKETCH**

Dr. Biebuyck is the Eric A. Walker Chair Emeritus at the Pennsylvania State University and Milton S. Hershey Medical Center in Hershey, Pennsylvania where he was the Senior Associate Dean for Academic Affairs (1997-2000); Associate Dean for Academic Affairs (1991-1997); and the Eric A. Walker Chair of Anesthesiology (1977-1997). Before coming to Penn State, he was Assistant Professor of Anesthesia and Medical Foundation Research Fellow (1972-1974); Director of NIH Anesthesia Metabolic Research Laboratory and Lecturer in Anesthesia (1974-1976) at Harvard Medical School and Massachusetts General Hospital in Boston. He received the Doctor of Philosophy degree from Oxford University and his MB and ChB from the University of Cape Town.
DESCRIPTION OF PROJECT

Over the six-month period as a Petersdorf Scholar, I read extensively in the literature of professionalism and professional development. The disciplinary domains within which I read included medical education, sociology, anthropology, history of medical education, and moral philosophy. I interviewed 15 AAMC officers and staff members on the topic of professionalism and professional development, as well as officers and staff members of the Association of Academic Health Centers, Accreditation Council for Graduate Medical Education, National Board of Medical Examiners, and other organizations. It was a wonderful opportunity to bring together disparate points of view on professional development, professional values, and organizational change. My most persistent discussion partners as the project evolved were Brownie Anderson, Deborah Danoff, and Mike Whitcomb. In our first meeting, Brownie framed the opportunity for me powerfully: “Tom, the Association has many thread makers – we need a weaver!”

I’d like to think the product of my time as a scholar-in-residence was a tapestry of professionalism, pulling together threads from diverse domains into a richly patterned whole.

Perhaps as a consequence of this period of thinking and work, I now find myself thoroughly immersed in an ever-widening discourse on professionalism in medicine. My own ‘territorial view’ suggests that there are two tented camps among educators at the moment, the first emphasizing responsibility, accountability and rules, and a second inclined to emphasize learning from experience, reflection, and mindfulness of values. My contribution of A Flag in the Wind reaches into both camps and goes on to emphasize the importance of measurement, feedback, and organizational development. I suspect I will stay with this discourse. It seems close to what brought me to medicine originally.

MOTIVATION AND REFLECTIONS

My time as a Petersdorf Scholar was part of a sabbatical leave from Harvard Medical School that allowed me to focus on professionalism and professional values in medicine. The other activities of the sabbatical leave included six months in residence at the University of Tokyo.
School of Medicine and a year in residence at the Fetzer Institute in Kalamazoo, Michigan, a foundation dedicated to amalgamating mind-body-spirit. This sabbatical and related activity grounded me once again in my liberal arts foundations, including intellectual work in culture, philosophic and spiritual traditions, creative literature, and social science.

**PUBLICATION**


**PRESENTATIONS**

Within the AAMC, I presented my report to the Executive Council, Council of Academic Societies, Organization of Resident Representatives, and Women in Medicine Session at the AAMC 2003 National Meeting, and an AAMC staff seminar.

National presentations have been made at the Society of General Internal Medicine, Japan Society of Medical Education, Rheumatology Program Directors Annual Meeting, and New York State Association of Medical Schools. Grand Rounds presentations in medicine, surgery, anesthesiology, and otolaryngology have been completed at the Indiana University School of Medicine, where it has also been presented as a component of the White Coat Ceremony, Dean's Council, Clarian Systems Physicians, and Clarian Health System Board of Directors. Other invited presentations have been made during the past two years at 10 US medical schools.

**BIOSKETCH**

Dr. Inui is President and CEO of the Regenstrief Institute for Health Care, the Sam Regenstrief Professor of Health Services Research, and Associate Dean for Health Care Research at Indiana University School of Medicine in Indianapolis. A primary care physician, educator, and researcher, he previously held positions as Head, Division of General Internal Medicine at the University of Washington School of Medicine and as the Paul C. Cabot Professor and founding Chair, Department of Ambulatory Care and Prevention at Harvard Medical School. Dr. Inui's special emphases in teaching and research have included physician/patient communication, health promotion and disease prevention, the social context of medicine, and medical humanities. His honors include elected membership in Phi Beta Kappa, Alpha Omega Alpha, the Johns Hopkins University Society of Scholars, a USPHS Medal of Commendation, serving as council member and President of the Society of General Internal Medicine (SGIM), recipient of SGIM's Robert Glaser Award, and election to the Institute of Medicine (IOM) and subsequently as a member of the governing Council. He has participated in the publication of more than 240 manuscripts on a broad variety of topics.
DESCRIPTION OF PROJECT

The goal of this project was to study clinical skills education in American and European medical schools as part of the AAMC Project on the Clinical Education of Medical Students, and to draw some general conclusions from a variety of data analyses, a survey of deans, and through visits to selected schools. From this, an approach to creating an explicit clinical skills curriculum for undergraduate medical education is being developed. Additional objectives included promotion of a national dialogue among clinical educators, dissemination of information about the state of clinical skills education, and development of a consensus among clerkship educators regarding the clinical skills education of medical students.

From my year of study, I have learned that this element of basic medical education remains mostly implicit in students’ educational experience. As a result, there is a national need for better standardization in the teaching and assessment of students’ clinical skills performance development and of the standards which should govern their education. I had the privilege to learn first-hand about attempts to develop model programs in clinical skills education both here and abroad, and that there is much that educators can learn from each other. This experience also provided ample validation that there is much that needs to be done to improve the curricular process of clinical skills education. It has also influenced me to become more involved in this area within my own academic career.

MOTIVATION AND REFLECTIONS

The primary motivation was my concern for the inadequate and deteriorating nature of clinical skills performance education of medical students during their UME experience.

Becoming a physician requires an attitude of professionalism and self-directed learning, appropriate knowledge acquisition, and the continuous development of skills performance ability. This knowledge, skill set and values statement pervades the professed culture of medical education at all learning levels. However, I believe that the element of skills development is the weakest of our undergraduate medical education triad.
Upon returning to academic medicine after a lengthy period of community practice, I became concerned about the deteriorating amount and quality of opportunities for medical students to develop basic clinical skill performance ability. Although there are many and increasing regulatory, legal, financial and institutional reasons for this, it also seems evident that the lack of an explicit, rigorous emphasis in the UME curriculum upon the development of clinical performance competency is the rate-limiting step in the development of students' generic clinical method proficiency.

**PUBLICATIONS**

*The AAMC Project on the Clinical Education of Medical Students: Clinical Skills Education*, 2004 (Monograph), Association of American Medical Colleges.


*Recommendations for Clinical Skills Curricula for Undergraduate Medical Education*, 2005 (Monograph), Association of American Medical Colleges.

**PRESENTATIONS**

AAMC Task Force on the Clinical Skills Education of Medical Students, June 2003

*Grand Rounds*: Georgetown University, May 2003; University of Virginia, July 2004 and September 2004


*Faculty Development Sessions*: Tufts University, November 2004; Harvard Medical International (Dresden Technical University) April 2005; Clerkship Directors in Internal Medicine, October 2005; AAMC Annual Meeting, November 2005; Society of Teachers of Family Medicine, April 2006

*Clinical Skills Workshops*: Uniformed University of the Health Sciences, January 2005; University of California, Irvine, June 2005

**IN DEVELOPMENT**

Faculty Development Task Force Subcommittee Working Group on Preclerkship Clinical Skills Education Consensus on Clinical Skills Assessment

**BIOSKETCH**

Dr. Corbett was an undergraduate at Florida State University (1966) and graduated from the University of Chicago School of Medicine in 1970. Following a surgical internship (SUNY Syracuse) he spent two years in general practice in rural Virginia. He completed internal medicine residency while a Clinical Scholar at Johns Hopkins University (1973-75). He returned to rural practice in Virginia spending four years in a community health center and five years in private practice. Following a sabbatical year at Stanford University (1984-85), he joined the full time faculty at the University of Virginia. As a clinical educator, Dr. Corbett has been involved at every level of health science education, both medicine and nursing. This includes course and clerkship leadership, faculty and resident teacher development, educational evaluation, curriculum development and grant-supported clinical education innovation. He has received many recognitions and awards for his work including an endowed chair and research fund provided by a devoted patient. He most recently received an All University Teaching Award. He currently chairs an AAMC Task Force on the Clinical Skills Education of Medical Students and is the Anne L. and Bernard B. Brodie Professor of Medicine and Associate Professor of Nursing, Department of Medicine, University of Virginia School of Medicine.
DESCRIPTION OF PROJECT

“I believe that reforming medical education is the most serious challenge the leadership of academic medicine’s institutions now face.”
ME Whitcomb, Academic Medicine, 78:1, 2003.

An extensive and intensive review of the medical education literature reveals that dissatisfaction with medical education is not new. The history of the development of Graduate Medical Education (GME) from 1850 to the present is replete with repeated calls for improvement of educational standards and process, and the literature of the period provides a registry of concerns regarding the adequacy of GME over time. Thus, recognition of the inadequacy of the GME process to develop adequately educated and prepared practitioners has been materializing and growing over the past half century.

The development and growth of ambulatory care settings for teaching and learning, along with supplementing and complementing the hospital setting, led to many changes to facilitate learning and has been an important factor in the evolution of medical education.

The literature review, coupled with wide ranging discussions with prominent educators and educational researchers by personal visits, telephone discussions, e-mails and letters, indicated that the topic is sufficiently large as to require limitation in extent to achieve a workable scope. Thus, the work focused on the specialties of Internal Medicine (IM) and Family Medicine (FM), where a sizable literature identified self-assessed deficiencies of preparedness in both these specialties. These deficiencies led to careful reviews and analysis of the ACGME program requirements for both specialties.

The current program requirements for internal medicine are exhaustive in detail and process and are very light on the requirements for specific procedures or conditions. Those for family medicine are similar on detail and process but are more directive regarding some specific procedures and conditions.
Many attempts have been made to identify what has failed in the educational program and processes to result in the perceived inadequacies of the practitioners produced. Suggestions include, not surprisingly, organizational leadership, research in medical education, alterations in and inadequacies of the national health system, financing of medical education – all of these are seriously lacking.

Leading organizations of both specialties recognize these educational and preparational shortcomings. Both have revised and restated their respective education philosophies and plans and both await public scrutiny and appropriate implementation. Thus these specialties appear to be moving ahead with change.

Key lessons learned about diffusing innovation into practice through education are not unexpected. They include: effective senior management and clinical leadership, appropriate useful data, required changes in organizational culture, and coordination across disciplines or departments – they are all necessary. Sustainability with dedicated infrastructure and expertise along with positive relationships between cooperating organizations are also essential. Finally, perceived ability of innovations to reduce external threats can influence speed of diffusion. (Bradley, et al, The Commonwealth Fund, 2004)

**MOTIVATION AND REFLECTIONS**

I had been chair of the Committee on Program Requirements of the ACGME for a few years prior to this sabbatical year and the questions stated in the title had grown in my thoughts and matured through discussions with Dr. Whitcomb. I enjoyed the privilege of being at the Association, seeing the leadership in action, particularly Jordan Cohen, interacting with the AAMC’s extraordinary staff and experiencing the wonder of living in Washington just two blocks from the office.

**PRESENTATIONS**

Several presentations and roundtable discussions with AAMC leadership and staff were organized.

**BIOSKETCH**

Dr. Winship is Chief of the Cook County Bureau of Health Services, and former Vice Chancellor of Health Affairs and chief executive officer at University of Missouri Health Care. He is currently Professor of Medicine at Rush Medical College, and Clinical Professor of Health Policy and Administration, School of Public Health, University of Illinois at Chicago. Dr. Winship has devoted his professional life to research, academic medicine and medical administration. He has held numerous academic appointments, including Dean of the Stritch School of Medicine at Loyola University in Chicago; and Director, Division of Gastroenterology, Professor and Associate Chair of the Department of Medicine and Associate Dean for VA Affairs at the University of Missouri School of Medicine in Columbia. Dr. Winship also has held such administrative appointments as Medical Center Director of the Veterans Administration Medical Center in Kansas City, Missouri; and Associate Deputy Chief Medical Director for Health Affairs in the Department of Veterans Affairs, Washington, DC. In 1990, he received the Distinguished Service Medal and Award from the Department of Veterans Affairs. Dr. Winship has served on the editorial boards of several research and specialty journals and was Associate Editor of the *Journal of Laboratory and Clinical Medicine*. He has held leadership positions with numerous professional organizations including the Accreditation Council for Graduate Medical Education and the University HealthSystem Consortium. He received a medical degree from the University of Texas Medical Branch in Galveston, and completed internship at the Ochsner Foundation Hospital in New Orleans, medical residency at the University of Utah College of Medicine in Salt Lake City and gastroenterology fellowship at the Yale University School of Medicine.
DESCRIPTION OF PROJECT

The purpose of this project was to develop a methodology for Academic Medical Centers (AMCs) to demonstrate accountability. It is a generally accepted fact that it is important for AMCs to be accountable to stakeholders and the public both for their own and everyone’s benefit. Having had the comprehensive experiences of being a medical school department chair, Dean and AMC vice president, I well understood the workings of AMCs and the need for accountability. However, little work had been done in actually determining how AMCs should be accountable and what should be the guiding principles.

The first step in the project was to speak to a variety of experts; there were 30 in all and these included AMC deans and vice presidents, healthcare policy experts, health-care economists, ethicists, and others. The next step was to discuss the project internally among the wise and experienced AAMC staff. We had a number of lively, enriching conversations about the underlying principles and workings of AMCs and many other educational and philosophic issues.

I then set about to writing the monograph. In my thinking, with the help of Jordan Cohen, Bob Dickler and others, I decided on certain approaches. Firstly, I divided accountability into Level I and Level II Accountability. Level I Accountability encompasses institutional requirements such as accreditation and others and Level II Accountability involves institutional choices and how an AMC elaborates or carries out its mission. For example, what are the number of medical students and residents? What types of clinical programs exist? What is the research strategy? The monograph dealt with Level II Accountability and also classified the domains of accountability in an AMC (education, research, clinical care and additional public service) and elaborated a roadmap for achieving accountability. It was published and widely disseminated to the academic medicine community in May 2005.

MOTIVATION AND REFLECTIONS

I have had a long career in academic medicine and wanted to move into health policy after my tenure as a medical school Dean. In addition, having been a Dean, I saw the need for Academic Medical Centers to be more accountable. Although I knew that this project would be very difficult and take considerable effort, I hoped it
would make a unique contribution to the field and serve as a stimulus for change.

I learned a considerable amount from this project. It gave me a chance to think about many aspects of Academic Medical Centers, how they function and their basic philosophy in a manner that I had never considered before. In addition, by moving to Washington, I had the opportunity to meet many interesting “movers and shakers.” Perhaps the main educational experience was interacting with the many fine professionals at the AAMC, each of whom had something unique to teach. This was the best aspect of my experience. I should also note that concurrently, I was a scholar-in-residence at the Institute of Medicine working on a project related to a public-private consortium to do effectiveness research. In that context my completed projects and publications have incorporated how Academic Medical Centers should be accountable; and how to fund, oversee and promote effectiveness research, quality of care in teaching hospitals, regional IRBs, medical manpower and other issues.

The impact on my career was that I moved from being a Petersdorf Scholar to becoming the Chief Research and Development Officer of the VA where I now oversee a $1.7 billion research program. But more than that, I gained a much greater insight into what I had been doing in my entire career in academic medicine and the nature of the institutions that I was part of. In addition, I made many new friends.

**PUBLICATIONS**


**PRESENTATIONS**

My work resulted in the opportunity to conduct numerous internal presentations and roundtable discussions at the AAMC and to make a formal presentation on Accountability in Academic Medical Centers at the 2005 AAMC Annual Meeting in Washington, DC.

**BIOSKETCH**

Dr. Kupersmith is the Chief Research and Development Officer in the Department of Veterans Affairs in Washington, DC. He is a graduate of New York Medical College where he also completed training in internal medicine. Subsequently, he completed a cardiology fellowship at Beth Israel Medical Center in Boston. Following research training in the Department of Pharmacology, he joined the faculty of the Mount Sinai School of Medicine where he rose to the rank of Professor and was Director of Clinical Pharmacology. He then became Chief of Cardiology and V.V. Cooke Professor of Medicine at the University of Louisville before being recruited as Chair, Department of Medicine at Michigan State University. Next, Dr. Kupersmith was appointed Dean, School of Medicine and Graduate School, Vice President for Clinical Affairs at Texas Tech University as well as CEO of the Faculty Practice. The many advances in the medical center included a comprehensive strategic plan; a marked stepwise drop in faculty attrition rate; legislative initiatives and growth of the research enterprise; important recruitments; many educational initiatives and construction projects; improved scores of entering students and an increased number of minority students. In addition, Dr. Kupersmith played an important early role in establishing a new medical school in El Paso, Texas.
DESCRIPTION OF PROJECT

Public academic health centers are very complex organizations that must address the four distinct missions of education, research, patient care and public service. The spectrum of responsibility in each is briefly outlined within the scope of my project:

- **Education**
  - undergraduate level (nursing, allied health)
  - graduate level (public health, basic sciences)
  - professional (medical, dental, pharmacy, advanced practice nursing)
  - post-graduate (residency and fellowship programs; post-doctoral basic science)
  - continuing health professions

- **Research**
  - Basic
  - Clinical
  - Health Services

- **Patient Care**
  - Inpatient
  - Outpatient
  - Population-based

- **Public Service**
  - Employer
  - Advisory capacity to legislatures and state and local agencies

The most complex setting is that of an academic health center that is part of a large and comprehensive public university; located on or near that university’s main campus; having health science colleges in addition to the college of medicine; and having an integrated hospital.

For the purposes of my work, I used the AAMC definition of “integrated”. No single governance model has been developed that seems to be the answer to addressing the challenges of managing these diverse institutional missions.

This project identified 22 institutions that met the criteria above. After gathering baseline data on NIH funding, Moody’s bond ratings, NSF ratings of graduate programs, and other relevant data, site visits were conducted at 14 of the institutions. Structured interviews were conducted with the university president (or chancellor), the provost, the vice-president for business and finance, the vice-president for
health sciences, the dean of medicine, and the dean of one other health science college. The questions posed fell into nine areas as noted below:

1. Does the leadership of the university appreciate and understand the distinct mission of the AHC? Does it recognize the unique cultural characteristics of the AHC?

2. Is the institution able to be agile in responding to market forces? In particular, can it permit the AHC flexibility in pay scales (for recruitment and retention of key personnel)? Is there flexibility in purchasing processes?

3. Does the AHC have the ability to operate out of the sunshine? Are private meetings with the governing board permitted?

4. Can the AHC develop the discipline to manage systems that are often different from those of the university (IT, general ledger, etc.)?

5. Can the AHC cultivate and sustain high caliber leaders?

6. To what extent is the AHC able to escape from extraneous political forces such as unions?

7. Are the practice plan, COM, and hospital able to jointly plan, especially in those areas for which major capital will be required?

8. Are the hospital and practice plan able to acquire and retain capital in accounts insulated from those of the university?

9. Does the organizational structure facilitate and encourage interdisciplinary education and research that cuts across the colleges?

**MOTIVATION AND REFLECTION**

Given my long career in academic medicine, passionate interest in medical education and a unique understanding of organizational leadership and the multitude of national organizations contributing to this agenda, I was enamored by the opportunity to explore the complexity of selected academic health centers in the context of their relationships with expansive public universities. Therefore, I am grateful to Jordan Cohen, Bob Dickler, and the exceptional staff of the AAMC for the time and excitement this project afforded me to engage in these interviews and the information and perspectives they imparted.

**PUBLICATIONS**

The report is now under development and will summarize the findings at each institution including the common themes that emerged as well as unanticipated discoveries.

**BIOSKETCH**

In 2005, Dr. Rice was selected to become the fifth President of the Uniformed Services University of the Health Sciences in Bethesda. Previously, he served as Vice-Chancellor for Health Affairs at the University of Illinois at Chicago (UIC). Originally from Atlanta, Dr. Rice received his medical degree from the Medical College of Georgia in 1968. He interned at Bowman Gray School of Medicine at Wake Forest University, Winston-Salem and in 1973 he completed his residency in general surgery at the National Naval Medical Center in Bethesda, Maryland. From 1973 to 1975, he was a research fellow at the Naval Medical Research Institute in Bethesda. Dr. Rice was Professor of Surgery, Physiology and Biophysics at UIC from 1993 to 2005. He was also the Vice Dean of the College of Medicine, 1994 to 1999. He has authored more than 200 scientific papers, abstracts, and chapters in medical textbooks. His research interests, many funded by the National Institutes of Health, have been in the biology of lung injury and in mechanisms of cell and tissue injury in shock. From 1991-1992, Dr Rice was a Robert Wood Johnson Health Policy Fellow and served as a Legislative Assistant to Senator Thomas A. Daschle (D-SD). He also served on the Board of the Accreditation Council on Graduate Medical Education from 1998 to 2004 and as its Chair from 2002 to 2004. During his military career Dr. Rice was commissioned in 1966 as an ensign in the U.S. Naval Reserve Medical Corps and promoted to lieutenant in 1968. In 1969 he became a member of the Medical Corps in the U.S. Navy and in 1971 he was promoted to lieutenant commander and then to commander in 1975. Back in the Naval Reserve Medical Corps in 1989 he was promoted to captain in 1991. From 1990 to 1993 he served as Trauma Surgeon to the President of the United States.
DESCRIPTION OF PROJECT

The project involved two primary components: a survey of the roles and responsibilities of chief medical officers (CMOs) and an exploration of the needs of AMC-based CMOs for interaction with colleagues who hold similar positions. We developed a rather comprehensive web-based questionnaire (37 items with many subcomponents) that was designed to identify the demographics, roles and responsibilities of CMOs in AAMC member institutions. In addition, they were asked to list their major accomplishments and principal challenges and rate their job satisfaction and innumerate those factors that either enhanced or impaired success in these roles. This survey was sent to 340 CMOs including those with similar clinical leadership roles but different titles, such as Medical Director, Vice President for Medical Affairs, Vice Dean for Clinical Affairs or Chief of Staff. The results from 154 (45% response rate) revealed the following key findings:

◆ these are relatively new positions for AAMC member institutions, with almost half (48%) created within the last 10 years,

◆ the titles vary and the responsibilities are broad, but the greatest time commitments involve clinical quality and patient safety, inpatient and outpatient services, and graduate medical education,

◆ the most important factors that fostered success were personal stature in the institution, commitment of the CEO to the goals of the position, and commitment of other hospital or health system administrators to the position’s goals, and

◆ the areas that present the greatest challenges for the future include finances, hospital operations (particularly relating to quality, safety, access and throughput) and human relations (especially involving physicians and recruitment).

Many other findings are relevant as well, but the key point is that AAMC member institutions now turn to a designated physician leader to coordinate and manage clinical care, much in the way that medical schools rely on Vice Deans for Education or Research to coordinate those efforts.

In addition, we organized the first AAMC-sponsored program for CMOs at the 2004 AAMC Annual Meeting. In this session, several CMOs described their roles in various types of institutions (e.g., integrated hospitals, independent hospitals, health systems or Veterans Affairs hospitals). Other CMOs discussed the management of high-profile clinical events or new initiatives to enhance open clinical communication (e.g., crew resource management). The session attracted a standing room only audience and it
received very positive reviews from the attendees, who recommended that similar meetings be held in the future. Thus a steering committee of CMOs from AAMC member institutions was appointed and another session, focusing on the interface between clinical and educational excellence, was held at the 2005 AAMC Annual Meeting. Again, there was great interest and the attendees emphasized the value of this meeting thus an AAMC professional development group for CMOs is being created.

MOTIVATION AND REFLECTIONS

My interest in the roles and responsibilities of CMOs in academic medical centers was stimulated by the growing expectations for clinical excellence in the practices and teaching hospitals that are the sites for undergraduate and graduate medical education in the United States. The expectations for excellence have increased in recent years, in response to public and professional awareness that coordination and integration of care are essential for safe, high quality care, and for outstanding education of tomorrow’s doctors. In turn, increasing the profile of quality and safety stimulated an interest in clinical leaders who focus specifically on clinical excellence and patient safety. Thus the position of CMO appeared to be increasing in both number and importance among AAMC member institutions and recognized as such by the AAMC leadership. In 2004, Robert Dickler and AAMC President, Jordan Cohen hosted a focus group meeting for a dozen chief medical officers from AAMC member institutions. I was impressed by Dr. Cohen’s personal involvement in the topic along with his committed presence and participation in the lively dialogue throughout the day. And I am grateful to Robert Dickler who subsequently sponsored my application to Dr. Cohen for the position as a Robert G. Petersdorf Scholar-in-Residence.

Near the end of my Petersdorf Scholar-in-Residence, Robert Dickler and Jordan Cohen offered me the opportunity to stay at the AAMC to lead the formation of this professional development group, a position that I accepted because I share their commitment to fostering clinical excellence in order to enhance both undergraduate and graduate medical education. To reiterate, none of this could or would have happened without the Petersdorf Scholar Program, and Jordan Cohen’s interest, commitment and support. Along the way, I gained an even greater respect for Dr. Cohen’s leadership, vision, communication skills, ethical values and commitment to diversity in medical education and health care for all segments of society – a constellation of skills and values that is truly remarkable and benefits all who are fortunate enough to experience them.

PRODUCTS

The survey results have been analyzed and the manuscript prepared and submitted for peer review publication.

For the AAMC, I expect the more important product will be the formation of the professional development group for AMC-based CMOs, not unlike the professional development groups for practice leaders (GFP), residency leaders (GRA) or student leaders (GSA). We have begun that process by sponsoring a day long meeting for Chief Medical Officers during the 2006 AAMC Annual Meeting in Seattle.

The results of the survey were reported at a related AAMC seminar in January 2005, to the Council of Teaching Hospitals Governance Meeting in February 2006, and at a special plenary session during the Council of Teaching Hospitals and Health Systems Administrative Board Spring Meeting in April 2006.

BIOSKETCH

Dr. Longnecker is Director, CMO Program in the AAMC Division of Health Care Affairs, and the Robert D. Dripps Professor Emeritus of Anesthesiology and Critical Care at the University of Pennsylvania School of Medicine. He spent his prior career as a physician-scientist, physician-educator and physician-administrator, first at the University of Missouri, then at the University of Virginia where he was the Harold Carron Professor of Anesthesiology, and subsequently at the University of Pennsylvania where he served successively as Chair of Anesthesiology, Vice Dean for Professional Services and Senior Vice President-Corporate Chief Medical Officer of the University of Pennsylvania Health System. Dr. Longnecker is the author of numerous scientific articles and chapters and the editor of six medical textbooks in anesthesiology and three reports from the IOM, including one related to astronaut health and another to risk reduction strategies for human exploration of space. In addition, he served as President, American Board of Anesthesiology; President, National Resident Matching Program; Chair, AAMC ERAS Committee; President, Association of University Anesthesiologists, and President, W.T.G. Morton Society. Elected as a fellow of the Royal College of Anaesthetists (UK) and member of the Institute of Medicine (IOM), he chairs the IOM Committee on Aerospace Medicine and Medicine for Extreme Environments and is a member of the National Advisory Council of NASA.
The project is a study of leadership. Leaders in medicine must facilitate change across competing missions, organizational structures, cultures and budgets. This involves creating interactions and links across organizational units of autonomy. They are working with a diverse constituency that includes physicians who are selected and trained to be autonomous. These individuals are hard working and strive for ever-increasing excellence and prominence in the area of individual responsibility. Many of the leaders are themselves physicians and have been formed by the system that values autonomy above all.

The problem, then, is a paradox. How do leaders schooled in a culture of autonomy lead others with a similar background to create effective change, when the power and capacity for that change is generated by the energy of interactions that challenge autonomy?

Complexity science has identified a few simple rules by which complex adaptive systems operate.

- The source of emergence, the process of movement from chaos to creative change, is the interaction of agents who mutually affect each other.
- Small changes can lead to large effects.
- Emergence is certain but there is no certainty as to what it will be.
- Greater diversity of agents in a system leads to richer emergent patterns.

Our hospitals and academic health centers are complex systems and there are simple rules that govern their leadership. Complexity science offers a new perspective on leadership suggesting that interactions and relationships are the energy or currency of our business and that creativity, culture and productivity generating emergence, stem from these connections. In short, a component of the power of leadership is the capacity generated in relationships and interactions.

The purpose of the study is to investigate the leadership of universities with academic health science centers to discover tools and strategies used by presidents, CEOs, vice presidents and deans to successfully navigate change in an environment that values independence and autonomy and where people must work together in diverse teams. Structured interviews with presidents, CEOs, vice presidents
and deans are under completion. The leaders discussed their leadership of a complex issue that cuts across disciplines, missions and budgets.

The project has been a true learning process for me. It has been a privilege to speak with the leaders of our institutions about the challenges they face. I have been struck by the similarities of the challenges across institutions and across disciplines. My thinking and reflection about these leadership cases are framed by knowledge of chaos theory and complexity science. The opportunity to study these new sciences has broadened my understanding of complex systems and of leadership.

In pondering the conclusions drawn from the project there are discernible simple rules for leadership of our complex health systems as has been predicted by the new science. The project has revealed that we do not prepare our leaders for leadership, that we do not select our leaders based on qualities essential to leadership and that we are fortunate that our leaders have the ability to learn as they go.

**MOTIVATION AND REFLECTIONS**

Throughout my life I have always had three goals before me, one educational, one physical and one spiritual. Several years ago I ran my first marathon, which was a major physical goal. I decided this was a good time for a major educational goal. I had never had a sabbatical and my professional focus had been one of administration and leadership. I could not pass up the opportunity to study in depth what I had been practicing. The added opportunity to contribute to the knowledge in the field was just icing on the cake! This was an opportunity for educational growth in three venues, reflection on experiential learning from my previous leadership experiences, study of chaos theory and the science of complex adaptive systems, and research through structured interviews with the leadership of academic health centers. It is a luxury to take time from a busy administrative career to reflect, learn and grow.

The experience of being a Petersdorf Scholar-in-Residence has been enlightening personally and professionally. It should be a requirement for midlife! I am most thankful for the opportunity.

**PRODUCTS**

This research is still in progress and will result in a report and peer reviewed publications in the near future.

A series of presentations will be scheduled when the work is completed and key aspects will be featured during a special session at the 2006 AAMC Annual Meeting.

**BIOSKETCH**

Dr. German is a graduate of Harvard Medical School, was a resident in medicine at Strong Memorial Hospital at the University of Rochester, and took a fellowship in rheumatic and genetic diseases at Duke University. Dr. German began her faculty work at Duke in the Howard Hughes Medical Institute studying adenosine metabolism. She was also Associate Dean of Medical Education at Duke. Next she spent 13 years at Vanderbilt practicing rheumatology and serving as the medical education dean. During that time she was national chair of the AAMC Group on Student Affairs and Vanderbilt was ranked first in the nation in student satisfaction. She left Vanderbilt to lead Saint Thomas Hospital in Nashville as its president and CEO and was chief academic officer of Saint Thomas Health Services. At Saint Thomas she led a successful hospital turn around and improved patient, staff and physician satisfaction.
DESCRIPTION OF PROJECT

My project has allowed me to attempt to further articulate the “clinical-care gap”, the disconnect between knowledge about best treatment practices and actual care, or the gap between what we know we should be doing and what we are doing. While a key component to closing that gap might be construed as continuing medical education, there is a problem with our current understanding and delivery of CME: it is unable, in its current state, to adequately help physicians meet the needs of patients. In the end, any discussion about CME must revolve around patients, especially in the context of physician practice and patient outcomes. And it is apparent that patients are not getting the best quality of care at all times.

Thus my goals for this initiative were to focus on the root causes of CME’s ‘failure’, not in a negative or critical sense, but in the spirit of helping make the system better. There are at least three elements to any improvement process, couched as recommendations from my work as a Petersdorf Scholar. First, we need to be able to undertake much more comprehensive and effective CME interventions, a process which will require new funding for CME and new understandings of information delivery methods. Second, we need to re-align the CME credit system with patient care, effective self-directed learning and health care outcomes – not on attendance at CME events. Third, we must assure that best evidence drives the system – not only in a clinical or research sense, but also in an effort to use best implementation strategies.

These recommendations are anchored in, and must use the platform of the huge enterprise devoted to CME, the maintenance of competence and continuous professional development. Further, any improvement must be grounded on the large body of papers, reports and studies about the delivery, accreditation and effect of CME.

Being a Petersdorf Scholar has allowed me the opportunity to review and distill what we know about CME and its place in health care, and to identify as well as respond to some of the definitive barriers to change. In the clinical realm this process would be akin to extracting the key recommendations from clinical practice guidelines, finding those supported by best evidence, developing tools to help the quality improvement process and then moving forward to implement best practices.
**MOTIVATION AND REFLECTIONS**

I am grateful for the opportunity to apply this methodology to CME credit and delivery and look forward to seeing its product, continuing to meet with colleagues who can digest and implement its findings and contributing to the creation of an environment in which patient care and physician performance are the measurables of health care and CME, and supported by best-practice educational activities.

**PUBLICATIONS**

This research and policy-writing will conclude in the summer of 2006. To date, the research has produced a draft policy document for internal review at the AAMC, forming the basis for a report for future, broad dissemination to the educational community. It is anticipated that several peer-reviewed publications will also contribute to the literature on continuing medical education.

**PRESENTATIONS**

Workshop on the Clinical Care Gap and Knowledge Translation: The New Future for CME, March 2006, University of Colorado Health Sciences Center, Aurora

Knowledge Translation: A Hot Topic In CME, Society for Academic Continuing Medical Education Spring Meeting, April 2006, Key West, Florida

Opening Plenary: Not Your GrandMa’s CME: The Clinical Care Gap, the Death of Credit and the Emerging Discipline of Knowledge Translation, Western Group on Educational Affairs Spring Meeting, April 2006, Asilomar, California

Several more presentations at various national meetings are planned during the coming year.

**BIOSKETCH**

Dr. Davis is Professor of Health Policy, Management and Evaluation and Professor of Family and Community Medicine at the University of Toronto. He also serves as Principal Investigator of the University of Toronto Li Ka-Shing Center for Knowledge Translation at St Michael’s Hospital and is Chair of the Guidelines Advisory Committee of the Ministry of Health and Long-term Care for Ontario and the Ontario Medical Association. From 1994-2005, he was Associate Dean, Continuing Education, Faculty of Medicine, University of Toronto. Dr. Davis completed his medical training at the University of Toronto and entered private family practice in Burlington, Ontario, where he began his life-long interest in continuing medical education. Following his development of the inter-professional continuing education program at Burlington’s Joseph Brant Hospital, in 1977 he was appointed Director of Continuing Medical Education at the new McMaster University Faculty of Health Sciences. An honorary member of the Royal College of Physicians and Surgeons of Canada, Dr. Davis has won numerous awards, most recently the Ian Hart Award for Contributions to Medical Education from the Canadian Association of Medical Education. In addition he has authored more than 100 peer-reviewed publications, dozens of chapters and edited two major books on CME practice.
DESCRIPTION OF PROJECT

The Association of American Medical Colleges has played a major leadership role in educating for professionalism through a sustained series of activities over the past several decades. More recently, professionalism has been identified and mandated as a competency throughout the educational spectrum – from admission to medical school through maintenance of certification.

Building on the AAMC’s extensive portfolio coupled with the substantive work of two former Petersdorf scholars, Drs. Herbert Swick and Thomas Inui, a creative initiative is underway to learn how institutions are addressing ‘professionalism’ and to identify innovative approaches and best practices to inform the efforts of all AAMC constituents. This activity is in concert with previous recommendations from the AAMC Council of Deans for follow-up on determining the state of medical education for professionalism.

The work involves a series of 2-3 day visits to 12 US and Canadian medical schools and academic medical centers identified by the AAMC senior staff and galvanizes a unique opportunity to identify and document what professionalism means and the success factors which transform the institutional culture and environment to educate accordingly. The work is not confined to determining what the curriculum provides about professionalism but also what is transmitted through the institution’s corridors and cafeteria.

Short structured interviews are conducted with institutional leadership including the dean of the medical school, health system CEO, chief financial officer, other deans and key faculty, medical students and house staff. Using appreciative inquiry, the work is advanced through a set of core questions and a brief reflective exercise regarding what does the term “professionalism” mean and describe the culture and environment of the institution and its roles in educating for professionalism.

The project will conclude at the end of 2006 with a comprehensive report of the findings, and best practices and set of recommendations that can help inform other institutions involved in such transformation as well as the AAMC. Several peer reviewed publications are planned in addition to a panel presentation at the 2006 AAMC Annual Meeting.
MOTIVATION AND REFLECTIONS

The extraordinary opportunity as a Petersdorf Scholar brings the joy of pursuing my enduring interest in professionalism in the context and complexity of medical education and the unique roles of institutional culture and environment. The gift of time, new friendships, and the stimulus of discovery are empowering as are the rich culture and nurturing environment of the AAMC in its ongoing education and professional development of staff. It is a privilege to engage in exciting work that can contribute to advancing the profession as a whole and to join in honoring and celebrating the leadership legacy of Robert Petersdorf and Jordan Cohen.

PUBLICATIONS


PRESENTATIONS


Witzburg RA, Baffi-Dugan C, Blank LL, Papadakis MA: GSA Plenary Session: Professionalism in Medicine — What Are We Looking For and How Do We Find It? AAMC Annual Meeting, October 30, 2006

BIOSKETCH

Ms. Blank is currently a Petersdorf Scholar-in-Residence at the Association of American Medical Colleges and a member of the Arnold P. Gold Humanism Honor Society Advisory Council and Chair, Awards and Nominations Committee. She is a recipient of the AAMC Special Recognition Award (2004) and an Honorary Fellow, European Federation of Internal Medicine (2005) in conjunction with her work to advance the physician charter on medical professionalism. In addition, she is an Honorary Fellow of the Gold Foundation Humanism Honor Society (2004), and a recipient of the distinguished Loveland Award of the American College of Physicians (2001), Founders Award of the Association of Program Directors in Internal Medicine (1997) and Special Recognition Award of the Association of Professors of Medicine (1997) for her contributions to graduate medical education and the internal medicine community. She enjoyed a 25-year career with the American Board of Internal Medicine and concluded her tenure as Senior Vice President, ABIM Foundation in September 2005.
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“In the Division of Medical Education, we have been incredibly fortunate to have a number of distinguished senior level individuals join us as Petersdorf Scholars over the years – beginning with Gene Kallenberg and Carl Hunt, then followed by Herb Swick, Don Nutter, Tom Inui, Gene Corbett, Dan Winship, and this year – Dave Davis and Linda Blank. Because of their vast experience and general qualifications, they have contributed much to the division’s agenda and the AAMC’s mission, and at very little cost to the Association. In virtually all cases, the scholars were able to work independently thereby being able to lead projects that otherwise would have required a substantial time commitment from our very busy fulltime staff. In fact, I doubt that it would have been possible to achieve the results produced by the scholars in any other way. They not only contributed through their expertise, insights and commitment, they added an exceptional personal touch to the culture and environment of the AAMC. The experience also enriched the scholars, provided new opportunities and was instrumental in their own career development.” – Mike Whitcomb

“Each of the Petersdorf Scholars I have had the pleasure to work with – Malcolm Cox, Joel Kupersmith, Chip Rice, David Longnecker, and Deb German – has undertaken projects of enormous value to the Association’s membership. Of equal importance, during their time at the Association they have become valuable colleagues who have provided new insights drawing on their ‘real world’ experiences for many of the issues we deal with.” – Bob Dickler

Robert G. Petersdorf, MD
President
Association of American Medical Colleges
Washington, DC
1986 – 1994

Scholar, leader, educator, communicator, mentor, healer, innovator